Curtin School of Allied Health

Factors Influencing Access to Paediatric Speech Pathology Services in Western Australia

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Human Ethics

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number HRE2018-0116.

Signature:

Date: 9/2/2022

Abstract

Between 5% and 12% of children have Speech, Language, and Communication Needs (SLCNs). SLCNs impact a child's Health-Related Quality of Life, and over time their academic and financial success. It is important to address SLCNs, but some families find service access difficult, while others may be unable to access appropriate services.

A model of access to paediatric speech pathology services in Western Australia was constructed using a Constructivist Grounded Theory approach. Semi-structured in-depth interviews focussed on perspectives and experiences of speech pathology service access were conducted with caregivers of children who have SLCNs, and speech pathologists who provide services to children with SLCNs.

Analysis of interviews identified that service access is multifactorial. Families needed a range of resources to initiate and maintain services, each of which presented different challenges for each family and service combination. The Model of Access to Speech Pathology Services (MASPS) can be used to improve service access through informing the design or review of service provision, as well as providing recommendations to families, and speech pathologists.

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There are many people who have supported me directly and indirectly to complete my PhD. More than this, these people have made completing my PhD a truly enjoyable experience. Without you, this thesis and my life would not be the same.

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Acknowledgement of Country

We acknowledge that Curtin University works across hundreds of traditional lands and custodial groups in Australia, and with First Nations people around the globe. We wish to pay our deepest respects to their ancestors and members of their communities, past, present, and to their emerging leaders. Our passion and commitment to work with all Australians and peoples from across the world, including our First Nations peoples are at the core of the work we do, reflective of our institutions' values and commitment to our role as leaders in the Reconciliation space in Australia.

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List of Abbreviations

Australian Bureau of Statistics	ABS
Australian Qualification Framework	AQF
Australian Statistical Geographic Standard Remoteness Area	ASGS-RA
Better Start for Children with a Disability	Better Start
Chronic Disease Management Plan	CDM Plan
Constant Comparative Analysis	CCA
Constructivist Grounded Theory	CGT
Health-Related Quality of Life	HRQL
Helping Children With Autism	HCWA
Human Research Ethics Committee	HREC
International Classification of Functioning, Disability and Health	ICF
Model of Access to Speech Pathology Services	MASPS
National Disability Insurance Scheme	NDIS
Socio-Economic Indexes for Areas – Index of Relative Socio-economic Advantage and Disadvantage	SEIFA-IRSAD
Speech, Language, & Communication Need	SLCN
Speech Sound Disorder	SSD
Speech-Language Therapy	SLT
Western Australia	WA
World Health Organisation	WHO

1. Personal Context Statement

As a new graduate speech pathologist prior to commencing my PhD, I had conversations with other recently graduated speech pathologists about the unexpectedly high rate at which families did not attend appointments. These conversations typically led to discussions of families being unmotivated, or simply not motivated enough to attend services. I found the outcome of these discussions incongruent with my worldview for two reasons. Firstly, families were typically discussed within a binary framework as being ‘motivated’ or ‘unmotivated’ to access services. Secondly, the families who were described as unmotivated were also typically described as being from lower socio-economic backgrounds.

I found the notion challenging that families were either motivated or unmotivated, as this seemed a simplistic outcome of a complex set of dynamics that make up each family unit. I have had significant and ongoing health needs in my life that resulted in surgery at the age of 14. In the lead up to this, my family and I met with a range of health professionals over many years. In order to balance my lifestyle and the lifestyle of my family, we followed some health advice closely, and other health advice less so. Our family may have been interpreted to be unmotivated by those professionals whose advice we did not follow closely. Now as a health professional, coming to the end of a research project investigating service access, I reflect that my family were highly motivated to seek and follow health advice. However, this may not have been the perspective of all the health professionals with whom we interacted.

With reference to socio-economic status, I grew up in a household that was middle income (Organisation for Economic Co-operation and Development; Organisation for Economic Co-operation and Development, 2019a, 2019b), but in a suburb of Perth, Western Australia’s (WA’s) state capital, that is typically viewed as having a lower socio-economic status. As such, on paper our family may have appeared to some health providers to support the narrative that people of lower socio-economic backgrounds were unmotivated to access health services. Conversations with my speech pathology peers around the impact of family’s low socio-economic status impacting on their access of services occasionally centred around discussing clients in stereotypically low socio-economic suburbs, including the one in which I grew up and lived as a new graduate.

While working at a specialist government primary school as a speech pathologist I provided services that sought to address my clients’ speech and language needs, and was required to refer families to a range of service providers for clinical services related to other range of practice areas (Speech Pathology Australia, 2016). In referring clients on, I found that some families experienced difficulty in accessing services, while others accessed services with relative ease. I wanted to be able to best support each of my clients to be able to access the services that would support them to engage in their education.

As access to speech pathology services is part of the application process to the school where I work, the speech pathology community typically view these children as having good access to services relative to the broader population. Despite this, I observed that some families still experienced difficulties with accessing services. Thinking of the broader community, for me it was logical to draw the conclusion that there were families who were not able to access speech pathology services, and who were therefore not able to apply to enrol within the specialist school.

The school had a proactive and policy-driven approach to absenteeism, and so I felt that my approach to speech pathology service access could also be driven by a theory or framework, and that perhaps there were proactive steps that we as an organisation could take to best support our clients and their families. In mid-2016, I began looking for models of service access within the context of my work. I was unable to find one and so reached out to Suze Leitão, Mary Claessen, and Peta Dzidic. I had worked with Suze and Mary across different research studies through both workplace projects and my honours research. Peta was introduced to me as their colleague who had more experience with methodological aspects of model generation. The discussions that we had around service access for my clients, and broadly for the speech pathology profession in WA, helped to form the basis of my PhD research. As part of these discussions we identified that there was no existing theoretical model of service access, and as such felt that an inductive approach with the goal of creating a model would be most appropriate. For these reasons Constructivist Grounded Theory (CGT; Charmaz, 2012) was selected as the appropriate method for this research.

Within my research, I interviewed caregivers of children with Speech, Language, and Communication Needs (SLCNs) and clinicians who provide services to children with SLCNs. Participants from both groups accessed or provided speech pathology services in WA. As a speech pathologist working in WA, and knowing that health is managed at a State Government level in Australia I felt that it was important to make use of the existing legislative boundary, containing my data collection within WA. At the time that I began my PhD candidature, service access literature predominantly included the perspectives of clinicians reflecting upon their provision of services. While these views are important, I felt that it was also important to include consideration of the perspectives and experiences of families. I sought to approach my research as a researcher who had insider experiences and knowledge, rather than solely as a ‘speech pathologist’. However, I felt that I would be perceived mainly as a speech pathologist who was conducting research, and that this would mean different things for each of my participant groups.

As my research considers my own profession, I attempted to appreciate my professional knowledge and experiences rather than to diminish them. For me, this meant appreciating that each participant had knowledge and experiences that would inform their perspective of me as a speech pathologist, and therefore inform the data they shared within their interviews. During data collection some participants felt that I understood their point. Both clinician and caregiver participants demonstrated this by summarising answers with ‘you know what I mean’ or ‘you know what it’s like’ when discussing speech pathology services. In these instances, I encouraged participants to expand on their comment by using prompts similar to ‘could you elaborate… for the sake of the recording?’. This allowed me to encourage participants to explain their contributions more fully without having to highlight that we may have held different perspectives. In this way, I sought to reduce the assumptions that I was required to draw from interview data, and in doing so sought to base data analysis on the dataset, rather than in my own perspective/s.

While I am not a caregiver and am in that respect an outsider to one of the project’s participant groups, caregivers seemed to answer more fully when speaking about their experiences of parenting. This may have been because they viewed me as a ‘speech pathologist’ in addition to, or perhaps rather than as a ‘researcher’. In this way caregivers may have perceived the research to be collecting data on their perspectives as non-speech pathologists and outsiders in their own right. However, it is also worth considering that caregiver participants accurately understood that I was not a caregiver myself, and so provided more rich and detailed descriptions to me as an outsider with regard to parenting.

Throughout data collection I occasionally shared specific information about my work context with some participants in order to foster positive research relationships. Some caregivers discussed experiences of how speech pathology and education intersected either positively or negatively, potentially without knowing that I work as a speech pathologist within the Department of Education. Where I felt that participants were editing their responses because they were aware that I work in education, I reassured them that their contributions would be deidentified, and that the research outcome would be stronger if they were comfortable to share a full description of their perspectives and experiences. Additionally, some caregivers shared negative perspectives or described experiences of speech pathology in education, without knowing that I work in education. In these cases, I told participants at the end of the interview that I work in an education setting, while also reassuring them of their anonymity and thanking them for their candour. This led to some caregiver participants sharing their surprise and occasionally offering an apology. However, I felt that it was best that my employment within the Department of Education was disclosed immediately following their interview, and that I could assure them directly that the content of their interview was supportive of the research.

Within analysis I reflected on my group membership through memo creation. In particular, I noted instances where participants of either group shared perspectives and experiences that were unexpected, based on my own previous experiences. In addition to this, quality procedures were put in place to ensure that the model was grounded in the dataset from which it is built. Doing so was supportive of seeking to investigate access a social construct, in which the experiences and perspectives of both caregivers *and* clinicians integrated.

Within this Personal Context Statement, I have sought to state the basis of actions that led to my PhD research, and to acknowledge the aspects of myself as a member of the WA community that are relevant to this research. Within this research, I have not sought to directly address the impact of socio-economic status or parental motivation on the utilisation of speech pathology services. Rather, I have sought to use CGT to gain an understanding of access to paediatric speech pathology services in WA that is grounded in data drawn from the perspective and experiences of both caregivers and clinicians as decision makers within service access.

2. Background

Communication difficulties

Communication difficulties are reported to affect between 5% and 12% of the paediatric population (Cronin, Reeve, McCabe, Viney, & Goodall, 2020; Law, Reilly, & Snow, 2013; Snow, Bagley, & White, 2017). This population is heterogeneous due to the broad and varied nature of paediatric communication difficulties (Gascoigne & Gross, 2017). The term Speech, Language, and Communication Need (SLCN; Bercow & Department for Children Schools and Families, 2008; Law et al., 2013) refers to all communication difficulties faced by this group, including difficulties with hearing, language, speech, voice, stuttering, and pragmatics. SLCN is a broad term which encompasses all aetiologies, and captures functional communication needs that can be developmental, acquired, or disordered in nature, irrespective of a diagnosis (Bishop, Snowling, Thompson, Greenhalgh, & CATALISE Consortium, 2016). The impact of any given communication difficulty on an individual is dependent on their own context (Kilpatrick, 2020; World Health Organisation Quality of Life Group, 1995); however, the presence of SLCNs increases the risk that an individual will have a reduced Health-Related Quality of Life (HRQL; Kilpatrick, 2020; McCormack, McAllister, McLeod, & Harrison, 2012; Ruben, 2000; Sugden, Baker, Munro, & Williams, 2016). HRQL is used to describe the extent to which health status impacts an individual's ability to lead a fulfilling life (Hilari, Cruice, Sorin-Peters, & Worrall, 2015; Hilari, Needle, & Harrison, 2012; World Health Organisation Quality of Life Group, 1995). SLCNs that are not addressed can impact an individual's communication across their lifetime, and have the potential to influence options available to those individuals, which can in turn influence their HRQL (Cronin et al., 2020; Snow et al., 2017). In young children SLCNs can limit opportunities for social interaction (Biggs, Carter, Bumble, Barnes, & Mazur, 2018; Gertner, Rice, & Hadley, 1994), participation in academic tasks (Jackson, Leitão, Claessen, & Boyes, 2021), and throughout their lifetime, can be associated with potential limitations in career choice, differences in financial success (Cronin et al., 2020; Ruben, 2000), and an increase in the risk of social isolation (Gertner et al., 1994; I CAN, 2017). Broadly, having an SLCN can be seen as impacting a child's academic, social, and vocational occupations (Jackson et al., 2021; Signor, Claessen, & Leitão, 2020). Higher rates of SLCNs have been identified in youth justice and incarcerated populations (Anderson, Hawes, & Snow, 2016; Snow et al., 2017), and rough sleeping populations (L. Andrews & Botting, 2020) as compared to the general population.

However, the reason for the correlations within these populations is not clear (Anderson et al., 2016; L. Andrews & Botting, 2020; Snow et al., 2017).

SLCNs are also associated with lower levels of academic qualifications (Conti-Ramsden & Durkin, 2012; Cronin et al., 2020), lower rates of employment (Catherine Carroll & Dockrell, 2012; Clegg, Hollis, Mawhood, & Rutter, 2005; Conti-Ramsden & Durkin, 2012), and communication difficulties in later life (Clegg et al., 2005). Given that the proportion of workplaces that rely on their employees' communication skills is increasing over time (Börner et al., 2018), SLCNs in the workplace have an increased potential to reduce overall productivity (Ruben, 2000) by impacting both the employee (Catherine Carroll & Dockrell, 2012; Clegg et al., 2005; Hilari et al., 2012) and the employer (Ruben, 2000). In addition to lower rates of employment (Clegg et al., 2005; Conti-Ramsden & Durkin, 2012), groups with lower language performance and/or SLCN are more likely to experience restricted choice in type of employment, due to differences in academic achievement (Conti-Ramsden & Durkin, 2012; Cronin et al., 2020; Ruben, 2000); can experience greater difficulty with attaining employment (Catherine Carroll & Dockrell, 2012); and, are more likely to be accessing welfare support (Clegg et al., 2005) than peers without communication difficulties. In these ways SLCNs can have an ongoing effect on individuals lives in both a direct and indirect manner.

SLCNs have several potential negative impacts on the HRQL of children (Feeney, Desha, Khan, & Ziviani, 2017), both in their immediate context (Biggs et al., 2018; McCormack et al., 2012), and potentially throughout their life (Hilari et al., 2015; Kilpatrick, 2020; Ruben, 2000). Measures of HRQL and/or Patient-Reported Outcomes are used infrequently within speech pathology practice (Cohen & Hula, 2020). Typically, speech pathologists measure the outcome of intervention as being an improvement in the client's desired communication behaviours (Cohen & Hula, 2020). In this way speech pathologists conceptualise, at least in their clinical measurement, the burden placed on the HRQL of children with SLCNs to be rooted in the SLCN itself. Feeney et al. (2017) outlines that the Disability-Stress-Coping model can be applied to view speech pathologists as managing children with SLCNs as having a chronic illness that requires multi-factorial management which changes over time. In this way, speech pathologists view the improvement of behaviours related to SLCN, as reducing the overall burden on an individual's HRQL. Consequently the successful delivery of speech pathology services is seen in the clinical measurement of improvement in clients' communication behaviours (Cirrin & Gillam, 2008; Leitão et al., 2017).

In the following paragraphs, I will outline how access has been explored within the existing literature, within both speech pathology services and more broadly within allied health and medical services. In line with the use of a CGT approach, this Background chapter not intended to be a comprehensive summary of the literature (Charmaz, 2012). Rather, the aim of this chapter is to present the literature that has been used to contextualise the research (Charmaz, 2012) within this thesis as related to the broader range of service access literature. In this vein, the focus is on literature that was published prior to this research commencing, however more recent publications have also been included. The following paragraphs will explore concepts of service access as well as literature related to service access for a range of health professions including speech pathology.

Existing Definitions of Access

Access is not clearly defined within healthcare literature. Some authors consider access to include the freedom to make use of a service, and in doing so differentiate between service access, and seeking and/or receiving services (McAllister, McCormack, McLeod, & Harrison, 2011; Wylie, McAllister, Davidson, & Marshall, 2013). Some authors consider access to include the freedom to make use of services, and seeking of services, but not the receiving of services (Mesidor, Gidugu, Rogers, Kash-MacDonald, & Boardman, 2011; Ruggero, McCabe, Ballard, & Munro, 2012). Access can also be considered to include the freedom to make use of services, as well as the processes of seeking and receiving services (McLeod, 2006). Throughout this thesis, ‘service access’ is used to refer to the broader concept, which includes the freedom to make use of a service, and the processes of seeking and receiving those services (Kovandžić et al., 2011; McLeod, 2006). Similarly, ‘services’ is used to refer to the collective assessment, intervention, and clinical management offered by clinicians and their colleagues through organisations as service providers. In this way ‘services’ does not refer to broard public health campaigns aimed at the general public. Given the definition of ‘service access’ above, the ‘services’ that are being discussed are ones that are sought or provided regarding the specific needs of a client, rather than generic services that a client would receive regardless of their specific needs.

Data analysis initially focussed on the temporal process of service access, which is to say the phases and sub-phases from seeking and attending services through to discharge from services. Charmaz (2012) suggests that analysis of this sort is appropriate when investigating procedural constructs in order for the researcher/s to place properties on a logical framework to discuss initial properties and proto-categories. The final model that has been constructed as part of this research does not specify properties and categories that relate to specific sub-phases of service access. However, where content is relevant to phases or sub-phases, this will be made clear to the reader.

Rates of access to speech pathology services

While speech pathologists are able to support children with their SLCNs (Speech Pathology Australia, 2020b), not all families access speech pathology services (McAllister et al., 2011; Skeat, Eadie, Ukoumunne, & Reilly, 2010; Skeat et al., 2014). For example, given that heightened parental anxiety is an indicator for referral for Speech Sound Disorder (SSD; Morgan et al., 2017), it is concerning that a third of families who had concerns about their child’s possible SSD had not sought support from a speech pathologist within McAllister et al.’s (2011) study. The most common reason given by parents was not perceiving services as being needed, despite their level of concern or the level of concern expressed by their child’s teacher (McAllister et al., 2011; McCormack et al., 2012). However, parents have been identified as one of the most reliable stakeholders for correctly identifying presence of a SSD (Harrison, McLeod, McAllister, & McCormack, 2017). This supports the view of Morgan et al. (2017) that parental concern can be used as a marker for the need for services. Similarly, Skeat et al. (2014) identified that parental concern was the strongest predictor of service use. Only around half of the families of children who had been identified as having a SLCN at four years of age, had both sought and received professional support by age five (Skeat et al., 2014). McAllister et al. (2011) identify that approximately 17% of families of children with SSDs who did seek speech pathology services were unable to access them, thus highlighting issues around service access. The possibility that there are factors within caregivers’ experiences that may impact their rate of access to intervention services for their child’s SLCN highlights the need for theoretical investigation of access to speech pathology services.

Models of Health Service Access

While there are few defined models of health service access, the differences between key models demonstrate that there are options in the way that health services are designed. As the speech pathology profession moves forwards, it is important that individual providers, as well as professional bodies adopt an understanding of service access that is aligned with their values and the provision of services that they wish to create. Law et al. (2013) suggest that an approach to health care which considers the existence of health care services as part of the community, such as within a public health model, may be appropriate for speech pathology as it would facilitate education of the community on SLCN to improve uptake of services. Further, Speech Pathology Australia (2016) has expressed their intention for Australia to have a speech pathology workforce that will use service delivery model/s that consider client perspectives as well as service equity. However, Speech Pathology Australia (2016) acknowledges that investigation is needed to inform such planning. Investigation into speech pathology service access is needed in order to move the profession towards providing services that are considerate of consumer perspectives, such as those proposed by Speech Pathology Australia (2016) and/or Law et al. (2013).

There are existing models of service access, such as the Health Service Coverage Model (Tanahashi, 1978) and the Cultural Determinants of Health Seeking model (Saint Arnault, 2018). The Health Service Coverage Model provides insight to the process of accessing health services, and the resources required for service utilisation (Tanahashi, 1978). However, this model is grounded in a perspective of ‘provision’ rather than ‘access’ and as such is more closely tied to transactional healthcare, where the focus is on the service/s delivered, rather than on relational healthcare in which the therapeutic relationship between health professional and consumer is the focus of care (Gray, Sidaway-Lee, White, Thorne, & Evans, 2018; Reeve-Johnson, 2016). Using a provision-based framework to guide investigations into service access would be inconsistent with more recent shifts towards understanding service access from a consumer perspective (Speech Pathology Australia, 2016), as well as challenging in relation to existing definitions of access to allied health services (McLeod, 2006; Mesidor et al., 2011; Ruggero et al., 2012).

The Cultural Determinant of Health Seeking model (Saint Arnault, 2018) considers the seeking of health services by consumers within their community. As outlined above, the seeking of services is only one important part of service access (McAllister et al., 2011; McLeod, 2006; Mesidor et al., 2011; Ruggero et al., 2012). While the seeking and coverage of a service within a community are important within the overall access of health services by that community, as summarised below, not all families are able to access speech pathology services, even when they are aware of how to seek services for which there is availability (McAllister et al., 2011). If, as speech pathologists, we are intending to review our service provision to the community (Speech Pathology Australia, 2016) it is important to be able to consider factors impacting service access, including consumer perspectives, and through phases of service access.

Factors Impacting Service Access

The following paragraphs outline the factors affecting service access from the research literature. These factors are discussed in steps of increasing relevance to speech pathology services in WA.

Healthcare Service Access Outside Australia

Research conducted outside Australia into access to healthcare has focussed on medical services (Kovandžić et al., 2012; Mesidor et al., 2011), and specific needs, such as Autism Spectrum Disorders (Chiri & Erickson Warfield, 2012), physical disabilities (Scheer, Kroll, Neri, & Beatty, 2003), or aging populations (Batsis et al., 2019; Sze & Christensen, 2017). Some studies have considered the impact of the structure of healthcare systems on consumers, with a focus on the direct costs associated with facility usage (Gitobu, Gichangi, & Mwanda, 2018), challenges faced by consumers of services in rural areas (Graham & Underwood, 2012), as well as the impact of perceptions of disability held by first-nations populations (Hickey & Wilson, 2017).

Transportation access was a common factor identified within the literature as having impact on consumers' ability to access services (Gitobu et al., 2018; Mesidor et al., 2011; Scheer et al., 2003) in both rural (Graham & Underwood, 2012) and urban (Sze & Christensen, 2017) areas. However, as Graham and Underwood (2012) highlight from their interviews with rural consumers, transportation access is not necessarily more difficult in rural areas, but rather made complex by the great distances that need to be covered to attend services.

High cost of treatment was identified by a number of studies (Chiri & Erickson Warfield, 2012; Gitobu et al., 2018; Mesidor et al., 2011). Both Mesidor et al. (2011) and Gitobu et al. (2018) suggest addressing the high cost of treatment in different ways. Mesidor et al. (2011) explored the perspectives of administrative staff, program directors, service providers, and a nurse practitioner on the role of a nurse practitioner as a healthcare advocate for people with psychiatric disabilities within a behavioural healthcare setting in the USA. This research identified that having multiple avenues to pay for services, and specifically the option of using a health fund, supported access to services (Mesidor et al., 2011). Similarly, Gitobu et al. (2018) found that the national government introducing a subsidy of maternal health services in Kenya improved mothers' utilisation of these services. However, it is worth noting that not all consumers were able to access the subsidised services due to the financial impact of indirect costs, such as the financial cost of travel (Gitobu et al., 2018).

Further to this Gitobu et al. (2018) discussed the importance of cultural considerations within service access. Within their study, they identified that consumers' culturally derived perspectives of the maternal health services impacted on service utilisation. This is in line with considerations made by Kovandžić et al. (2012), who identified stigma around accessing services as an important factor of service access when exploring the experiences of English-Somali people accessing community mental health services within Liverpool in the UK. While Kovandžić et al.'s (2012) research provides in-depth information for individuals accessing mental healthcare services, some factors may be specific and therefore limited to the English-Somali population that was the focus of the research, or to the mental health services that were provided, such as ethnic-based geographic boundaries. Research such as this highlights the importance of context when considering how people access services (Kovandžić et al., 2012; Liamputtong, 2013). Notions of time and place playing a role within the context of service access are noted in Graham and Underwood's (2012) exploration of family's access of an early childhood program within two rural communities in Canada. Members of each of the two rural communities identified their needs to access services as being different to that of an urban population, but analysis of interview data suggested that there were also differences between the needs of these two rural communities (Graham & Underwood, 2012). While there are differences between rural and urban communities in terms of the way that they access services, it is important to note how this research highlights that there are factors which impact service access beyond the location of those services (Graham & Underwood, 2012).

Telehealth Services

Some researchers have acknowledged and sought to address challenges faced by rural communities by investigating the use of telehealth services (Orlando, Beard, & Kumar, 2019; Sarsak, 2020; Yousuf Hussein, Swanepoel, Mahomed, & Biagio de Jager, 2018). Telehealth is any health service provided over a distance, with the aid of digital technology (Orlando et al., 2019; Sarsak, 2020). These services can be telephone or video modes of in-person services (Orlando et al., 2019; Sarsak, 2020), or they may be services with custom hardware and/or software that have been designed for a specific purpose, or for use the use of a specific consumer or consumer group (cf. Sarsak, 2020). Allied health services, including speech pathology, have had an increased focus on the provision of telehealth services in the decade since 2010, but adoption of these service has been accelerated by the COVID-19 pandemic (Lawford et al., 2022). Telehealth is presented as being able to improve service access by addressing the high cost of travel for people living within rural communities that is associated with in-person services (Sarsak, 2020; Yousuf Hussein et al., 2018). However, service access for rural communities is impacted by more factors than travel and the location of services (Graham & Underwood, 2012). Some research has also considered the way in which telehealth supports clinicians to provide in-community and in-home services that would otherwise not be possible (Orlando et al., 2019) due to the distance of the clinic from the client.

Telehealth services are seen as an appropriate mode of service delivery by both clinical and consumer participants (Orlando et al., 2019; Sarsak, 2020; Yousuf Hussein et al., 2018), however within these studies consumers also expressed a preference for in-person services if they were available (Lawford et al., 2022; Orlando et al., 2019). However, the reason for this is not yet clear (Lawford et al., 2022; Orlando et al., 2019). While it is important that health professions continue to innovate with technology in order to ensure that services are provided to a wide range of consumers in a range of ways, providers should also seek to ensure that telehealth services are not second-rate to in-person services (Lawford et al., 2022; Orlando et al., 2019; Sarsak, 2020; Wylie et al., 2013; Yousuf Hussein et al., 2018). This is also important given that telehealth can be seen as supporting the access of marginalised populations (Lawford et al., 2022; Orlando et al., 2019). In their work, Sarsak (2020) encourages occupational therapists to consider that their professional codes of practice apply to telehealth service provision, just as they do to in-person service provision.

While the COVID-19 pandemic has accelerated consumers’ use of telehealth services, it is important to consider that the cost and infrastructure needed for telehealth services are different to in-person services, but not absent (Lawford et al., 2022; Orlando et al., 2019; Sarsak, 2020). To this end, it is important to note that the reliability of telecommunication infrastructure is variable between different nations (Orlando et al., 2019), and that even within countries such as Australia where high-speed internet coverage is common, it is not universal (Lawford et al., 2022). Furthermore, people with disabilities may face additional or a greater magnitude of difficulties in accessing the technology required for telehealth services (Lawford et al., 2022). With regard to the direct cost of services, funding sources for in-person services are not always able to be used for telehealth intervention (Sarsak, 2020). Within Australia, as of January 2022 Medicare subsidies also apply to telehealth service just as they have previously to in-person services (Department of Health, 2022), however this may not be the case with all funding options.

While telehealth services can be an effective model of service provision for rural and metropolitan consumers (Lawford et al., 2022; Sarsak, 2020), it is important for clinicians and health services to consider the balance of opportunities and challenges presented by telehealth. For example, a service may need to be adapted to be appropriately delivered via a telehealth format (Lawford et al., 2022), consumers may need access to additional technology to use telehealth services (Orlando et al., 2019), and/or a lack of telecommunication service provision may exclude some clients for participating in telehealth services (Orlando et al., 2019). Furthermore, clients with complex needs may require support to set up or use the technology associated with telehealth services (Lawford et al., 2022). While consumers indicate that they are satisfied with telehealth services, it is important to bear in mind they may also prefer future services to be in-person, or may see the quality of service to be related to the therapeutic skills of the clinician rather than the modality of service provision (Orlando et al., 2019).

Speech Pathology Service Access Outside Australia

Research conducted into speech pathology service access (outside Australia) highlights two key themes. Firstly, there is a need for community awareness of communication needs, and of the speech pathology profession (L. Andrews & Botting, 2020; Crowley et al., 2013; Glogowska & Campbell, 2004; Wylie et al., 2013). Secondly, there is a need for service delivery to be adaptable, not only to each individual client (Klatte et al., 2020; Mandak & Light, 2018) but also to individual communities or nations (Bercow & Department for Children Schools and Families, 2008; Wylie et al., 2013).

Awareness of communication needs, and the availability of speech pathology services among health professionals working with people with SLCN are important strategies in improving service provision for under-serviced populations (L. Andrews & Botting, 2020; Bercow & Department for Children Schools and Families, 2008; Crowley et al., 2013). Crowley et al. (2013) discussed the provision of speech pathology services to under-serviced populations with SLCN within Ghana, while L. Andrews and Botting (2020) explored the communication needs and lack of service utilisation of people who are rough-sleepers and long-term homeless in London. The difference in the under-serviced populations of these two publications highlights the importance of awareness as being an important factor of service access for speech pathology. In discussing awareness of communication needs, L. Andrews and Botting (2020) emphasise that it is difficult to estimate the population of people who are rough-sleeping or long-term homeless that have SLCNs, *because* the professionals working with these populations have a low awareness of communication needs and how they present. In this way, limited awareness contributed to limited availability of services.

Similarly, Glogowska and Campbell (2004) found that caregivers' awareness of communication needs within their communities played a role in how they responded to identifying communication needs within their own children. Parents who had low awareness of the relatively high prevalence of SLCN, who were then referred to a speech pathology service, experienced feelings of anxiety and isolation with regard to commencing therapy (Glogowska & Campbell, 2004). Conversely, parents who were aware of children in their community that had been supported by speech pathology services felt that therapy would be beneficial, which led to feeling responsible as a parent to act early regarding the identified SLCN. This point was also emphasised within the Bercow Report (Bercow & Department for Children Schools and Families, 2008). The report highlights that timely early intervention can reduce the ongoing burden of SLCN for individuals, but that early intervention is dependant on early *identification* of communication needs by the families and professionals within each child's community.

While awareness of the potential benefit of speech pathology services is important, both Glogowska and Campbell (2004) and Klatte et al. (2020) discuss the importance of clinicians working with caregivers to build towards therapeutic outcomes. Klatte et al. (2020) identified within their realist evaluation of clinical collaboration that speech pathology therapy can be supported to work towards participation outcomes for clients when clinicians work to build a relationship with caregivers that is based in mutual understanding and seeks to co-design tailored intervention approaches. Caregiver wellbeing (with relation to speech pathology services) is supported when caregivers are able to discuss their concerns with clinicians (Glogowska & Campbell, 2004; Klatte et al., 2020). This occurs both when caregivers are able to share their experiences of monitoring development with clinicians (Glogowska & Campbell, 2004), and when caregivers create the conditions for collaborative practice within a therapeutic relationship (Klatte et al., 2020).

On a larger scale, this link between awareness and availability of services is discussed by Wylie et al. (2013). When awareness of needs, including of communication needs, is low within a community, the priority to accurately measure and report on those needs is also reduced (Wylie et al., 2013). Wylie et al. (2013) demonstrates how different measurements of population disability across the globe inconsistently include communication needs, and that communication needs are less likely to be included in measurements of population disability in majority world nations. The way in which the prevalence of SLCNs are measured within populations can impact the way in which governments plan for and resource service provision (Wylie et al., 2013). Even within minority world countries, such as the United Kingdom, differences in the way that SLCNs are identified and recognised have been recognised as impacting the funding and subsequent services that are available for families (Bercow & Department for Children Schools and Families, 2008).

Regardless of the scale of service provision, literature on speech pathology service access has considered the importance of each service being able to adapt to the community/ies which it serves. Applying family-centred care for clients with complex SLCN allows the clinician to provide services which support the client to participate, considering the family as the recipient of services, with each family member having different roles and responsibilities within intervention (Mandak & Light, 2018). While one therapist may work in a family-centred approach with most or all clients on their caseload, the steps they take for intervention for each family would look different, as interventions are adapted not only to each client, but to the diverse contexts of their families (Mandak & Light, 2018). Mandak and Light (2018) indicate that family-centred services can also appear differently for the same family at different times. For example, as a client becomes more mature and is less likely to have their primary caregiver attend speech pathology services with them in the clinic room, the clinician can modify their approach to suit the changing needs of their therapeutic relationship (Mandak & Light, 2018). Similarly, service designers are able to take into account the culture of individual communities in order to best support the community members' service access (Graham & Underwood, 2012). Wylie et al. (2013) suggests that access to services for majority world nations may be improved if service provision is designed in a way that is considerate of each nation's needs and culture, rather than by importing and adapting service design from minority world nations. These sentiments are echoed by Graham and Underwood (2012) who identified that rural service users preferred health programs that were designed for their individual communities, rather than a rural versions of an existing urban program. Just as there are differences between individual nations (Wylie et al., 2013), and individual families (Mandak & Light, 2018) which justify differences in service provision, there are also differences between individual rural communities which service designers should take into account (Graham & Underwood, 2012).

While awareness and adaptability are important factors of speech pathology service access, it is important to note that each of the authors discussed in this section sought out the perspectives of professionals and service providers in their datasets, with only few considering the data from caregivers (Glogowska & Campbell, 2004). It must be considered that people with SLCNs and/or consumers of speech pathology services have broadly not had input into these datasets. As such, the recommendations made in these publications may not reflect the needs and wants of the people with SLCNs nor of the consumers which they are intended to support.

Healthcare Service Access Within Australia

Health services literature within Australia has predominantly focussed on services provided to non-metropolitan consumers (Dew et al., 2013), and Aboriginal and Torres Strait Islander people peoples (Hollinsworth, 2013; Li, 2017). Similarly to the outcomes of research conducted in other nations (Gitobu et al., 2018; Graham & Underwood, 2012; Wylie et al., 2013), the need for adequate service options, and culturally appropriate services are key recommendations of these publications (Dew et al., 2013; Hollinsworth, 2013; Li, 2017).

Dew et al. (2013) conducted focus groups and in-depth interviews regarding access to allied health services with carers and people with disabilities who were living in regional towns (pop. 20-40,000), smaller towns (pop. 1-3,000) and rural communities (pop. <1,000) in New South Wales. These interviews identified high indirect costs of service access, and long wait times as key barriers to service access. Long-wait times in non-urban areas may be related to the lower per-capita availability of health services and professionals in non-urban areas. While a paucity of services is important to consider, particularly in relation to oppressed cultural groups such as Aboriginal people (Hollinsworth, 2013; Li, 2017), with respect to Dew et al.'s (2013) research, it should be considered that there were no participants from metropolitan areas in the dataset, and so the comparison between metropolitan and non-metropolitan areas may be one of perspective, rather than of comparison. Li (2017) suggests that the paucity of health professionals in non-urban areas of Australia disproportionately affects the health needs of Aboriginal and Torres Strait Islander peoples, as these groups represent a higher proportion of Australia's non-metropolitan population.

The affordability of services is an important factor of health service access within Australia, in consideration of both direct and indirect service costs (Dew et al., 2013; Fauk, Ziersch, Gesesew, Ward, & Mwanri, 2022). While affordability of services is a common factor for health service access (Dew et al., 2013; Gitobu et al., 2018;

Mesidor et al., 2011), research within Australia has considered marginalised populations (Fauk et al., 2022; Li, 2017). Li (2017) discussed health service accessibility in relation to the experiences of Aboriginal and Torres Strait Islander populations, while Fauk et al. (2022) considers the experiences of health service access for African migrants to South Australia, as well as the perspectives of the providers of those services. In doing so both publications highlight how indirect financial costs are compounded for marginalised groups within Australia, as they experience a range of social difficulties beyond difficulties with health service access alone (Fauk et al., 2022; Li, 2017). Fauk et al. (2022) indicates that policies have failed to address the particular difficulties faced by migrants to Australia. Hollinsworth (2013) states how the systemic oppression of Aboriginal and Torres Strait Islander peoples within Australia has resulted in both the over medicalisation of Aboriginal and Torres Strait Islander bodies, and created barriers between their communities and health services (cf. Hollinsworth, 2013).

Awareness plays a role in the accessibility of health services (L. Andrews & Botting, 2020; McAllister et al., 2011), however Fauk et al. (2022) suggests raising awareness in a culturally appropriate way is also important. Service providers can support the service access of marginalised populations by building relationships with key community leaders, and ensuring that information is presented in a way that supports the understanding of community members from both a linguistic (Fauk et al., 2022; Li, 2017) and cultural standpoint (Fauk et al., 2022). Professional education for service providers focussed on cultural competence, along with building strategic relationships within consumer communities is highly valuable in improving service access for marginalised populations within Australia (Fauk et al., 2022; Li, 2017). Notions of co-construction with various community groups are grounded in the idea that health services benefit from being designed with consideration for particular populations, rather than adapting or importing existing service delivery models from other communities (Fauk et al., 2022; Graham & Underwood, 2012; Li, 2017; Wylie et al., 2013). Li (2017) summarises the key aspects of health service access in Australia by suggesting that strong services designs are ones which are geographically, financially, *and* culturally appropriate.

Speech Pathology Service Access Within Australia

Research into speech pathology service access within Australia has identified a range of factors that impact service access. Scarcity of services resulting in waitlists (Commonwealth of Australia, 2014; McGill, Crowe, & McLeod, 2020; Ruggero et al., 2012) or an absence of local service providers (Commonwealth of Australia, 2014;

McLeod, 2006; Raatz, Ward, Marshall, Afoakwah, & Byrnes, 2021) was a key factor identified within Australian speech pathology service access literature, particularly within non-metropolitan areas (McCormack et al., 2012; Verdon, Wilson, Smith-Tamaray, & McAllister, 2011). Beyond this, travel (McAllister et al., 2011; Raatz et al., 2021; Verdon et al., 2011), awareness of communication needs and speech pathology services (Lim, McCabe, & Purcell, 2017; McAllister et al., 2011), and clinicians' adaptability to family's needs (Auert, Trembath, Arciuli, & Thomas, 2012; Commonwealth of Australia, 2014; Raatz et al., 2021; Watts Pappas, McAllister, & McLeod, 2016) were identified as factors of service access.

The way in which service scarcity impacted speech pathology service access within Australia presented differently in different geographic areas. In metropolitan areas, this was typically experienced as long waitlists for services (McAllister et al., 2011; McGill et al., 2020), or service policies that restricted the hours clinicians could spend with each client, which subsequently lowered the dosage of intervention available to each client (Ruggero et al., 2012). In non-metropolitan areas this presented as a restricted number of service options, or a lack of any local speech pathology service providers (McCormack et al., 2012; McLeod, 2006; Verdon et al., 2011). This pattern of the differing impact of a low supply of speech pathology services across rural and metropolitan areas was also observed by The Senate Inquiry into communication disorders (Commonwealth of Australia, 2014). While the initial solution to a lack of services is for speech pathology as a profession to seek to increase supply of its services to the community, this is in itself complicated. Some speech pathology areas of practice are more specialised and are therefore more scarce, or require the support of additional infrastructure or resources which are often located at hospitals or health centres (Raatz et al., 2021). Furthermore health professionals are less likely to live within non-metropolitan areas, which may reduce the relative availability of services to non-metropolitan populations (Commonwealth of Australia, 2014; Li, 2017).

Both the direct and indirect properties of travel were identified as factors which impact service access (McAllister et al., 2011; Raatz et al., 2021; Verdon et al., 2011). Raatz et al. (2021) identified three subthemes of travel in their exploration of metropolitan and non-metropolitan families' access of pathology outpatient paediatric feeding services. The burden of travel included aspects of organising travel for children who had feeding difficulties, sometimes as part of a complex disability, as well as transport specific issues such as negotiating traffic and parking (Raatz et al., 2021). The identified costs of travel included the direct financial costs as well as indirect costs such as the time-cost on the caregivers' occupation as well as potential lost income (Raatz et al., 2021). Raatz et al. (2021) also identified that for non-metropolitan families, travel was associated with a feeling of geographical disadvantage because services were not available within their own community. Similarly, McAllister et al. (2011) found that families living outside metropolitan areas of Victoria and New South Wales were required to travel to cities or major regional hubs in order to access services. Non-metropolitan families' need to travel greater distances amplified their need to both organise travel, as well as organise associated factors such as care for other children (Commonwealth of Australia, 2014; McAllister et al., 2011). Based on the varying density of services in non-metropolitan areas of New South Wales and Victoria, the distance that families are required to travel was identified as highly variable (Verdon et al., 2011). Verdon et al. (2011) found that up to a third of people living in non-metropolitan areas of these states lived more than 50km travel distance from a speech pathology service, with 50km having been identified as a critical distance of acceptable travel in these areas (Verdon et al., 2011). Furthermore, non-metropolitan areas in these states were broadly underserviced by the speech pathology profession as compared to metropolitan areas, leading to inequitable provision of health services (Verdon et al., 2011). Both scarcity of services (Raatz et al., 2021; Ruggero et al., 2012) and, perhaps consequently, travel (Commonwealth of Australia, 2014; McAllister et al., 2011; Raatz et al., 2021; Verdon et al., 2011) were more commonly identified as challenges of accessing speech pathology services for non-metropolitan participants. However, McAllister et al. (2011) indicates that rurality may not present unique challenges to families accessing services, but rather magnify the impact of the factors to which families are exposed.

Given that Australia is one of the least densely populated nations (Central Intelligence Agency, 2022), telehealth may provide an appropriate solution to the geographical disadvantage (Raatz et al., 2021) faced by non-metropolitan families. However, these service provision options are not universally available, and come with their own challenges.

Beyond the availability of services, community awareness of services has also been identified as a factor impacting service utilisation (Lim et al., 2017; McAllister et al., 2011). McAllister et al. (2011) set out to investigate the proportion of children with SSDs accessing speech pathology services, as well as the barriers to families accessing these services, and the sources of information sought by families. 13 in-depth interviews were conducted with parents of children with SSDs who were attending early childhood centres in New South Wales and Victoria. An objective measure for diagnosing SSDs was then compared with rates of contact with a speech pathologist. Only 35 of the 91 families had sought speech pathology services based on concerns raised about their child’s speech (McAllister et al., 2011). McAllister et al.’s (2011) survey of parents indicated that most families had not accessed services because they felt that services were not warranted. For families who sought information regarding their child’s SLCN, information was mainly provided by teachers (70.9%), family members living outside the home (56.9%), and friends (46.2%; McAllister et al., 2011).

While it is positive that participants in McAllister et al.’s (2011) research sought out people within their community for information on speech pathology services, this relies on community members having a knowledge and understanding of SLCN and speech pathology services that is sufficient for them to be able to act as catalysts for service access. Jessup, Ward, Cahill, and Keating (2008) reported an under-identification of SSDs by teachers, suggesting that some children with SSD may not be identified by teachers, nor subsequently referred for services. Jessup et al. (2008) also note that SSDs have a more accurate rate of identification than language difficulties, a point which is supported within parental health seeking behaviours of children with SLCNs (Skeat et al., 2010). This is a point of concern, as language difficulties have an impact on children’s HRQL (Kilpatrick, 2020; Le et al., 2020), and up to 50% of families of children with language difficulties have not actively sought out support (Le et al., 2020). While McAllister et al. (2011) identified some key factors that impact speech pathology service access in Australia, their work was focussed on the identification and service utilisation of children with SSDs. Jessup et al. (2008) indicate that investigations based on existing diagnoses may focus on children with more severe difficulties, and preference selection of children experiencing speech difficulties rather than language difficulties, as speech difficulties are less complex to identify.

Compounding this is the current focus on early intervention services. Early intervention is important in order to address the needs of children in a timely manner, and to reduce the ongoing burden of their communication needs (Bercow & Department for Children Schools and Families, 2008). However, The Senate found in their inquiry into communication disorders, that a focus on early intervention meant that children whose needs were not identified within this ‘early’ period were often only able to access limited services, if at all (Commonwealth of Australia, 2014). It was also noted by The Senate that the definition of ‘early’ intervention was not fixed, but vague and dependent on each service provider, and that the impact of this vague defining was magnified in rural areas (Commonwealth of Australia, 2014; McAllister et al., 2011).

Beyond commencing services, families also experienced challenges in their ongoing access of services (Le et al., 2020; Watts Pappas et al., 2016). Le et al. (2020) indicates that families of children with language difficulties who do seek out support may find services to be insufficient. The limited nature of some public services (Ruggero et al., 2012) meant that some families felt that services were insufficient to address their needs (Le et al., 2020). Accessing services also burdened families with additional direct and indirect costs (Le et al., 2020). Ongoing access of health care services presented a significant direct cost for families, and while there was an acknowledgement in the literature of the impact of indirect healthcare costs, these types of costs were identified as an area for further exploration (Le et al., 2020).

Once families had identified need and were accessing services, the degree to which families perceive clinicians to be friendly, knowledgeable, and empathetic impacted their ongoing access of services (Auert et al., 2012). Auert et al. (2012) identified that clinicians could support a family's service access by acting in a way that was approachable, and demonstrating that they could support decision making around a family's needs in a way that was both considerate of the family, and evidence-based. Open communication and shared decision-making supported families to access service in an ongoing manner and also plan for the end of services (Auert et al., 2012; Hersh, 2003; Ruggero et al., 2012). Conversely, Watts Pappas et al. (2016) found that caregiver's expectations of collaborative practice within speech pathology services was in-part dependent on their perception of how pervasive their child's needs were. Importantly Watts Pappas et al. (2016) notes that speech pathologists can deliver collaborative services while either acting as a leader/expert within services, or co-designing services. The collaborative and family-centred aspect is achieved through understanding and adapting practice in consideration of the needs of the client and their family (Watts Pappas et al., 2016). Families were more universally engaged in the goal setting and planning of intervention, but moderated their involvement in therapeutic activities based on whether they perceived themselves to be helping or hindering the impact of therapeutic tasks (Watts Pappas et al., 2016).

With reference to paediatric speech pathologists' knowledge of services in particular, Ruggero et al. (2012) notes that it is important for clinicians to share information about age-cut offs or other service policy limits, in order to avoid sudden and unexpected discharge. In this way, awareness of services extends beyond an awareness of service providers within or beyond a family's community (Auert et al., 2012; McAllister et al., 2011; McCormack et al., 2012), and includes an awareness of the limitations of any service being accessed by a family (Ruggero et al., 2012).

Stakeholders investigated within the literature

The international and Australian research has identified some barriers and facilitators of access to healthcare, and highlights the need for future research to include multiple stakeholders and to consider the experiences of people with various SLCN to allow them to advocate for services. Most studies have focussed on the perspectives and experiences of either caregivers and clients (Auert et al., 2012), or clinicians (Lim et al., 2017).

Few studies have considered the perspectives of both caregivers/clients *and* clinicians. Within Australia some studies have explored service access by geographic region (Dew et al., 2013), and some by diagnostic or client factors (McAllister et al., 2011; McCormack et al., 2012; McLeod, 2006). Of those that considered communication needs, each did so through the lens of diagnostic factors, and focussed on clients with SSD (Harrison et al., 2017; Jessup et al., 2008; McAllister et al., 2011; McCormack et al., 2012; McLeod, 2006). Ruggero et al. (2012) collected survey data nationally, but did not conduct in-depth interviews with families, which limited their ability to consider the experiences of families with children who have SLCN in an in-depth manner.

There may also be contextual differences between states within Australia. McAllister et al. (2011) found differences in the sources of information sought by families in New South Wales and Victoria. Victorian families were more likely to have sought information from teachers, while New South Welsh families were more likely to have sought information from print media such as books, magazines, and newspapers. While these differences are small, McAllister et al. (2011) suggest that these differences may be as a result of a difference in policies between these states. Consideration of the context of data based on existing boundaries, such as between the health systems of different states within Australia, is consistent with grounded theory investigations (Charmaz, 2012; Liamputtong, 2013).

While the similarities and differences in the factors identified through the comparison of different health systems (Lim et al., 2017; McAllister et al., 2011) highlights challenges with the transferability to the WA community, it should also be noted that similar challenges with transferability would theoretically exist between populations (Charmaz, 2012; Liamputtong, 2013). While their work identified important factors that impact services access, Raatz et al. (2021) consider the service accessibility of paediatric feeding services in metropolitan and non-metropolitan Queensland, and Hersh (2003) considers service access from the perspectives of clinicians who provide services to people with aphasia within Australia.

Constructs investigated within the literature

Within the body of research into factors influencing access to healthcare services, some studies have directly considered the work of clinical and managerial staff (Mesidor et al., 2011); while others have considered caregivers and clients (Dew et al., 2013); however, most have investigated families (Chiri & Erickson Warfield, 2012; Kovandžić et al., 2012; McAllister et al., 2011; Ruggero et al., 2012; Scheer et al., 2003). While investigation of each of these stakeholders' perspectives is important, few studies have investigated client/caregiver and clinician perspectives at the same time (McCormack et al., 2012). Conducting research into stakeholders' perspectives in a segregated manner limits the evidence available for design of efficacious service delivery (Liamputtong, 2013; McCormack et al., 2012; Vallino-Napoli & Reilly, 2004). By only considering the views of a limited number of stakeholders within a community, the ability of researchers to understand the stakeholders' community is limited (Braun & Clarke, 2006). Healthcare access must be considered as not only the services that are available *to* the community, but also *within* the community in which health providers operate, as clinicians are members of the communities in which they provide services. As such, to gain a deeper understanding of the factors impacting service access it is important to consider the perspectives and experiences of both key stakeholders of paediatric speech pathology services for children with SLCN, caregivers and speech pathologists.

Further to this, few studies have focussed on factors specifically affecting access to speech pathology services (Crowley et al., 2013; Law et al., 2013; McAllister et al., 2011; McCormack et al., 2012; McLeod, 2006; Raatz et al., 2021). While some of these studies were conducted in Australia, they considered the experiences of a small number of participants (McCormack et al., 2012; McLeod, 2006), or were focussed on particular SLCN (Jessup et al., 2008; McAllister et al., 2011). This identifies that a significant gap in the research in relation to the factors which influence access to paediatric speech pathology services in WA.

The aim of this research is therefore to investigate the factors of access to paediatric speech pathology services that seek to address the needs of children with SLCN in WA. This will be achieved through analysis of the experiences and perspectives of caregivers of children with SLCN, and the speech pathologists who work with children with SLCN that are shared within semi-structured in-depth interviews. This aim will be explored in more depth in the following Methodology Chapter.

Significance

While other studies have explored caregivers' (Mesidor et al., 2011) or clinicians' (Lim et al., 2017) experiences and perspectives of access to services, few studies have investigated both key stakeholders. Further to this, studies that have investigated access in an in-depth manner have focussed on the experiences of specific populations of participants, reducing the transferability of the outcomes to the broader context of services in WA. Grounded Theory methodologies suggest that the interpretation of findings are sensitive to cultural and geographical boundaries (Charmaz, 2012). As such, the translation of findings between countries, such as between Ghana and Australia in the case of Crowley et al.'s (2013) work, may be problematic. This is important as WA presents a unique population distribution. WA is 252.66Mkha, has a population of 2.66M people, and subsequently has a population density that is significantly lower than other Australian States and Territories, second only to the Northern Territory (Australian Bureau of Statistics, 2022a). Furthermore, most residents live in the Greater Perth Metropolitan area (Australian Bureau of Statistics, 2022b). Similarly, care must be taken with interpretation and generalisation of findings for studies which investigate particular diagnostic features, such as in the work of McCormack et al. (2012) into SSDs, and studies that investigated access in a broad manner, which may not have allowed for participants to share the nuanced details of their experiences and/or perspectives (Charmaz, 2012; Ruggero et al., 2012).

This study contributes to knowledge by presenting a model of access to speech pathology services in WA that is grounded in caregiver and clinician perspectives and experiences. This model will be able to be used by service designers to create or revise service delivery in a way that is community focussed, facilitates and/or reduces barriers to families accessing services, and that will ultimately result in more children with SLCN and their families accessing appropriate support.

3. Methodology

This chapter outlines the use of grounded theory methods, with reference to the philosophical assumptions made within CGT. Content within this chapter supports the reader to interpret the thesis by providing background on seminal grounded theory methodologies, with a focus on CGT, and methodological points relevant to how this grounded theory was constructed. In doing so, this chapter provides the theoretical basis for the actions within the Method chapter. The phases of CGT will also be summarised with specific reference to the constant comparative method, memo creation, and sampling strategies used within the current project.

Aim

The aim of this research is to investigate the factors of access to paediatric speech pathology services that seek to address the needs of children with SLCNs in WA. Investigating access to paediatric speech pathology services in WA in a way that is considerate of the perspectives and experiences of multiple stakeholders will aid in understanding how services can be improved to best serve the SLCN population. In this way, a deeper understanding is not only one of breadth that seeks to understand access from an operational process, but also one of depth that seeks understanding from the reported experiences of stakeholders within the community. Given that there is no published model of speech pathology service access that could be applied and tested, an analytic approach that supports theory generation was adopted. In consideration of the intention to generate theory, and the basis of this theory being in the experiences of the stakeholders, a grounded theory approach was selected as the most appropriate to address the aim of the project (Charmaz, 2012; Creswell, 2012; Liamputtong, 2013; Tweed & Charmaz, 2012).

Research Design

The research project was designed to construct a model of service access for paediatric speech pathology services in WA. A qualitative CGT approach was used because it facilitated the construction of a model of access and was an appropriate philosophical fit for my perspective of ‘access’ as a social construct with which caregivers and clinicians have experiences as decision makers and providers of these services respectively.

Grounded Theory

Grounded theory is a qualitative approach to data analysis which supports theory generation in areas which have not previously been explored in a theoretical manner. Since its discovery by Glaser and Strauss (1967) Grounded Theory has developed and diverged. An alternate version of Grounded Theory emerged though the work of Strauss and Corbin (1990), while CGT was built and presented as a third seminal version through the work of Charmaz (2012). While the grounded theory methodologies presented by Glaser and colleagues, and Strauss and colleagues are separately referred to as ‘Grounded Theory’ they are distinct methodological approaches.

There are common and defining features which are evident within each of the seminal grounded theory methodologies. All grounded theory methodologies seek to contribute to a body of knowledge through the analysis and explanation of a social process in a way that generates theory that is grounded in the observations of collected data (Charmaz, 2012; Glaser & Strauss, 1967; Rieger, 2019; Strauss & Corbin, 1990). An iterative process of data collection and analysis is used within grounded theory methodologies to ensure that the developing theories remain grounded in observations of the data (Charmaz, 2012; Glaser & Strauss, 1967; Rieger, 2019). In this way, grounded theory methodologies have a focus on inductive reasoning at the start of a project (Rieger, 2019). While the influence of modes of reasoning change in different ways in each approach, all grounded theories shift within their analysis to include abductive reasoning across their duration (Charmaz, 2012; Rieger, 2019). Abductive reasoning in grounded theory methodologies manifests in part as the constant comparative method, wherein researchers compare pieces of data (lines or incidences interview transcripts, memos, codes) from various sources. The constant comparative method supports analysis by facilitating researchers to make decisions around sampling based on the analysis of data that has been collected (Rieger, 2019). In line with this, the nature of data collection within this research shifted across the project. Initially purposive sampling was used to seek out data, while later in the project, analysis drove data collection consistent with use of inductive and abductive reasoning (Rieger, 2019). This process of analysis driven data collection is known as theoretical sampling (Charmaz, 2012; Glaser & Strauss, 1967). Once data is collected it contributes to the analysis, which then informs future data collection: creating an iterative relationship between data collection and analysis (Charmaz, 2012). Multiple levels of codes are used to describe and connect data (Charmaz, 2012; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Researchers also create reflexive memos to record their thoughts and perspectives on the existing dataset. Within this research I reflected upon data that had been collected up to the point of the creation of each memo, and how that data related to the broader social context of ‘access’ as a construct (Rieger, 2019). In most grounded theory methodologies, including CGT, memos are both a part of the audit trail, as they document the researchers' developing perspective, and also serve as data as part of the construction of understanding throughout the project (Charmaz, 2012).

Philosophical Assumptions

While there are historical and contextual factors for the differences in philosophical approaches between the seminal approaches of grounded theories, it is important to note that Charmaz (2012) sought to move grounded theory away from the objectivist epistemological assumptions of Glaserian Grounded Theory (Glaser & Strauss, 1967) and Straussian Grounded Theory (Strauss & Corbin, 1990) by shifting the focus of CGT as a grounded theory methodology towards a constructivist paradigm (Charmaz, 2012; Rieger, 2019). Within a constructivist worldview, reality is considered to be constructed by those people within it (Rieger, 2019). The participants of a particular construct each contribute and hold an understanding of the meaning of that construct for all participants. A constructivist research paradigm is one where research methods are considerate of a perspective that views truth as held by each person who contributes to a construct within a community, while also acknowledging that each person may have different experiences or perspectives of the construct, and each of these are held as true (Rieger, 2019). In this paradigm, the products of this research are a version of truth that has been construct*ed* by those individuals involved in the research (Rieger, 2019), namely, the researchers and participants. Therefore, in moving grounded theory methodology towards a constructivist paradigm it was necessary for CGT to present a more responsive procedural approach (Charmaz, 2012; Rieger, 2019). Rieger (2019) notes that links between the grounded theory methodologies are viewed by some scholars as the development of grounded theory as an applicable methodology moving from Glaserian Grounded Theory to Straussian Grounded Theory through to CGT. The differences between the philosophical assumptions of each of the seminal versions of these grounded theory methodologies impact on the way in which the researcher interacts with knowledge and data (Berthelsen, Grimshaw-Aagaard, & Hansen, 2018).

Within CGT, researchers are seen as the co-creators of knowledge (Rieger, 2019). Within constructivist grounded theory methodologies co-construction can be observed in the way that both the researchers and participants contribute to the data that is shared and the way that it is analysed (Charmaz, 2012). In this way data is seen as subjective based on researchers' involvement in both its collection *and* analysis (Charmaz, 2012). This philosophical approach places value on the input of the researcher as being a part of the context within which the research is being conducted (Rieger, 2019). Researchers using CGT actively consider their impact on the iterative analysis of the dataset to ensure that theories are rooted in the data as it was presented by participants, not solely in the researchers' interpretation of the data (Charmaz, 2012). Within a CGT methodological approach, focus on incorporating knowledge by using abductive reasoning, researchers conducting CGT can seek out information and models related to their area of investigation (Rieger, 2019), but must acknowledge the impact of this information on their perspective and subsequently on the data collection and analysis (Charmaz, 2012). As with other grounded theory methodologies, the overarching aim of the research remains the exploration and explanation of areas not previously explored in a theoretical manner (Charmaz, 2012; Glaser & Strauss, 1967).

Perspective and Context

In seeking to understand how families access community-based services, I have sought to understand and explain access to speech pathology services as a social construct. Recognising the construct of 'access' in this way aligns with a grounded theory methodology (Charmaz, 2012). Based on the background that led me to this project, I see myself as part of the profession that I am investigating, and within that, as contributing to families' access to services within my profession. As such, I see myself as part of, and not separable from the community that I am seeking to investigate. All researchers bring their own context to the data that they analyse, just as all individuals are shaped by their social context (Charmaz, 2012). The notion that researchers can simultaneously be separable from their own social context and also retain their status as experts was proposed by Glaser and Strauss (1967) as part of the Glaserian Grounded Theory methodology. However this is inconsistent with how construct knowledge is formed and held within a community, especially as it discounts the researcher's field-relevant knowledge which impacts analysis and interpretation of data (Charmaz, 2012; Glaser & Strauss, 1967). Being part of the profession that is being investigated, I bring field-relevant knowledge that has helped to shape the aim of the current project. By providing referrals and information about services to families who have children with SLCN in my clinical work I am seeking to create access. This aspect of my field-relevant knowledge indicates that I see access as being created by individuals within a social system.

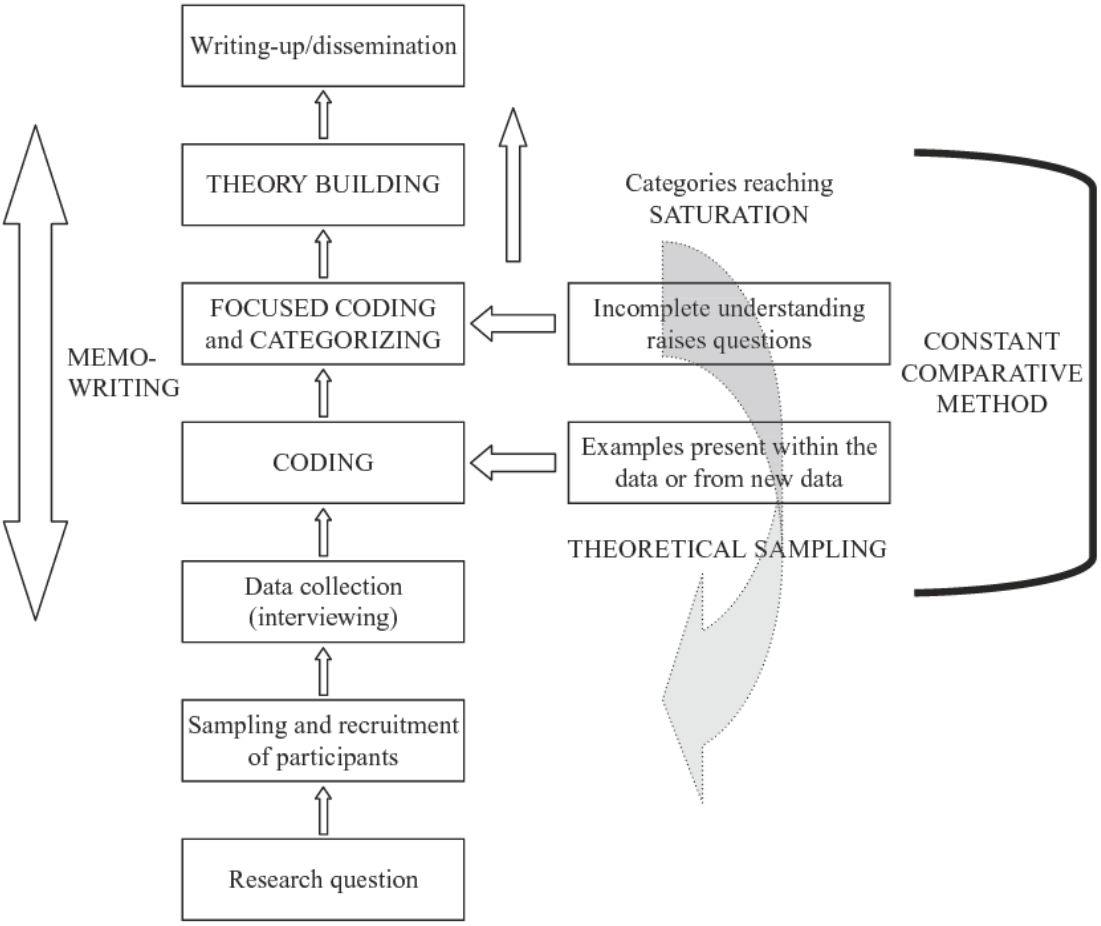
Approaching my research with this acknowledgement in mind is consistent with a constructivist paradigm of a CGT approach (Charmaz, 2012; Rieger, 2019). In initial conceptualisations of this research, the aim sought to define the challenges faced by consumers in accessing services. However, as part of the development of this research I have refined the aim of the research project to consider the *factors* which impact paediatric speech pathology service access. In doing so I have shaped the type of data that will be considered within the project, which reinforces the selection of a CGT approach (Rieger, 2019).

Conducting a Constructivist Grounded Theory

The process of conducting CGT is inherently iterative due to the combination of the constant comparative method and theoretical sampling, discussed below. The phases within CGT (Charmaz, 2012) are ordinal and iterative with each piece of data passing through each phase, but at different times. The phases within CGT (Charmaz, 2012) that guide the process of data collection, analysis of data and engagement with participants have been outlined by Tweed and Charmaz (2012; See Figure 1). In considering interview transcripts as the primary source of data within grounded theory methodologies, each piece of data is collected, goes through multiple phases of coding, and may have memos created about it (Tweed & Charmaz, 2012). Memos and coding of data within the dataset impact on the way that each subsequent interview is

Figure 1

A visual representation of Grounded Theory (Tweed & Charmaz, 2012, p.133)



conducted and therefore impact on how each subsequent addition to the dataset is collected.

Sampling

Multiple sampling methods are used within CGT, with a particular focus on purposive and theoretical sampling (Charmaz, 2012). Purposive sampling was used initially to recruit participants who were seen as able to provide understanding related to the concept of 'access' as a social construct (Creswell, 2012). Within CGT participants are identified by researchers based on their field-relevant knowledge (Charmaz, 2012). Snowball sampling supports recruitment through existing participants, wherein people who have participated in the research project provide information to potential participants (Creswell, 2012). Snowball sampling is philosophically consistent with a constructivist paradigm in that it makes use of the social connections between the people who come together to contribute to a construct.

Maximum variation sampling within qualitative research is used to facilitate variation within the dataset (Creswell, 2012). By reflecting on the homogeneity and variation within the dataset, researchers can seek to ensure that a variety of perspectives and experiences are present in the dataset (Charmaz, 2012; Creswell, 2012). Theoretical sampling is a key feature of grounded theory and is used to investigate questions that arise from data analysis and seek the theoretical saturation of properties and categories in model as it is being constructed. Theoretical sampling is a data-driven analytical approach of CGT which requires researchers to sample and recruit based on their analysis of exiting data (Charmaz, 2012; Glaser & Strauss, 1967). In grounded theory methodologies this occurs in two ways. With reference to recruitment, theoretical sampling drives the identification and recruitment of additional groups of participants as researchers identify within the analysis of data that there are potential participants that have a pertinent perspective or experience related to the construct of investigation (Charmaz, 2012; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Theoretical sampling encompasses all steps within related sampling, from the critical reflection of analysis to the subsequent recruitment of additional participants or modification of data collection protocols (Glaser & Strauss, 1967). With reference to data collection, theoretical sampling is the process by which data collection evolves and/or is revised through the course of the data collection.

Data Collection

Semi-structured in-depth interviews are the primary source of data (Charmaz, 2012; Creswell, 2012; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Collection and analysis of extant documents as supplementary data is also consistent with CGT (Charmaz, 2012). Due to the iterative nature of data collection and analysis within CGT, participants can take part in multiple interviews (Charmaz, 2012).

Analysis

Data collection and analysis inform and shape one another, while also being iterative in nature. The coding of data, writing of memos, and use of the constant comparative method are key elements of the development of understanding within CGT (Charmaz, 2012; Glaser & Strauss, 1967; Rieger, 2019).

Memo Creation

Researchers use memo creation to capture their thoughts about data in an open and reflexive manner (Charmaz, 2012; Rieger, 2019), and these memos are also included as part of the dataset. The creation of memos is an active part of data analysis that is used to consider patterns across the dataset (Rieger, 2019) as well as to reflect on researchers' own developing perspective in relation to the dataset (Charmaz, 2012; Liamputtong, 2013). In this way, the process of memo creation not only generates data but also forms part of the project's audit trail (Liamputtong, 2013). It must be recognised that 'perspective' as presented by Charmaz (2012) within a CGT methodology occurs not only at the commencement or initiation of the project, but also develops over time. This developing perspective throughout the research project is reflected within creation of memos and use of the constant comparative method. Because memo creation forms part of the audit trail, it is tied to other quality procedures (discussed below; Charmaz, 2012; Liamputtong, 2013).

Coding

Initial coding is used to describe the experiences and perspectives shared by participants (Charmaz, 2012). This process of description shifts the focus onto identifying the key sentiments shared by participants within interviews, support researchers to avoid relying on their perspectives too heavily. CGT typically makes use of line-by-line, and incident-with-incident coding of interview transcripts (Charmaz, 2012; Liamputtong, 2013). Word-by-word coding is used by researchers, but not routinely (Charmaz, 2012).

Focussed Coding and Categorisation.

Following initial coding, focussed codes are applied to transcripts in consideration of the data and initial codes within and across transcripts (Charmaz, 2012). The ongoing categorisation of focused codes allows for exploration of incomplete categories. This process informs data collection in two ways: it raises areas of possible theoretical interest, which is used to add to the scope or detail of the interview guides; and, it facilitates the understanding of categories to become more complete, this analysis is then used to reduce the lines of inquiry in the interview guides. As categories are considered more complete, inquiry shifts towards confirmation of understanding gained in previous interviews. The constant comparative method is then used to repeatedly compare new and existing data. This strategy ensures rigour in construction of categories through exploring the homogeneity of components of the construct being investigated, shifting properties and categories towards theoretical saturation.

The Constant Comparative Method.

The constant comparative method is an analytical strategy whereby researchers actively compare codes with codes; codes with memos; and, memos with memos to explore consistencies across the dataset (Charmaz, 2012; Glaser & Strauss, 1967). This strategy frames reflective consideration of not only data, but also the impact of researchers' own perspective on their analysis of the data (Charmaz, 2012). Use of the constant comparative method supports the development of an in-depth theoretical understanding of the construct being investigated as it is grounded in the data, while also informing theoretical sampling, and memo creation. As discussed above, theoretical sampling is used to shape interviews via refinement and revision of the interview guides, and potential sampling of additional participant groups (Charmaz, 2012). The ongoing use of the constant comparative method contributes to the development of focussed codes as it facilitates exploration of commonalities, differences, areas of interest in within the theoretical understanding of that is being constructed from the dataset.

Theoretical Saturation.

Theoretical saturation is a core element of grounded theory methodologies which outlines that analysis in a given category is considered to be complete when analysis of new data yields no further understanding of the category (Charmaz, 2012; Glaser & Strauss, 1967). Within CGT, when the properties of a category become refined, data collection for that category will shift to focus on seeking confirmation of the properties within the category. Once properties within a category are refined, and no further properties arise from data analysis related to that category, it is considered theoretically saturated (Creswell, 2012), and data collection related to that category ceases. While consistent with the relativist epistemological and ontological perspectives of CGT, theoretical saturation also serves a pragmatic role in that it allows data collection to cease on topics that are no longer yielding new understanding of greater depth than has already been established in the dataset, increasing the efficiency of the project. Different categories become complete at different times due to the nature of qualitative data collection (Rieger, 2019), and this, in part, shapes continued data collection. Theoretical saturation informs the use of interview guides within data collection.

Theoretical Coding and Theory Building.

Theoretical coding is used to investigate the nature of the relationships between categories (Charmaz, 2012). In this way theoretical coding facilitates the organisation of complete categories to one another (Charmaz, 2012). As with other steps of analysis within CGT, researchers act in a reflexive manner in consideration of all existing data within the dataset (interviews, codes, and memos) that relate to each category in order to ensure that that the subsequently constructed theory remains grounded in the data that is used to build it (Charmaz, 2012).

Quality Procedures

High quality and rigorous research is ensured in CGT through respondent verification, reflexive journaling, and acknowledgement of researchers' own perspectives, both at the outset of the research and in an ongoing manner through memo creation (Charmaz, 2012; Liamputtong, 2013). Collectively these components contribute to the dataset of the research, while also functioning as an audit trail (Liamputtong, 2013).

Respondent Verification

Throughout data collection, respondent verification is used to clarify points of discussion and to ensure participants' experiences were recorded accurately (Charmaz, 2012). In the construction of some grounded theories, transcripts of interviews are provided to participants to allow them to check for any errors made in recording or transcription (Liamputtong, 2013). This is related to the way in which CGT holds participants reports as true accounts of their lives.

Audit Trail

Research positionality in grounded theory methodologies is documented throughout the research process primarily via memo creation, but also in the researchers contribution to the co-construction of the data (Charmaz, 2012; Liamputtong, 2013). These processes reflect what in other qualitative methodologies might deem as a quality procedure and refer to as an audit trail. Methods used within this research that were identified as quality procedures are discussed in more detail in the Method Chapter.

4. Method

As outlined in the Methodology Chapter, CGT is a non-linear approach to data analysis of overlapping cumulative phases. While sampling, memo-writing, and constant comparison are used in each of the analytic phases, they are applied in different arrangements. For this reason Charmaz (2012) describes CGT as a cluster of analytical strategies. Data moves through the analysis at different times with different transcripts of data being within different phases in parallel to one another (Tweed & Charmaz, 2012). For example, theory building can commence when some interview transcripts are in their earlier phases of coding. In this way, CGT is less of a stepped ordinal process, and more of an orchestral approach to data analysis.

While we must bear in mind the iterative nature of CGT, for clarity in this chapter I will move through discussion of each of the key phases (interviewing, initial coding, focused coding and categorisation, and theory building) in an ordinal manner. Memo creation is discussed prior to the phases of coding as it is applied throughout coding and theory building.

This study was approved by the Curtin University Human Research Ethics Committee (HREC; HREC number HRE2018-0116).

Participants

There are two groups of participants in the current study: caregivers of children who have SLCN, and speech pathologists who work with the SLCN population. Caregivers who participated were currently accessing, attempting to access, or had recently accessed paediatric public, private, or non-government organisation speech pathology services within WA for their child/ren who have SLCNs. As understanding gained through CGT is sensitive to time and organisational structure within the community (Charmaz, 2012; Liamputtong, 2013), caregiver participants needed to have been seeking or have accessed services ‘recently’. ‘Recent’ was defined as within the current services framework. The current framework of services within WA was operationally defined as any time following the updates to the major public service providers, the Child Development Service and National Disability Insurance Scheme (NDIS), that occurred on July 1st, 2017. Clinicians who participated in the research project were required to have been currently delivering direct clinical paediatric speech pathology services to children with SLCN, and working for a public, private, or non-government organisation/s that provides clinical speech pathology services in WA. Speech pathologists were excluded from participating in the research project if their primary role was related to tasks other than providing individual and/or group intervention aimed at addressing clients' SLCN. Speech pathologists whose primary role was related to tasks other than the provision of intervention were excluded because of the conceptualisation of access and the way in which it was being explored within this research. This research therefore sought to construct a theory grounded primarily within interview data from people who had relevant perspectives and experiences with service access. Access was seen as existing between the clinician as a service provider, and the caregiver as the primary decision maker related to services for the client. For this reason speech pathologists whose primary role did not include the delivery of direct services were excluded from participating.

Across the course of the project, 27 participants (11 clinicians, 16 caregivers) provided data via 32 semi-structured in-depth interviews (13 clinicians, 19 caregivers). Caregiver and clinician participants were asked similar questions drawn from semi-structured interview guides tailored to each participant group.

In the next section I will outline the demographics, service access and participation of the caregiver participants who were recruited. Following this I will outline the demographics, service provision, and perspectives of client participation for clinician participants.

Caregiver Participants

Caregiver Demographics.

Caregiver participants were asked to describe the remoteness of their home location, as well as provide their street address for calculation of socioeconomic and remoteness ratings relative to the Australian population. Socio-economic ratings used the ABS's SEIFA-IRSAD decile, while remoteness ratings made use of the ABS's ASGS-RA rating. All twelve participants who identified that they lived in a metropolitan area were categorised as living in a major city (RA0). Of the four participants who identified that they lived in a regional area, three were categorised as living in an outer regional area (RA2), and one as living in a remote area (RA3). Caregivers described their family's socioeconomic status using a range of descriptors, one caregiver described her family's socioeconomic status as 'high', while ten responses were variations on 'middle income'. Three caregivers indicated that they were 'working class', one caregiver described her family's socioeconomic status as 'tight but we manage', and one used the descriptor 'lower'. Caregivers lived in areas that could be categorised into deciles four through ten on the SEIFA-IRSAD (Australian Bureau of Statistics, 2018a). Three caregivers lived in areas that have a SEIFA-IRSAD decile of 4, one lived in an area rated as 5, four lived in areas rated as 6, four lived in areas rated 7, one lived in an area rated as 8, two lived in areas rated as 9, and one lived in an area with a SEIFA-IRSAD rating of 10. Caregivers self-reported the highest level of education that they had attained or were working towards against the Australian Qualification Framework (AQF; AQF Council, 2013). Caregiver educational attainment ranged from year 10, to doctoral studies. Caregivers reported having completed year 10 high-school (*n*=1), a certificate III (*n*=1), a diploma (*n*=3), a bachelor's degree (*n*=4), a bachelors degree with honours or with the addition of a graduate certificate (*n*=7), a masters degree (*n*=2), or a doctoral degree (*n*=1). All caregiver participants identified themselves in an open text-field as the mother in their family. All except two caregiver participants indicated that they lived with a partner with whom they shared the care of their children. This partner was described using a small range of terms including partner (*n*=1), father (*n*=1), husband (*n*=4), or dad (*n*=8). Of the two caregivers who indicated they lived with only their children, one indicated that she was a single mother, and one indicated that care of her children was shared with a partner who did not live with them. Participants had an average number of 2 children, with a range from 1 to 5.

Caregiver Service Access & Participation.

Caregivers were asked to indicate which services they had accessed for each of their children. Cumulatively caregiver participants had sought or accessed speech pathology services for a total of 23 children, occupational therapy for 11 children, physiotherapy services for 5 children, psychology services for 5 children, educational tutoring for 4 children, and social work for one child. Caregivers also indicated that they had accessed 'other' services for a total of 4 children, including dietetic (*n*=1), chiropractic (*n*=1), optical (*n*=2), and paediatric medical services (*n*=2). Caregivers sought services for their children across each of speech pathology's scope of practice areas (Speech Pathology Australia, 2015), with the most common areas for services being speech (*n*=15), language (*n*=10), and fluency (*n*=5), and less common being hearing (*n*=2), voice (*n*=1), and multimodal communication (*n*=1). Caregivers indicated that the children for whom they were seeking services, had diagnoses of Developmental Language Disorder, Childhood Apraxia of Speech, delayed speech, Autism, fluency disorders, and conductive hearing loss. Seven caregivers indicated that the children for whom they were seeking services did not have a formal diagnosis related to communication.

Caregivers were asked to provide a short summary of their child's needs or an informal diagnosis they had received using an open text field in the survey. I used this information to shape the interview by seeking to better understand the concerns that caregivers had for their children. Most caregivers had sought speech pathology services from a private or non-government organisation (*n*=14), with only few families being unsuccessful in doing so (*n*=2). Private and non-government organisations have been grouped together as funding used at these organisations is similar, and interviews revealed that some participants did not make a distinction between these services. Many caregivers sought paediatric clinical speech pathology services from a public provider (*n*=13) and most were successful in accessing these services (*n*=11). Some families accessed speech pathology services from a private or non-government organisation only (*n*=4), while others accessed public speech pathology services only (*n*=4). In WA speech pathology services delivered by a public provider are free-of-charge to the consumer, and are publicly funded. For the services that caregiver participants accessed at private and non-government organisations, most had accessed Medicare's Chronic Disease Management (CDM) Plan subsidy (*n*=10). While clinicians indicated that they occasionally lowered their private rate so that families could access fully subsidised services using a CDM Plan, no caregiver participants had experience with this. Few caregivers used funding through the Department of Social Services Helping Children With Autism (HCWA; *n*=1), or the Department of Communities disability funding (*n*=1), and no caregivers reported accessing the Department of Social Services Better Start for Children with a Disability (Better Start) funding. While these funding schemes were active during data collection, they were in the process of being grandfathered, in line with the rollout of the NDIS. Some caregivers reported receiving funding via the NDIS (*n*=3), however one indicated that funding was inaccessible due to a lack of local providers in the Outer Regional Area in which they lived. Almost all caregiver participants who had accessed services provided by a private or non-government organisation had used private funds/savings (*n*=10), or subsidised payment for services using their private health fund (*n*=7). No caregivers reported accessing community grants to access services, or provided the name of any additional funding sources. Most caregivers were currently accessing speech pathology services at the time of their interview/s (*n*=10), while few were not currently accessing services, but had done so recently (*n*=5), and one caregiver participant was not currently accessing services, but had done so prior to July 1st 2017, and was currently re-seeking services. Of the caregivers who were currently or who had recently accessed services, all had accessed individual services (*n*=15), and some had accessed group services (*n*=6). No families had accessed telehealth services at the point of their first interview[1]. Caregivers did not identify any other service types that they had accessed. Most families had accessed services weekly (*n*=7), while some accessed fortnightly (*n*=5), few had accessed monthly services (*n*=2), and one participant indicated having accessed services at various frequencies. Most caregivers indicated that booked clinical appointments were regularly attended (*n*=12), few participants indicated that they occasionally missed or rescheduled appointments (*n*=2), and one participant indicated that their attendance at booked clinical appointments was irregular, usually being missed or rescheduled.

Clinician Participants

Clinician Demographics.

Clinician participants answered survey questions related to themselves as a clinician, their clients, and their service including service locations and funding. Most clinicians worked at one workplace with a work fraction of three (*n*=1), or four (*n*=2) days per week, or full-time (*n*=7), while one clinician worked the equivalent of full-time across two workplaces. At the time of their first interview clinician participants had worked as a speech pathologist for a period between 1 and 26 years (*M*=9.08, *sd*=10.16). One clinician participant indicated that she was a new graduate, five clinicians indicated they were early career speech pathologists, one clinician indicated that she was an experienced speech pathologist, and three clinicians indicated they were senior speech pathologists. One clinician indicated that she did not identify with any experience categories.

Clinician Service Provision.

Clinicians were employed by public service providers (*n*=3), non-government organisations (*n*=2), or private practice (*n*=6) clinics. Participants also indicated that they had worked in a range of private, public, and non-government organisations prior to their current employment. Some participants had worked for public service providers outside of WA (*n*=2) and/or worked within the WA Department of Education (*n*=2). All clinician participants provided individual services (*n*=11), and most provided group services (*n*=8). At the time of their first interviews only one participant indicated they currently provided telehealth services. All clinician participants indicated that they delivered services at a clinic location (*n*=11), while most also provided services in clients' homes (*n*=7), or at school with (*n*=7), or without, the caregiver present (*n*=7). Clinicians were asked to share the address of their clinic, and the locations into which

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[1] It is worth noting that all participants completed their first interview prior to the COVID-19 pandemic, though follow-up interviews were conducted after the commencement of the pandemic

they provided services. Some clinicians described the locations of service provisions using suburbs, regions, or postal codes. This location data was used to identify the socioeconomic (SEIFA-IRSAD) and remoteness (ASGS-RA) deciles of clinician participant's clinics. Most clinics were situated within metropolitan Perth, WA's state capital, and provided services to clients within a metropolitan area (RA0; *n*=8), one participant provided services from a clinic located in an inner regional area (RA1), and provided services to clients living in inner and outer regional areas. Another participant provided services from a clinic in an outer regional area (RA3) to clients who lived in outer regional, remote (RA4), and very remote (RA5) WA. Another clinician provided services from a clinic in a remote area to clients living in remote and very remote WA. Clinicians described their client-base's socioeconomic status as disadvantaged (*n*=1), low (*n*=4), low to middle (*n*=2), middle (*n*=3), and professional (*n*=1). Clinicians provided services from clinics that were situated in areas with SEIFA-IRSAD deciles of 1 through to 9 (mode=8; *M*=6.55). Clinician participants indicated that they provided services each of speech pathology's scope of practice areas (Speech Pathology Australia, 2015) including speech (*n*=11), language (*n*=11), fluency (*n*=10), multimodal communication (*n*=7), and voice (*n*=3), as well as hearing (*n*=1). Of the clinicians who provided services through a private or non-government organisation, all provided services paid for by the families (*n*=8), and also accepted family's private health fund rebates, most also provided services funded by the NDIS (*n*=7), or subsidised with a CDM Plan (*n*=6). Few clinicians also indicated that they occasionally elected to provide services at the rate of the CDM subsidy (*n*=3) in order to provide a gap-free service to families. Clinicians also provided some services funded by grandfathered funding schemes, HCWA (*n*=5), Better Start (*n*=4), Department of Communities disability funding (*n*=4). No clinicians were currently providing services paid for through a community or charitable grant. Some of clinicians who worked for non-government organisations or private practice clinics also provided services paid for by the public Child Development Service that had been outsourced by the WA Department of Health.

Perspectives of Client Participation.

Most clinicians indicted that their clients typically attended clinical services weekly (*n*=5) or fortnightly (*n*=5), with one clinician indicating services were typically provided at least weekly. Few clinicians indicated that their clients attended clinical services regularly without rescheduling appointments (*n*=2), most indicated that their clients attended services occasionally while occasionally having to cancel or reschedule appointments (*n*=8), one clinician indicated that their clients attended services irregularly, usually having to reschedule or cancel appointments. While it was more common for clients to attend weekly or fortnightly appointments on a regular schedule, clinicians saw clients in a range of patterns.

Materials

Demographic Questionnaire

The information gained from the demographic questionnaire was used to frame the participants' responses within the interview, and to ensure a broad range of participants were recruited consistent with maximum variation sampling (Creswell, 2012). Caregiver and clinician questionnaires have been included as Appendix A. Demographic data was collected from caregivers relating to their geographic location, socioeconomic group, family structure, types of services and funding sought or accessed, and the regularity of their services. All data was collected as a self-report measure, with open description used where possible. Residential address was used for geographic location data. This was an open field in which most participants entered their whole address, however two participants chose to enter their suburb only. Each caregivers' residential address was used to calculate their remoteness using the Australian Statistical Geographic Standard Remoteness Area (ASGS-RA; Australian Bureau of Statistics [ABS], n.d.), and relative socio-economic status using the Socio-Economic Indexes for Areas – Index of Relative Socio-economic Advantage and Disadvantage (SEIFA-IRSAD) decile (Australian Bureau of Statistics, 2018a). By identifying ASGS-RA and SEIFA-IRSAD for each participant it was possible to view the range of participants with reference to their remoteness and socioeconomic position relative to the Australian population based on census data. Data was collected between April 12th, 2018 and June 24th 2020. At the commencement of data collection the 2016 census data had been collected, but not yet been released for public use. As such, 2011 ASGS-RAs and SEIFA-IRSAD deciles were collected for each caregiver participants' residential addresses, and clinician participants' clinic address and later converted to 2016 data once it became available. The ABS data reported in this thesis is based on 2016 census data (Australian Bureau of Statistics, 2017a), which was the latest available at the time of analysis. Participants' addresses were entered into the ABS Map (Australian Bureau of Statistics, 2017b), from which their ASGS-RA and area code was recoded. Each participants' area code was then used to look up their SEIFA-IRSAD using an ABS table (Australian Bureau of Statistics, 2018b).

Demographic data was collected from clinicians relating to their work fraction across their number of current workplaces, years of clinical practice, self-described career stage, sector of current and previous employment, type and location of service delivery, typical regularity of booking and attendance at appointments, clinic geographic location and service range, source of funding for services, description of client socio-economic status, and services delivered within the speech pathology scope of practice (Speech Pathology Australia, 2015). This data is reported on in the Participants section in this chapter. As with the caregiver demographic data, clinic addresses were used to calculate ASGS-RA and SEIFA-IRSAD deciles for clinicians' provision of services. When clinicians provided specific suburbs or postcodes for their service areas, the ASGS-RA and SEIFA-IRSAD deciles for these areas were also taken into consideration.

Semi-Structured Interview Guides

All interviews made use of an interview guide (see Appendices B, C, & D) that was structured around key topics of theoretical interest. Initial interviews explored participants' experiences and perspectives of service access by using open-ended questions based on my clinical experiences, and relevant literature (e.g., Lim et al., 2017; McAllister et al., 2011; Ruggero et al., 2012). These questions were open ended in nature allowing participants to share their experiences and insights and reflected the interviewing style of grounded theory methods (Charmaz, 2012; Glaser & Strauss, 1967). The interview guides were refined across the course of the project in response to areas of inquiry that arose, and theoretical saturation. More specifically, refinement occurred at pivotal points where my understanding of participant description and experience of access to paediatric speech pathology service evolved, and warranted reconsideration of the types of questions asked during interviews. For both caregivers and clinicians this occurred when my understanding of the questions became saturated. After 14 interviews were conducted, both interview protocols were updated to became shorter and more closed-ended as the aim of data collection shifted towards clarification and verification of the model as it was being constructed. Additionally, some participants took part in follow-up interviews, that were designed based on a similarly structured interview guide (see Appendix D) and tailored to each participant based on the data they had shared in their initial interview. Participants who provided rich initial interviews and who raised points relevant for further enquiry, were selected to participate in a follow-up interview. These participants were also selected as they each had a range of service access experiences, and between them had accessed services in a range of areas and from different providers.

Initial interviews followed the initial interview guide (Appendices B & C). As coding raised questions or incomplete understandings, I integrated questions about these topics into individual interviews as these topics were raised by participants. I modified my questioning as my understanding of the proto-categories developed in line with data analysis. These modification followed the same interview guide, but questions were phrased differently for participants, based on the information that they had shared. Questions also gradually became more closed ended as I understood some proto-categories better, as they stepped towards theoretical saturation. This natural questioning was conducted incidentally within individual interviews and is a form of theoretical sampling, as discussed below. Partway through data collection, the interview guide was updated to reflect several changes in questioning around the construct of access, as my understanding of the model was developing. The updated interview guides (Appendix C) were used for all subsequent participant interviews. Incidental modifications continued through subsequent interviews.

As co-construction is evident throughout CGT (Charmaz, 2012), participants were asked two direct co-construction questions within their initial interviews. Firstly, all participants were asked if they had anything else to discuss around speech pathology service access that had not been discussed as part of the questions from the interview guide. This was one of the ways in which participants could introduce new concepts for investigation. Secondly, as initial data collection progressed, participants were asked if there were any questions that the research should ask of the other participant group. This allowed participants to directly impact the process of data collection. For example, a clinician queried if caregivers knew what to expect when attending their first speech pathology appointment. Following this the question "Did you know what to expect when you went to your first few appointments?" was added to the caregiver interviews, and formalised in the updated interview guide (Appendix C). These interviewing strategies supported participants to contribute to co-construction related to their own experiences of service access, as well as their perceptions of the other participant group.

Follow-up interviews were conducted using the follow-up interview guide (Appendix D) with clinicians (*n*=2) and caregivers (*n*=3). Data collection shifted to using the follow-up interview guide as answers to the revised initial interview guide reached theoretical saturation and/or demonstrated reduced utility in further understanding the properties and categories. Follow-up interviews were based on the incomplete understandings of properties and categories from early versions of the model that was being built. The questions included in the follow-up interview guides were focussed on validating the understanding of categories in a more closed-ended way, and using open-ended and descriptive questions to further explore incomplete understandings in the dataset. Data collection ceased as data analysis reached theoretical saturation.

Data Collection Procedures

Participants provided data related to their experiences and perspectives of access to speech pathology services through semi-structured in-depth interviews and completed a demographic questionnaire prior to their initial interview. All data was made re-identifiable through the use of participant codes that were saved with participant names in a secure file, in line with the data management plan.

Questionnaire

Participants were sent a hyperlink to a Qualtrics XM survey which they were asked to complete prior to the initial interview, however participants were also able to complete the survey within the first interview with the researcher if they preferred. Participant demographic data was exported from Qualtrics XM into Microsoft Excel.

Semi-Structured In-Depth Interviews

Interviews were conducted face-to-face, via telephone or videoconference. All interviews were audio recorded for later transcription and analysis. Interviews took place at a mutually convenient time, with face-to-face interviews arranged at a mutually convenient location. All participants were given the choice of face-to-face, telephone, or videoconference interviews, however with the restriction that face-to-face interviews were only able to be conducted within the Greater Perth metropolitan area, in compliance with the research project's HREC approval. At the commencement of data collection videoconference interviews were conducted using Skype, however follow-up videoconference interviews were conducted using Cisco Webex in line with updated university policies. Parking fees for participants who chose to attend interviews conducted on Curtin University's Bentley campus was covered by the project's consumables budget for up to 2 hours. This was to ensure that participants were not financially penalised for this choice of interview location. Initial interviews were of approximately 60 minutes in duration. Prior to the one-hour mark, participants were given the option to extend the interview if the interview had not ended within the first hour. Initial interviews focussed on participants' experiences and perspectives about access to speech pathology services in WA.

At the end of their first interview each participant received a Coles Myer Group gift card to the value of $20.00. The gift card served as a gesture of thanks from the researchers to the participants, and not a payment.

Interviews were recorded on an Olympus LS-P2 dictaphone in .mp3 format. After each interview an audio memo was recorded without the participant present. Both audio recordings were uploaded to Curtin's research data drive as soon as possible. If it was not possible to upload the audio files on the same day of recording, they were instead transferred to a password secured Western Digital My Passport hard drive, and uploaded when Curtin's research drive could next be accessed.

Sampling Procedure

Participant sample sizes are not predetermined in grounded theories as theoretical saturation is used to determine the point at which sufficient data has been collected to address the aim/s of the research (Charmaz, 2012; Glaser & Strauss, 1967). This is in part an appreciation that data collected from each participant is variable within qualitative research (Rieger, 2019). At the outset of the study, each group was anticipated to include 20 to 30 participants, based on estimations presented by Creswell (2012). Just as sample sizes are not predetermined, neither is the number of interviews each participant takes part in, which is also dependent on the information that is shared within each interview. It was anticipated that most participants would take part in only one interview, however some would take part in multiple interviews.

Purposive Sampling.

Initially, purposive sampling (Creswell, 2012) was used to recruit participants through advertisements on social media, presentations at speech pathology professional forums, and e-mail contact with organisations who employ speech pathologists. Seven organisations agreed to display recruitment information. These organisations were each given a poster, flyers, and a spiel to post on their website, social media pages, or in their newsletters. Each of these organisations used these resources in different combinations that they felt were appropriate for their clients and staff. I made myself available to edit recruitment materials and complete reciprocal ethics applications as needed. Only one organisation asked for this support to edit recruitment materials for their website. Of the organisations who agreed to share recruitment information for purposive sampling, none required reciprocal ethics applications to be completed.

The Department of Health WA's Child Health Service's sites were investigated as appropriate public organisation for purposive sampling. In 2017, The Department of Health WA had recently restructured the management of their ethics approval process, which meant that in order to gain approval to display recruitment materials, a full ethics application structured as a pharmaceutical randomised control trial was required for each site. As such, this was seen as an inefficient recruitment site based on the project's timeline. This raised concerns about a potential lack of inclusion of participants from public services. Inclusion of participants who had experiences with the Department of Health WA was therefore monitored through the course of data collection as part of the demographic questionnaire.

In compliance with the research project's HREC approval, organisations that received recruitment materials were informed that they were not able to have clinicians directly encourage or invite clients' caregivers to participate in the study, and that flyers and posters should be used in more public spaces, such as foyers and waiting rooms.

Snowball Sampling.

Snowball sampling was supported within data collection (Creswell, 2012) through recruitment flyers that were offered to all participants following their first in-depth interview to distribute to other potential participants. Further to this, participant speech pathologists were asked to display a recruitment poster and/or flyers in a public space within their clinic. Participant choice to take materials for snowballing sampling did not impact their contribution or further participation in the study. As with purposive sampling I made myself available to edit recruitment materials and complete reciprocal ethics applications as needed, however this was not requested as a part of snowball sampling.

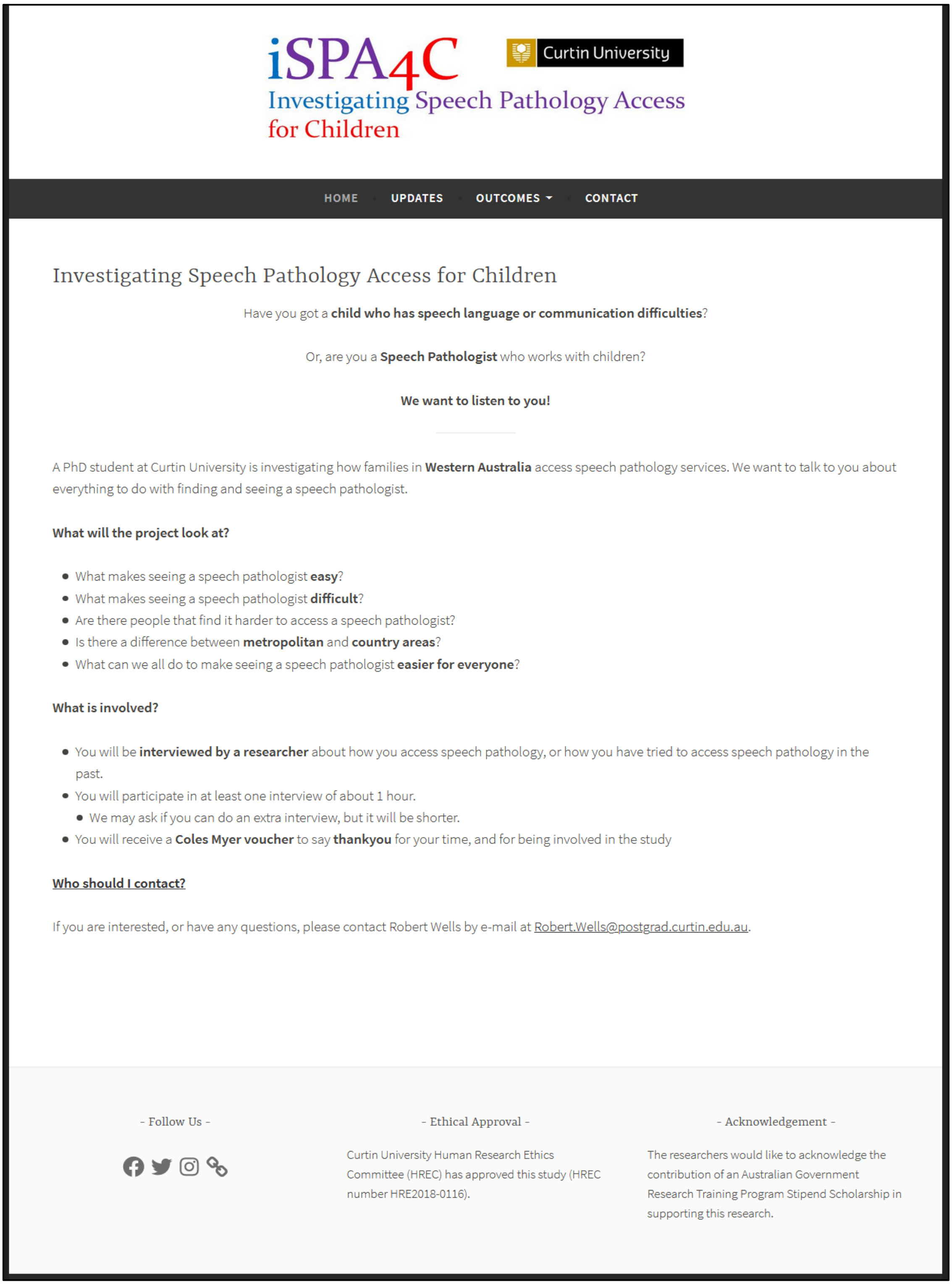
At the end of each participant's first interview they were given the opportunity to join the project's e-mailing list. Through the course of the recruitment phase of the research, this e-mailing list served as part of the project's snowball sampling by reminding its members about ongoing recruitment efforts by sending through links to recruitment information. Links to the join mailing list were also included on the project's website (https://ispa4c.com/; see Figure 2 for a screenshot), for interested members of the public to join.

Maximum Variation Sampling.

Maximum variation sampling (Creswell, 2012) was informed by demographic data collected prior to each participant's initial in-depth interview. The intention was to use this data to inform the recruitment of participants from demographic groups whose experiences and perspectives were not reflected in the emerging dataset. However, caregiver and clinician participant groups reflected a broad range of experiences and perspectives based on the data in the demographics questionnaire. Targeted recruitment

Figure 2

iSPA4C.com Website Screenshot



Investigating Speech Pathology Access for Children

Have you got a **child who has speech language or communication difficulties**?

Or, are you a **Speech Pathologist** who works with children?

We want to listen to you!

A PhD student at Curtin University is investigating how families in **Western Australia** access speech pathology services. We want to talk to you about everything to do with finding and seeing a speech pathologist.

What will the project look at?

- What makes seeing a speech pathologist **easy**?
- What makes seeing a speech pathologist **difficult**?
- Are there people that find it harder to access a speech pathologist?
- Is there a difference between **metropolitan** and **country areas**?
- What can we all do to make seeing a speech pathologist **easier for everyone**?

What is involved?

- You will be **interviewed by a researcher** about how you access speech pathology, or how you have tried to access speech pathology in the past.
- You will participate in at least one interview of about 1 hour.
  - We may ask if you can do an extra interview, but it will be shorter.
- You will receive a **Coles Myer voucher** to say **thankyou** for your time, and for being involved in the study

Who should I contact?

If you are interested, or have any questions, please contact Robert Wells by e-mail at Robert.Wells@postgrad.curtin.edu.au.

- Follow Us -

- Ethical Approval -

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2018-0116).

- Acknowledgement -

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of participants living or providing services in a regional or remote part of WA was conducted via the project’s newsletter on the 28th of October 2018, and then again on the 3rd of June 2019. While participants from regional and remote WA made initial contact following these dates, as participants were not asked about where they first saw the recruitment materials, it is unclear if this was a direct result of maximum variation sampling.

While no caregiver participants lived in areas categorised between one and three on the SEIFA-IRSAD, these deciles are less frequent within the WA population, and caregiver participants shared experiences related to a range of economic situations within interviews. It must also be noted that the SEIFA-IRSAD is indicative of socioeconomic advantage and disadvantage within clusters of the population, and so is indicative of a person’s neighbourhood not reflective of their specific socioeconomic position. No clinicians provided services from a clinic in an area with a SEIFA-IRSAD decile of 2, 5, 7, or 10. However, the clinician participants’ client-based lived in areas across the range of 10 SEIFA-IRSAD deciles. Requesting access to client addresses to inform estimations of socio-economic advantage and disadvantage quantitatively was beyond the scope of this project.

Caregivers were asked to report their highest level of education against the AQF (Australian Qualifications Framework Council, 2013). Their responses were compared to Australian educational attainment data (Australian Bureau of Statistics, 2012). Caregivers reported having attained education qualifications from high-school education to doctoral level studies. Caregivers had attained high-school education (*n*=1), a certificate III/IV (*n*=1), a diploma or advanced diploma (*n*=3), bachelor’s degree (*n*=4), a bachelor’s degree with honours or with the addition of a graduate certificate (*n*=7), or a postgraduate degree by coursework or research (*n*=4). No caregivers reported attaining a primary-school education, a year 12 high-school education, a certificate I, II, or IV, or an advanced diploma. However, caregiver participants reflected on the way in which their industry of employment impacted on their access of healthcare services and did not link this to their level of education. It should be noted that some professions require specific education, including a minimum level of qualification on the AQF. As the level of caregiver education was not reflected as important for access of speech pathology services within the data shared by participants it was not seen as essential that perspectives were shared from caregivers within each AQF level.

As part of maximum variation sampling it was noted that all caregiver participants identified as mothers, and that all participants were female. Participants were directly asked about the gender of caregivers accessing speech pathology services. Caregiver and clinician participants shared that mothers accessing services for children as their primary caregiver was typical within Australia. Considering the consistency with which this was observed, participant gender was seen as reflective of the gendered roles of caregiving and of the profession of speech pathology in context within which the study was conducted. For this reason maximum variation sampling was not conducted around participant gender. Theoretical sampling was conducted with reference to gender within the modification of the interview guides. In this sense, it would have been ideal to have recruited participants who did not identify as female, however this this was ultimately not practicable within the research timeline.

Theoretical Sampling.

Theoretical sampling in CGT is the process by which researchers seek to sample data in areas of theoretical interest as part of the developing dataset (Charmaz, 2012; Glaser & Strauss, 1967). Theoretical sampling is conducted using two key strategies. Firstly, through the adaptation and revision of interview questions as part of data collection. Within this project, theoretical sampling facilitated decision making around how interview guides were modified throughout data collection. And secondly, through the targeted recruitment of specific participants into participant groups, or the creation of new participant groups. The use of either strategy is driven by areas of theoretical interest as they develop within the dataset (Charmaz, 2012; Tweed & Charmaz, 2012).

Within this research project the interview guide was revised to include areas of theoretical interest such as: the impact of gender on service access, the impact of the severity of the client’s needs on the urgency of access; and, the impact of conversations between caregivers and clinicians about service funding. In addition to this, the revised guide also sought a greater level of detail on topics that had been identified within earlier interviews such as low caregiver awareness of self-referral to speech pathology services, and negotiations around different service delivery models. In this way, theoretical sampling revisions of the interview guides supported data collection to explore questions raised through data analysis while also moving incomplete understandings of existing properties and categories towards theoretical saturation, discussed below.

While CGT research has the capacity to identify and recruit additional stakeholder groups through theoretical sampling, within this research project no additional stakeholders were identified within the dataset. At the outset of the research, it was anticipated that referring agents such as teachers, general practitioners, or child health nurses, or indeed the clients themselves may be identified as important stakeholders within services access. However, the collected data indicates that caregivers hold the responsibility for decisions around how families access services for their children who have communication needs, and they do this within the paradigm provided by the policies and practices of services providers and clinicians. This is not to say that theoretical sampling of this form was not used within this project, but that theoretical sampling as a process of data analysis did not support the recruitment of another participant group/s.

Analytical Procedures

Semi-structured in-depth interviews were used as the primary data source within the research. Following interviews being conducted they were transcribed and sent to participants for verification. Three phases of coding were conducted moving from initial coding, focussed coding and categorisation, to theoretical coding. Each of these phases of coding will be discussed in turn.

Theoretical sampling was conducted to investigate areas of inquiry that arose throughout the process of coding. Participant responses were coded and categorised, with revised and follow-up guides shifting data collection towards theoretical saturation. I created theoretical codes that organised categories in relation to one another in order to gain a better understanding of paediatric speech pathology access as a construct within WA.

Memo Creation

Memos were created throughout the project, to support my reflection on my own understanding of the construct of service access. After each interview, without the participant present, I audio recorded a memo in which I documented my immediate thoughts and reflections on the data shared within the interview. Just as interviews vary in their richness of data, so too did these memos. Post-interview memos included my commentary on the individual interview, but also my reflections on the interview and how it related to the broader dataset. Voice recorded memos were transcribed following the same procedure as interviews, which is outlined in the Transcription section below. An excerpt of a post-interview memo is included below (see Table 1).

Memo creation also occurred throughout coding and theory building phases. I created audio, written, or visual memos when I identified a point, property, or concept in my analysis that I felt needed to be documented, or that would support analysis. Memo creation was used in parallel to each phase of coding to allow me as a researcher to be able to document relevant thoughts as they arose within analysis, without being confined by the specific intention of each type of coding. In this way, memos were then used to inform theoretical sampling and further data analysis, serving as a record of data-based reflections. During coding and theory building, memos were audio recorded (see Table 1 below), or written or drawn within the reflexive journal (see Figure 7).

Table 1

Except of Hellen's Post-interview Memo

Speaker	Transcript
Robert	This is the post-interview memo for SP11a. It was a really interesting interview. I think that the participant really explored a few things in a few different ways than I had seen before, so I think that was really good in terms of it being new novel data, but it linked really well to the dataset. The idea of availability came up again, so I think that's a bigger property. We talked a lot about the setting in which services were conducted as well as travel and public transport. They're bigger [more prominent] things that come up in your literature, which hadn't really been discussed before [in the dataset]. So, I think that it would be great to explore that more. We also talked about difficulties around difficult conversations in the coaching model, and how that might play out; and also about individual differences between clinicians using guidelines. How that even though there *is* a guideline, it might not be followed, or it might be interpreted and followed in a particular way by a particular clinician.
Duration	00'00" to 01'25" of a 05'16" duration audio memo.

Memos created throughout the project formed part of the audit trail, and therein allowed me to reflect on the impact of myself and my supervisory team on the collection and analysis of the data. The audit trail is explored in the Quality Procedures section below.

Transcription

Following data collection, audio files were uploaded to an online transcription service. Initially files were uploaded to Speechmatics, but files collected later in the project were uploaded to Rev. This procedural change was in response to changing price structures. Both Rev and Speechmatics had terms and conditions and privacy policies that protected the privacy of individuals for audio and transcript files. While both Speechmatics and Rev make use of automated databases, both allowed for recordings to be withdrawn from their databases if needed, in line with HREC policies.

After transcriptions were received from these services, they were transferred to a Microsoft Word document (.docx) and manually checked using Express Scribe

Transcription Software (NCH Software, n.d., version 8.26) and an Infinity IN-USB-2 Transcription Foot Control pedal. After being transcribed, each interview was checked by reading through the transcript while listening to the interview in full. Transcriptions were set out in a table with 'Speaker' and 'Transcript' columns, and rows labelled 'Robert', 'Participant', or 'Both' to indicate the speaker (see Table 2 for an example). Throughout the transcript underlining and *italics* were used to indicate emphasis that had been used within the interview; <chevrons> were used to indicate interjections; [brackets] were used to indicate where text had been replaced to provide context or readability, or to remove confidential information from the transcript; *asterisks* were used to indicate action or description; and, ellipses… indicated the end of sentences that were left incomplete, either through abandonment or as the result of an interjection greater than could be expressed with <chevrons>. Exclamation and question marks along with other punctuation features were used conventionally.

Table 2

Transcript Excerpt from Patricia's interview

Speaker	Transcript
Robert	Yeah, so 10 minutes as opposed to 20 minutes. And the way you describe it, it's sort of closer to where your life is, as opposed to being <in the other way> 20 minutes the other direction.
Patricia	Yeah. And plus, I didn't have, I mean now that I've got teenagers, it's...<mhmm> Just, the lifestyle is very busy as well. So back then, it was just them, they were all I was focusing on and now, and uni as well, it's just a little bit crazy. <mmm>
Robert	So a very different and potentially busier sort of lifestyle at the moment.
Patricia	Oh, yeah, it is! <okay> *laughs* <*laughs* okay> I'll be at the [stadium] till 8 o'clock tonight with the training. So yeah, it's a big day. <Yeah, busy> And then first thing in the morning tomorrow. <Ooh> Yeah, it's really, really hectic, but.
Robert	So what impact does going to speech therapy have on your life?
Patricia	It was okay, when I went back this week, it was okay, because it was... [my son] was actually, because he can be really shy, but this time he just, we sat down and he talked to me <mmm> and she was like, "Oh yeah, that's age appropriate." And that was really good.

Transcripts were then titled ‘Interview [date of interview]’ and sent to participants for participant verification, discussed below.

Coding

Initial Coding.

Initial coding sought to describe the content that each participant had shared within their interview by segmenting each transcript into lines and incidents of data (Charmaz, 2012). Within each transcript document, columns were added to the right titled ‘Initial Codes’ and ‘Focussed Codes’ respectively. Each transcript was then read, and initial codes were created that sought to describe the data presented in the transcript (Charmaz, 2012). Initial codes writing in line with the relevant lines or incidences within the transcript. Cells of the table were split or merged as needed so that codes were positioned alongside the relevant section of transcript. This allowed codes to be reviewed and discussed with ease, linking relevant pieces of data together within each transcript’s Word document (see Table 3).

By aiming to produce descriptive codes as a first analytical step, the researcher worked to not only identify the key pieces of information shared within each transcript, but to establish some cognitive distance between their own interpretations of the data and the analysis of the data. Charmaz (2012) presents this initial coding of transcripts as one of the ways in which researchers recognise and seek to minimise the influence of their own perspective over the analysis of data. By seeking to create codes that describe the actions and perspectives that have been shared within transcripts, the researchers are inserting a step between data collection coding for meaning – as is seen in focussed coding. By conducting descriptive initial coding the researcher acknowledged that they must first identify the aspects of the transcript from which meaning can be drawn. In this way, the researcher systematically sought to focus analysis on the *content* of each transcript rather than on their *perception* of the content.

Focussed Coding & Categorisation.

Focussed coding and categorisation are co-dependent stages of analysis. In focussed coding the researcher writes codes that identify the meaning shared in lines or incidences of the transcript and initial codes. Within categorisation, data is organised in categories and properties based on the meaning that has been identified. Common or meaningful focussed codes can be elevated to categorical labels where this is theoretically appropriate. The creation of early proto-categories informs the lens that the researcher brings to focussed coding. In this way focussed coding and categorisation

Table 3

Initial Coding on an Excerpt from Patricia's interview

Speaker	Transcript	Initial Codes
Robert	Yeah, so 10 minutes as opposed to 20 minutes. And the way you describe it, it's sort of closer to where your life is, as opposed to being <in the other way> 20 minutes the other direction.	
Patricia	Yeah. And plus, I didn't have, I mean now that I've got teenagers, it's...<mhmm> Just, the lifestyle is very busy as well. So back then, it was just them, they were all I was focusing on and now, and uni as well, it's just a little bit crazy. <mmm>	Noting that the lifestyle of a family with teenagers is busier than with young children, and that her life is busier now than it was when they were younger
Robert	So a very different and potentially busier sort of lifestyle at the moment.	
Participant	Oh, yeah, it is! <okay> *laughs* <*laughs* okay> I'll be at the [stadium] till 8 o'clock tonight with the training. So yeah, it's a big day. <Yeah, busy> And then first thing in the morning tomorrow. <Ooh> Yeah, it's really, really hectic, but.	
Robert	So what impact does going to speech therapy have on your life?	
Participant	It was okay, when I went back this week, it was okay, because it was... [my son] was actually, because he can be really shy, but this time he just, we sat down and he talked to me <mmm> and she was like, "Oh yeah, that's age appropriate." And that was really good.	Reporting feeling really good that she was told that her son was 'age appropriate'

inform one another as categories become more complete, approaching theoretical saturation.

Focussed Coding.

Focussed coding seeks to highlight the pertinent meaning of the data which facilitates categorisation, but is not a process of categorisation in and of itself (Charmaz, 2012). Focussed codes were written into the relevant column for line and incidences of each transcript based on the content of the transcript and reacted initial codes. Focused codes document the meaning shared within the transcript using a line-by-line or incident-with-incident approach. Word-by-word was not seen as appropriate as a consistent coding approach for this project given the volume of data that was collected. However, coding of the meaning held by individual words in transcripts of the dataset were coded when they were identified as meaningful.

Cells of the focussed coding column within the Word document of each transcript were split and merged as needed so that focussed codes appeared alongside their related initial codes and transcript segments, using the same process from initial coding. Focussed codes were created to align with one or several initial codes, and as such there were fewer focussed codes than initial codes within the research project (see Table 4). Given that CGT researchers are encouraged to avoid distilling data down to a set number or proportion of codes, the number of focussed codes are still significant and not feasibly able to be counted. Because focussed codes act in-part as labels, there is a wide range of similar codes, but no fixed ‘set’ or ‘pool’ of codes from which the project emerges or draws.

Table 4

Focussed Coding on an Excerpt from Patricia’s interview

Speaker	Transcript	Initial Codes	Focussed Codes
Robert	Yeah, so 10 minutes as opposed to 20 minutes. And the way you describe it, it's sort of closer to where your life is, as opposed to being <in the other way> 20 minutes the other direction.		

Patricia	Yeah. And plus, I didn't have, I mean now that I've got teenagers, it's...<mhmm> Just, the lifestyle is very busy as well. So back then, it was just them, they were all I was focusing on and now, and uni as well, it's just a little bit crazy. <mmm>	Noting that the lifestyle of a family with teenagers is busier than with young children, and that her life is busier now than it was when they were younger	The time-cost of distance is more significant when there are other demands in the family, particularly if there are teenagers (who have their own routines and commitments)
Robert	So a very different and potentially busier sort of lifestyle at the moment.		
Participant	Oh, yeah, it is! <okay> *laughs* <*laughs* okay> I'll be at the [stadium] till 8 o'clock tonight with the training. So yeah, it's a big day. <Yeah, busy> And then first thing in the morning tomorrow. <Ooh> Yeah, it's really, really hectic, but.		
Robert	So what impact does going to speech therapy have on your life?		
Participant	It was okay, when I went back this week, it was okay, because it was... [my son] was actually, because he can be really shy, but this time he just, we sat down and he talked to me <mmm> and	Reporting feeling really good that she was told that her son was 'age appropriate'	Caregivers feel positively about services that lead to a positive outcome, but acknowledge that there is a process of work to get there

she was like, "Oh yeah, that's age appropriate." And that was really good.	which may be difficult

Categorisation.

Creating categories broadly takes research from coding to theory building phases (Tweed & Charmaz, 2012; See Figure 1). Categories were created through identifying focussed codes that represented patterns or significance within the dataset. Charmaz (2012) indicates concepts can be contextualised through a variety of aspects, including the temporal steps within a processes. Using the temporal steps of ‘service access’ as a basis, initial categorisation was conducted through diagramming. In this process, I sought to outline the steps of access following common features of a structure shared by several participants, therein creating proto-categories. Initial categorisation demonstrated several steps of awareness held by caregivers, and then outlined several steps of initial access, and maintenance. These steps created pathways to the top of the ‘ladder’ representing attainment of client goals (Figure 3).

This model presented several challenges. Firstly, the ladder assumed that the ultimate aim of service access was goal attainment, and as data collection progressed it became clear that some clients’ goals develop over time, and may not clearly be ‘achieved’ at a set point. Secondly, from a formatting perspective it became increasingly difficult to include the properties of each category and with several proto-categories being presented more than once it wasn’t clear if properties should be included in the model on only once, or several places. One of the key concepts reflected in the initial ladder model was that families move through several phases of services access and that while there is a typical pathway, many families made deviations from this.

After recognising that the ladder structure was not going to work for the concept of access as it was being constructed in data collection, I met with one of my supervisors to talk through this typical pathway that families went through. Through the course of the meeting we discussed several phases that were similar to the general steps presented in the ladder model. The difference being this time that each bubble included properties. Using bubbles also allowed lines to be drawn between each bubble, demonstrating links and relationships between phases of access. I later used the audio recording of this meeting to re-draw the phases across several pages. These proto-categories were set out as bubbles across several pages in a temporal structure moving from left to write (see Figure 4), within which tentative initial properties were listed.

Figure 3

Early 'Ladder' Model (17/6/2019)

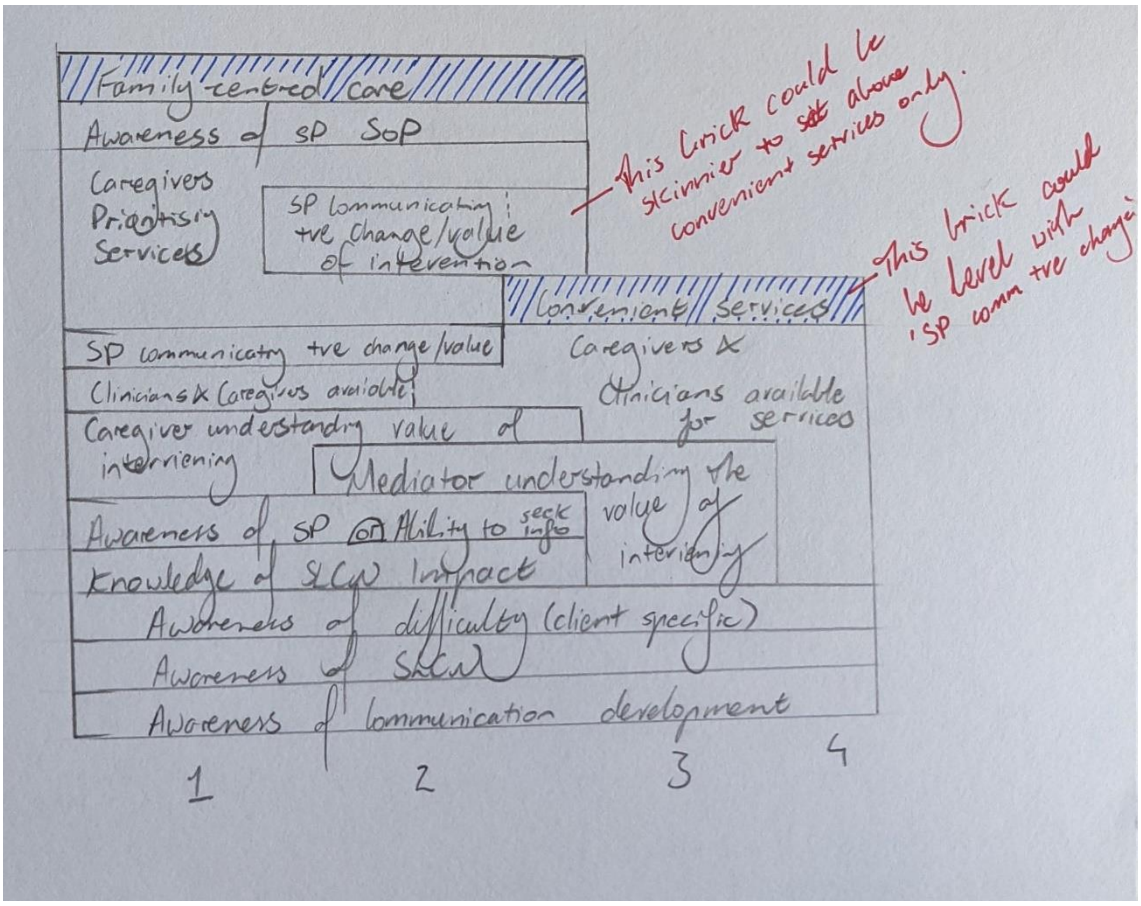
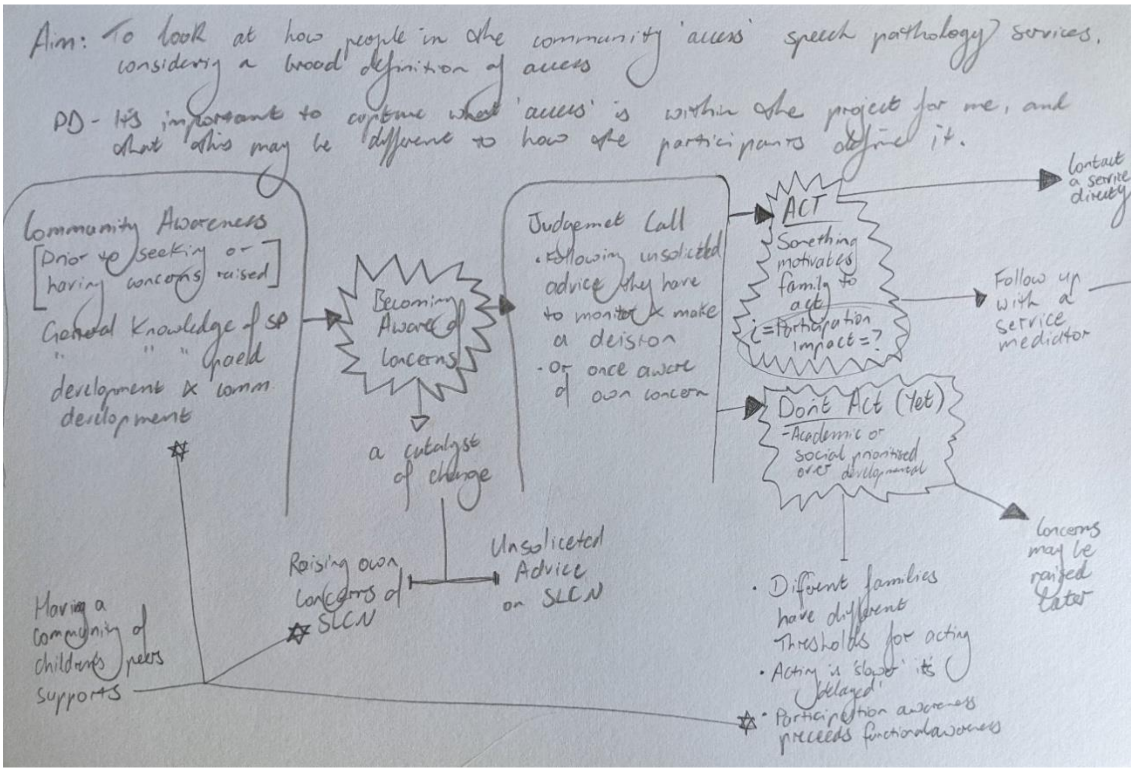


Figure 4

Temporal Model Page 1 of 4 (12/2/2020)



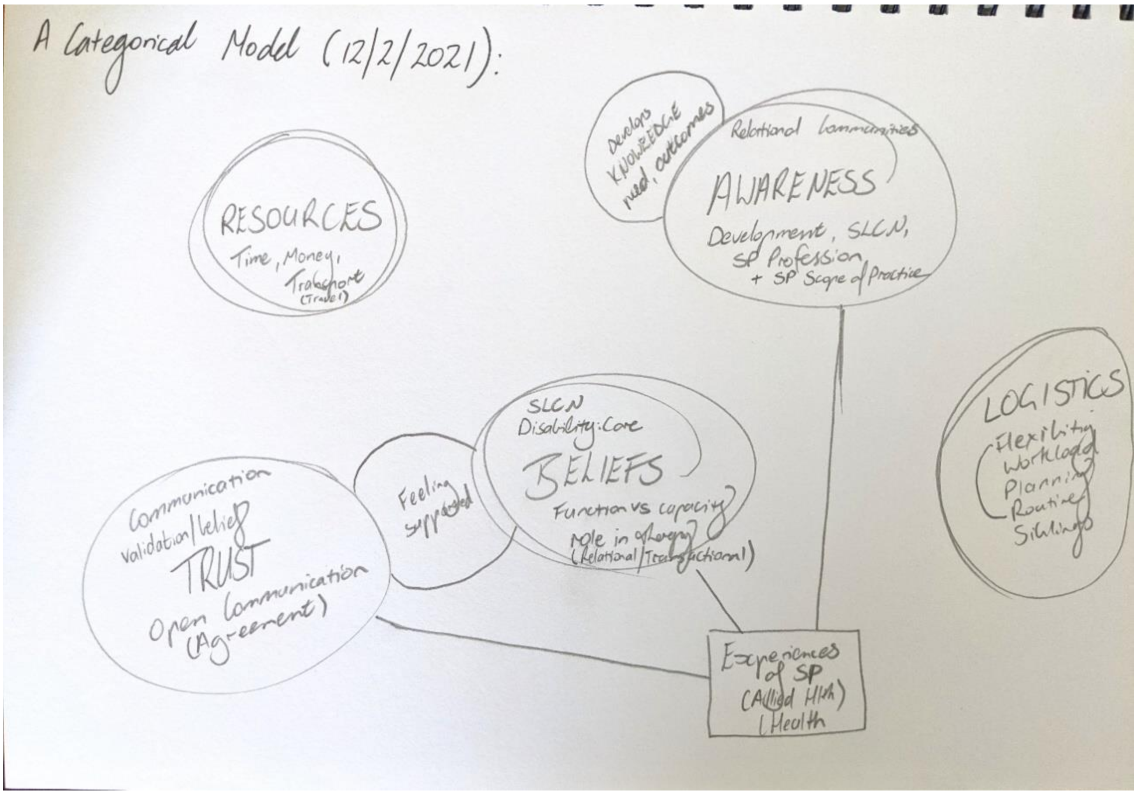
his drawing of proto-categories was then used in subsequent meetings as a prompt to discuss the properties of specific categories, and the positioning of proto-categories in relation to one another. By considering initial diagramming as being of *proto*-categories, I acknowledged that these may not be the final categories and properties, but that categorisation must commence in order to find an appropriate fit for the codes of the dataset. This initial step of diagramming with proto-categories served only as a framework for to facilitate categorisation.

At this time in the project, categorisation continued in parallel to data collection, initial coding, and focussed coding. While multiple phases of CGT occur in parallel throughout a research project, the point at which the temporal proto-model was built is exemplary of this, in that all data collection as well as all analytical phases were occurring at the same timepoint (cf. Tweed & Charmaz, 2012). As focussed coding continued two challenges arose with categorisation. Some identified properties of access were placed in several phases, such as within both initial access and maintenance, and other properties were not well placed within any given phase yet impacted all phases. With this in mind the properties a new model that was driven by cluster of properties was built. Initially this categorical model was drawn to address increasing similarities between initial access and maintenance phases (see Figure 5). However, as properties were clustered into proto-categories it became clear that a categorical model would be more robust in reflecting aspects of the construct of access.

After the creation of the first proto-version of the categorical model, conversations within supervision meetings continued to focus on the appropriateness of the model and the fit of the properties, as identified through focussed coding to the proto-model as it was being constructed. Transcripts were copied from their Word documents along with their initial and focussed code columns into a Microsoft Excel workbook with each transcript being given its own sheet. Two columns labelled ‘categorical codes’ were added to the righthand side of the transcript table. This allowed each transcript to be reviewed, and a statement of the applicable category and/or property to be added in a way that was attached to the transcript and earlier phases of coding. At the beginning of the process of categorical labelling within Excel I had intended to label all rows of each transcript within the dataset. However, as categorical labelling progressed the model began to approach theoretical saturation, and as such it was not efficient to label the categories of every transcript within the dataset. This process of recognising the approach of theoretical saturation is described in the relevant

Figure 5

Initial Drawing of the Categorical Model (12/2/2021)



section below.

Theoretical Coding.

Within CGT theoretical codes are created with the aim of coordinating the categories of the proto-model in relation to one another. Charmaz (2012) does not set out fixed parameters for theoretical codes. However within examples, theoretical codes are shown to be explanations of the links between categories, irrespective of length and format (Charmaz, 2012). Within this project theoretical codes were mostly handled in a similar manner to memos, they were audio recorded and created a record of the research team's perspective and understanding of how categories relate to one another. In addition to this, several meetings were held with a focus on discussing the boundaries and coordination of categories. These audio recordings of these meetings served as theoretical codes. After these meetings, I listened to the audio recordings and re-drew the next version of the model to reflect the understanding of access that was being constructed. In some meetings areas that needed updating were indicated with a blue post-it note, and areas that were highlighted as being incomplete and/or of theoretical interest were indicated with a pink post-it note (see Figure 6 for example). The notes taken on these post-it notes helped in the process of theoretical sampling, by indicating topics around which questioning needed to be developed: either generated or made more

Figure 6

Temporal Model with additional notes

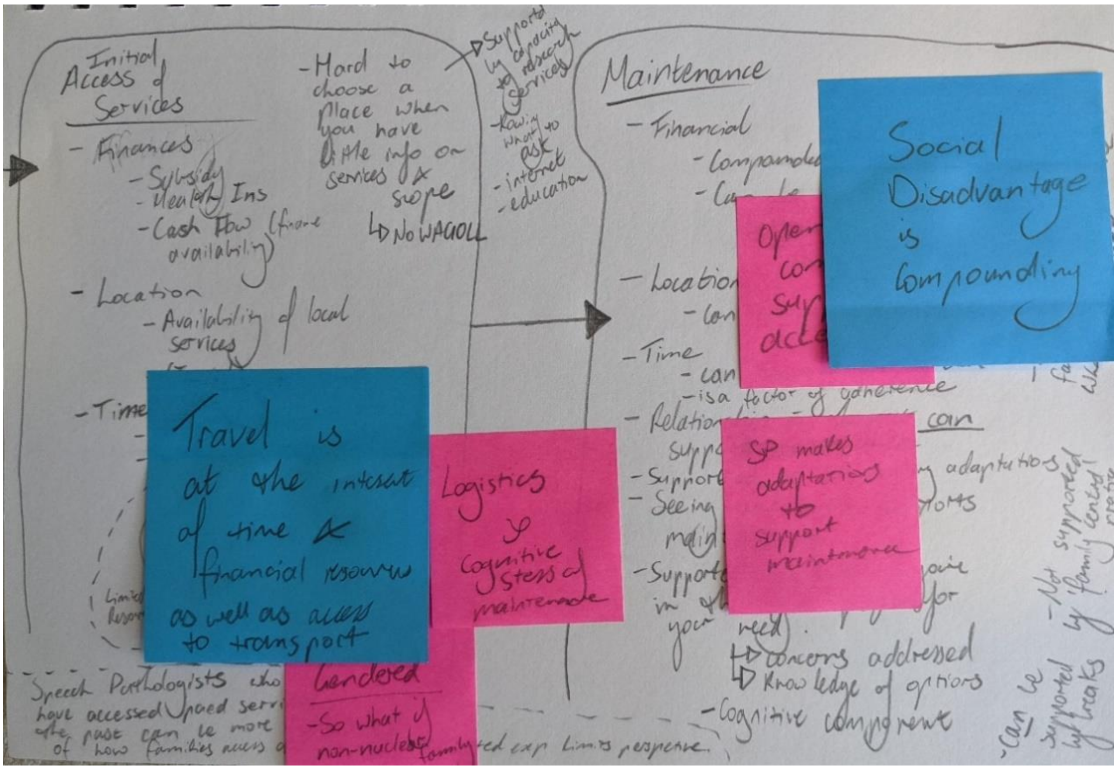
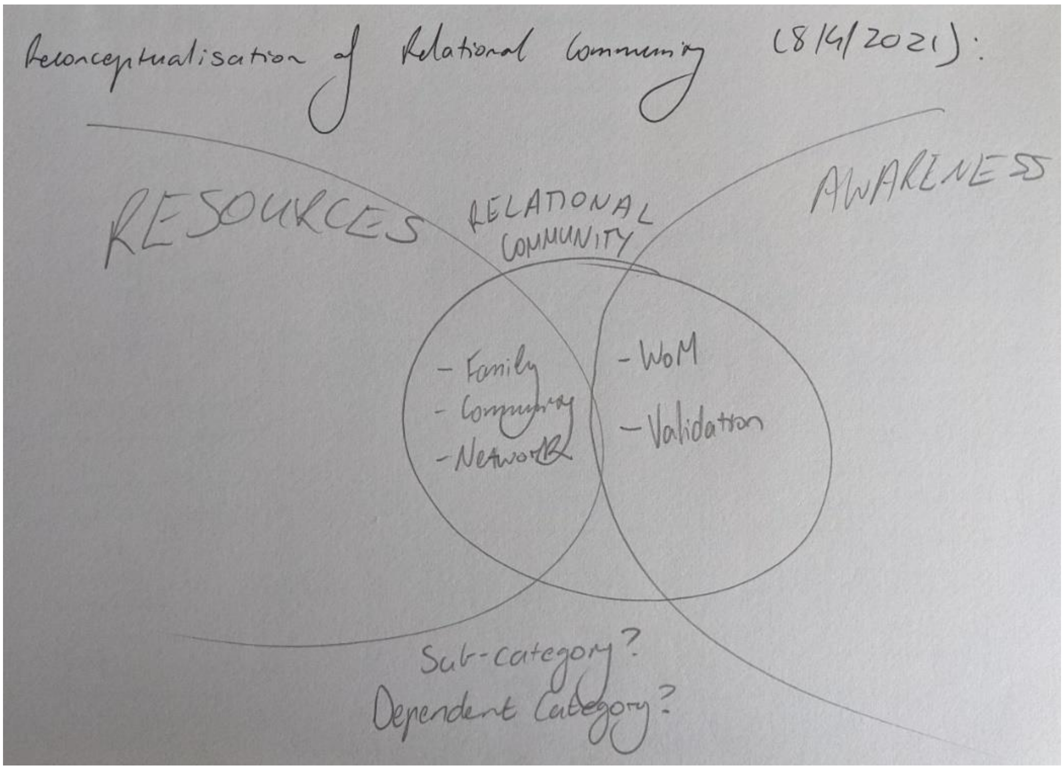


Figure 7

Visual Memo for the Re-conceptualisation of Relational Community as a dependent category (8/4/2021)



specific. Further to this, as new concepts for connections between categories were being constructed, they were drawn as visual memos. As the model is a visual reflection of the understanding of the construct of access, it was important that the relationships between categories could be communicated visually (see Figure 7 for example).

As the labels used for categories and properties changed through the project, focused codes were labelled within Excel using the labels that reflected the most recent understanding of the model. After creation of the categorical model I had monthly meetings with my supervisors in which we discussed each of the proto-categories and their properties. Between meetings I would continue with data categorisation and Excel and identify data that was incongruent with the most recent model. At each meeting we would focus on discussing how my understanding of access had developed since the previous meetings, and the fit within the model of the data that had been identified as incongruent. Following each meeting I would update the model and/or the proto-categories to reflect the discussions. In CGT the researcher is encouraged to move between focusing their analysis on the forest as a whole and on individual trees (Charmaz, 2012; Creswell, 2012). This iterative process of moving between categorisation of the data within individual transcripts and their application to the broader concept of the model supported me to develop a distance between my connection to the data, and my analysis of it. Focussing on the categorisation of data within individual transcripts allows me to explore each transcript in-depth and ensure that the model that is being constructed is grounded in the dataset. Shifting to discussing access as a construct that is expressed as a model which has categories and properties ensured that I understood the placement of data within the model. This ensured that model building and sampling were informed in a theoretically relevant way.

Theoretical Saturation

As discussed in the previous chapter, theoretical saturation is a process of data collection and analysis in which a property or category is considered complete because further data collection is not expected to yield new information or detail. Within data collection, theoretical saturation was considered when I reflected that participants were giving me expected or typical answers that were similar to the existing interviews in the dataset. Early in data collection, the questions were open ended and focussed on exploring participants experiences and perspectives, while throughout the course of data collection and analysis lines of questioning were removed or became more closed-ended. As codes generated from analysis of interview data became consistent with reference to the existing dataset, the questioning related to relevant properties and categories shifted. In the first instance, questioning shifted away from exploration and towards corroborating the understanding that was being constructed. This first change in questioning was made when I reflected on data provided by participants within specific lines of questioning as being ‘as expected’ or ‘typical’ within the broader dataset. Following this, once I reflected that participants’ responses to the closed-ended questions were no longer yielding new information or detail, I removed these questions from the interview guide. It is worth noting that theoretical saturation occurs for individual properties and categories rather than for the model, or indeed for data collection as a whole. Just as data moves through the phases of CGT at different times through the research project, different properties/categories also become theoretically saturated at different times.

An example of theoretical saturation in the interview guides can be observed with questioning related to family structure and gender. Throughout data collection information about caregiver participants’ family structure was collected using the demographic questionnaire. Within initial interviews while exploring barriers and facilitators to accessing speech pathology services, caregivers were asked to reflect on how their experiences of service access compared to other caregivers/families. Demographic data and interviews using this interview guide indicated that participants were mothers who typically reflected on their experiences as primary caregivers, and how they had supported other mothers as primary caregivers. Given the consistency of this pattern, follow-up interview guides (Appendix D) included a question exploring participants’ perceives of potential differences in service access for families who have non-typical structures. Here ‘typical structures’ were seen as two heterosexual parents living with and providing care for children, with the mother taking on the primary caregiver role as part of her workload. This example demonstrates how exploration of participants experiences allows for the identification of patterns, which can then be explored more directly, and then shift to closed ended questioning as the researcher constructs a clearer understanding of how a property/category fits within the construction of the larger model.

Quality Procedures

Quality procedures were used throughout this research to ensure that the model that was constructed is grounded in the dataset. In addition to memo creation, respondent verification and the creation of an audit trail were used to ensure accountability within the analysis of data and model building.

Respondent Verification

Respondent verification was used to support the co-construction of understanding, and to verify the accounts shared by participants. Interview transcripts were sent to all participants following transcription and manual checking. Participants were given the choice of receiving and reviewing their transcript via e-mail or physical mail. All participants chose to receive their interview transcripts via e-mail. In order to support participants in accurately reviewing the transcript of their interview/s, all transcripts were sent to participants within a month of the interview's recording. The e-mail sent to participants (Appendix E) outlined that they had 3 weeks to read, make relevant changes to, and return their transcript. Transcripts that participants sent through with changes within this 3-week period were accepted and included in analysis. For participants who made contact to confirm that they were happy with the transcript, or did not make contact within 3 weeks, the version of the transcript that they had been sent was be included in analysis. Most participants agreed with the transcripts that they had been sent and made no changes. No participants sent through changes after the indicated three-week cut-off period.

Audit Trail

An audit trail was used to note decisions that were made through the course of the research, creating a document of key milestones to look back to as the research progressed. I used a notebook to note and date key decisions, along with their justification. This reflexive journal also included written memos from throughout the research. In this project memos were created in two key ways: immediately following each interview; and throughout analysis as unique or connective reflections arose. These were either memos that were more appropriate to be written than audio recorded, or memos that documented my perspective relevant to decisions made through the course of the research rather than relevant to reflections on the dataset itself. I took minutes within an agenda template in every supervisory meeting. Each meeting was also audio recorded so that I could re-listen to the discussion of key decisions as needed. Documenting decisions through the course of the research project in a way that dated them and tied them to their justification allowed the decisions to be explicitly set in the context of the data that had been collected and analysed at that timepoint. This process allowed me to look back on key stepping points in the method of the model building, including the decisions around revising each version of the proto-model.

Team-based accountability

Meeting minutes from the course of the project form part of the audit trail. In addition to serving an administrative purpose, meetings were also held around the process of coding and model building. Meetings of up to 3 hours were held between myself and my supervisors approximately fortnightly between mid-March and the end of June 2021. These meetings were focussed on discussing the coding that had been done since the last meeting, and any queries regarding gaps that arose through the process of coding. These meetings also served as an opportunity for my supervisors to ask about the data in which the developing versions of proto-model were based. This process facilitated my familiarity with the dataset, provided a structured space for us to discuss data analysis as needed, and held me accountable to the use of codes in the process of data analysis. While no major issues were identified where I had coded or categorised data based solely in my own life experiences, these meetings gave us as a team space to discuss the grounding of the proto-model within the dataset. While meetings such as these are not an explicit strategy of grounded theory methods, they served to ensure that I was both familiar with the dataset and had also created cognitive distance between myself and my data. These meetings are not necessarily a strategy of CGT, they served as a quality procedure by keeping me accountable to the philosophical approach to data analysis.

5. Results: Introduction

Through the process of coding and comparative analysis outlined in the previous chapter, the Model of Access to Speech Pathology Services (MASPS; Figure 8) was generated. This model consists of seven categories and a list of three contextualising factors that reflect the cultural context in which the project's data was grounded. The intention of this chapter is to provide the reader with outlining how the model will be discussed. This chapter therefore should serve as an introduction to the Results section of the thesis. Chapters 6 to 9 seek to outline the model's categories by elaborating on their definitions, and by highlighting the properties of which they are comprised. Properties and sub-properties are shown in Figure 8 as dot-points within each coloured category. Each chapter begins with a summary to give the reader an outline and a figure of the model which highlights the positioning of the relevant sections to be discussed.

Chapters 6 to 8 present categories grouped together with the aim of extending the readers' consideration of service access. For example, Chapter 6 highlights the properties of the Resources and Logistics categories. In reflecting on my clinical experiences, the properties of the Resources category are more commonly considered by clinicians/service designers, and are more frequently considered in the literature. Logistics is concerned with the way in which these resources are applied to service access. Logistics is important and related to Resources, but less frequently considered in the literature. For this reason, I have structured Chapter 6 with the intention of talking the reader through these related categories to extend their thinking. The first three of the four results chapters have been structured similarly. Chapter 9 outlines the model's Contextualising factors.

Throughout the remainder of the thesis, I have used 'caregiver participant/s' and 'clinician participant/s' when discussing perspectives and experiences shared by each individual participant group. In the interests of making the thesis more readable there are instances where I only discuss 'participant' with no descriptor, in these cases I am referring to both participant groups together. The reader should note that individual groups have been specified where needed.

Both terms 'Aboriginal and Torres Strait Islander' and 'Aboriginal' are used within this thesis when referring to people who are members of Indigenous cultural groups within Australia or WA respectively. The phrase 'Aboriginal and Torres Strait Islander peoples' is typically used when referring to relevant national populations, services, and schemes; while the phrase 'Aboriginal' is typically used when referring to relevant WA populations, services, and schemes. These phrases are used in line with recent practice within Department of Health publications (Child and Adolescent Health Service, 2019; Department of Health, 2017b), and are not intended to cause offence. However, I would also seek to acknowledge to the reader that I am aware that I am using these terms as a person who is not Aboriginal or Torres Strait Islander.

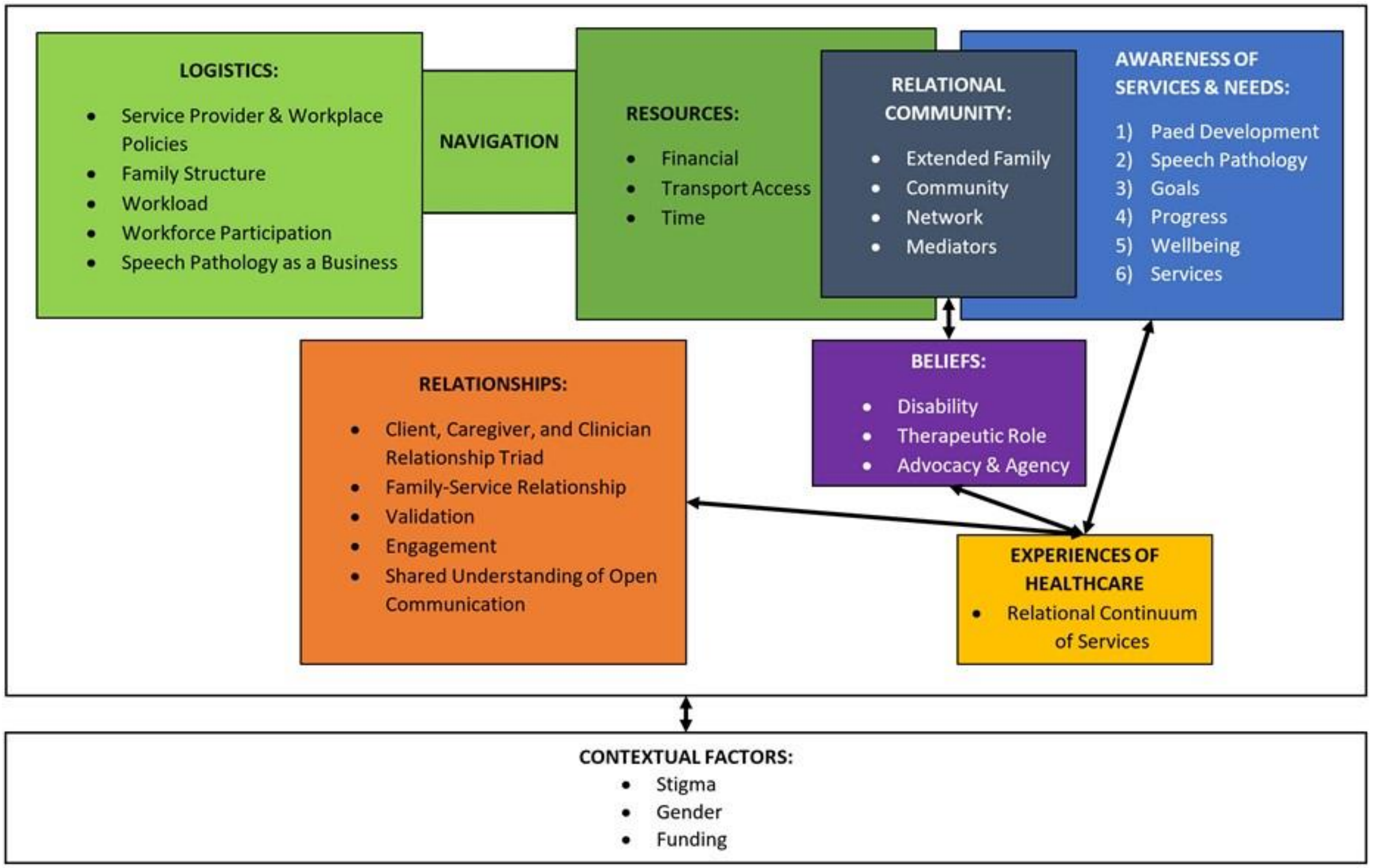
MASPS is the visual model drawn from the interpretive theory (Charmaz, 2012) that was generated using a CGT approach, and as such is grounded in the co-constructed dataset. Direct quotes have been included in the Results and Discussion chapters to provide the reader with insight into the participant voice, present direct examples, and reinforce the points being made (Bryant & Charmaz, 2007). Pseudonyms are provided as a source for each of the quotes. As CGT is an analytical approach there is not always a clear link between sections of decontextualised transcript and its related property or properties (Charmaz, 2012). It is important that the reader, and indeed service decision makers (service designers, clinicians, and caregivers) who use the model, understand that quotes and incidences included in this thesis have been selected as the most clearly illustrative examples from the broader dataset, and are not definitive descriptions of properties or categories.

At the outset of this research, it was intended that the eventual model could be used by service designers to identify barriers and facilitators potentially being experienced by an individual client with access difficulties, or to consider the positive and negative/limiting experiences of their clients' service access broadly. However, throughout the course of the research, the notion of barriers and facilitators became blurred, with almost all properties being able to be identified as either a barrier or facilitator depending on their quantity or interaction with other properties. The intention for service decision makers to be able to use the model to reflect upon and improve service access has remained throughout the course of the project. However, the way in which service decision makers could use the model has changed: instead of reflecting on individual facilitators/barriers, the structure of the model calls upon them to be considerate of a range of factors of service access that are indicated by the properties and categories of the model. The original title of the project was *Barriers & Facilitators of Access to Paediatric Speech Pathology Services in WA*, but has been changed to *Factors Influencing Access to Paediatric Speech Pathology Services in WA* to reflect this development in understanding.

Part-way through data collection it became important to have a clear understanding of the speech pathology services available to SLCN population in WA. In addressing this, I created a 'map' of available services based on their funding structures, based on publicly available procedural and business documents for public, non-government and private service providers and funding bodes. This ‘map’ has been included as Appendix F. While not part of the primary analysis of the dataset for this research, this document aided my analysis of participant interview data. The analysis of extant documents and the generation of analytical tools is considered appropriate within CGT (Charmaz, 2012). These extant documents (publicly available policy documents & business plans) were treated as secondary pieces of data, consistent with a CGT approach (Charmaz, 2012).

Figure 8

Model of Access to Speech Pathology Services (MASPS)

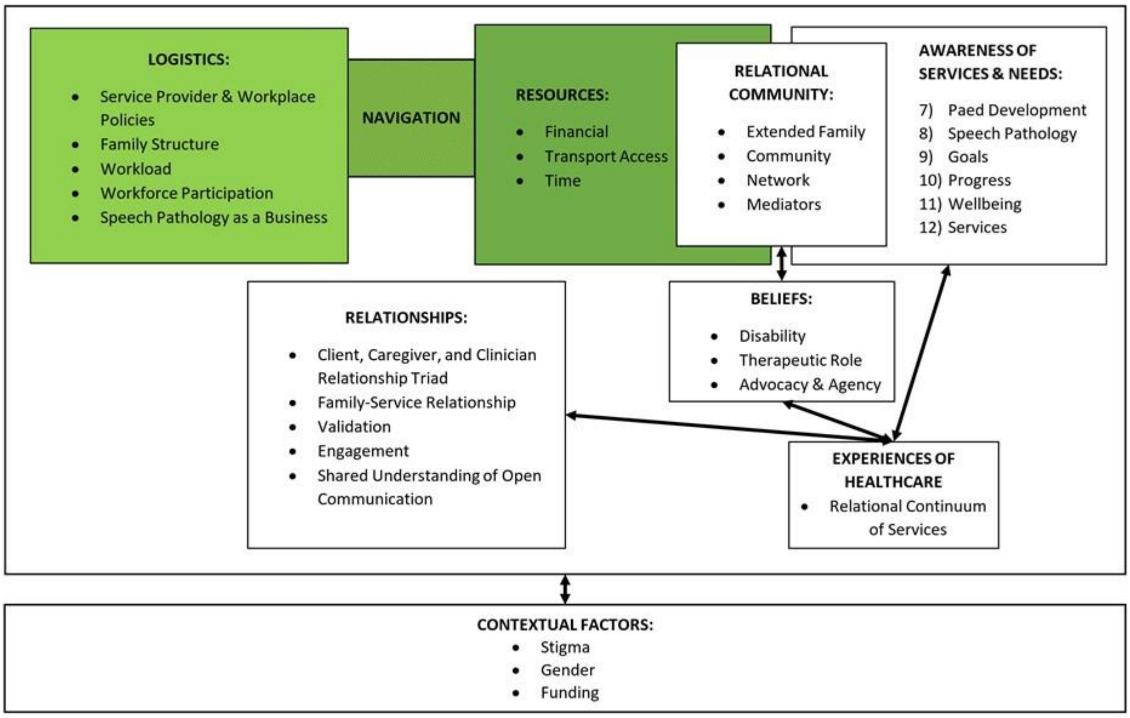


6. Results: Resources and Logistics

As acknowledged in the personal statement, prior to completing the study, typical conversations that I would have with clinicians and caregivers around service access tended to focus on the properties of Resources, as well as the motivation of clients' families. With this in mind, the purpose of this chapter is to outline how Resources and Logistics are related, and to consider how service access may be improved by moving from resources-centred considerations of service access, to a broader understanding which includes the Logistics of resource use. Held between Resources and Logistics is an active property of Navigation. This property identifies how caregivers negotiate the logistics of services with the resources that are available to them. The positioning of the Resources and Logistics categories and Navigation property is indicated in Figure 9 below.

Figure 9

Model of Access to Speech Pathology Services with Logistics and Resources Categories highlighted



Resources

Within the dataset, participants from both groups identified that accessing services required families to draw upon a range of resources. In some properties, Resources refers to anything that families were able to use to support their access of services. In general, within this category, having additional resources was discussed as linked to better access of services, though all caregiver participants described restrictions with at least one core property (financial, transport access, time) of Resources.

Financial Resources

Participants were not directly questioned about this, however both participant groups mentioned financial resources when asked about barriers to initial service access and maintenance of services, and often gave this topic emphasis. Given that participants in both groups frequently raised financial resources as a topic, it is unsurprising that it has become a property of the ‘Resources’ category. However, participants also discussed the financial cost of services as relating to their own financial resources, access/eligibility for funding packages, secondary costs, and indirect costs.

Caregiver and clinician participants discussed how families used their financial resources in relation to initial access and maintenance of services. Some services have a higher cost for initial appointments as there is a requirement that new clients undertake full assessments. In relation to this, participants from both groups perceived the financial cost of initial access as presenting a hurdle to services. Assessment appointments can be more expensive as they have additional costs such as test forms, as well as additional non-contact time for data analysis built into their pricing structure. Some initial appointments may also be longer in duration, in order for the clinician to both build rapport and administer the assessments, so the price may also be higher due to increased direct contact from the clinician as compared to an intervention session. Caregivers described having to save up for an initial/assessment appointment to obtain assessment-based recommendations from the service/clinician. Each service typically conducts their own assessments, and so families who had moved between clinics also expressed difficulty with having to repeatedly pay for initial sessions within these different clinics as they moved.

While there are funding packages available to support families to access services, there are different eligibility requirements for different funding packages, and families are not necessarily aware of these when they commence services. One of the most commonly discussed funding sources was Medicare’s CDM Plan. Participants expressed difficulty using subsidy plans of this sort, as they provide a standard subsidy which covers a flat amount of the cost, with no accommodation for additional financial costs of initial sessions/assessments. While identifying limitations in the use of the CDM Plan, participants were grateful that the system existed and that it is broadly applicable across allied health services, including speech pathology. After accessing initial appointments/services, caregiver participants expressed that the financial burden of the cost of service became a cumulative barrier to ongoing access to services.

All families were impacted financially either directly or indirectly, however families from different socioeconomic groups were impacted in different ways. While maintaining services, families began to financially plan for services within their pay cycles. Some families used a combination of savings and income within their pay cycle to pay for services, indicating that maintaining services presented a cumulative financial burden that would not have been possible in an ongoing manner. Families whose pay cycles could not accommodate having regular speech pathology sessions began to attend services less regularly or manage their finances in other parts of their life in order to navigate and continue to access services. This is illustrated in comments made by Dianne with an interview.

> Yeah, I’m fortunate enough that I don’t smoke, I don’t drink, I don’t do anything like that. So financially, it’s expensive, but it’s put into our budget, I have to meal plan, I have to make it work. Especially with me not working, so I’m a stay at home mum to the kids <yep> yeah. (Dianne)

Health insurance[2] was discussed as being a financial facilitator of services, but participants acknowledged that this came with its own challenges and financial management, in particular, that families had to plan out the use of their premiums to make it worthwhile from a financial standpoint.

Secondary financial costs were discussed infrequently, possibly as a result of physical tools being purchased and implemented less often in speech pathology as compared to other allied health professions. Some families had been asked to pay for additional resources in order to facilitate their use of strategies at home. Typically, these were children’s games or low-tech communication prompts/devices made by the clinician/service. The financial burden of these items was taken on directly by families, as secondary costs are typically not covered by health insurance or most funding schemes. Furthermore, families felt obliged to purchase these resources as they had typically already received the corresponding services, so proceeding without the resources may have made the services less effective.

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[2] While there is publicly funded healthcare in Australia, members of private health funds can access subsidies for private health services that are not covered by Medicare (Hopkins & Kidd, 1996). However, there are caps in place within any given calendar year. The total subsidy that is accessible to any given member within any particular sub-category depends on each fund member’s policy (cf. HBF, 2020; Medibank Private, n.d.)

While most participants in both participant groups acknowledged that services presented indirect costs for families, there was variation in the types of indirect costs discussed. Caregivers reported loss of income as a significant indirect cost of service. This was presented in both short- and long-term ways. Some caregivers took time away from paid work to take their child to services, presenting a short-term impact on their income. For caregivers with leave built into their contracts this presented as an opportunity cost: leave used to take their child to services could not then be able to be taken at a later date. For caregivers without leave built into their contracts, and/or who had exhausted the leave allocations on their contracts, attending appointments resulted in the direct loss of income. This type of experience is illustrated in Emily's comments.

> …you're still missing out on pay on that day. Yeah. <okay> Yeah, I know some of the other women from the [community group] saying "You know I just lose that day, I just… by the time I ferry the kids around and get them to these appointments. The day is gone." <yeah> I think they were doing a mix of government and private as well. They're having to pay for a service plus lose a day as well. Is quite challenging, especially if you're a low-income family. (Emily)

Alternatively, caregivers also shared how they had lost income in a more long-term way through choosing lower-paying yet more flexible employment, or through electing to have a lower employment fraction in order to have time during business hours without paid work to attend services.

Travel was discussed by participants as having a significant impact on families' ability to access services, presented as a combination of indirect financial cost, a secondary cost of time, geographical distance, and impacted by the families' transport options. Travel represents an indirect financial cost as families are required to pay for the running costs of their private vehicle, or for fares on public transport to attend services. While the indirect financial cost of travel would be present for all families attending services, the cost was highlighted in the descriptions of two extreme cases. One caregiver discussed spending hundreds of dollars each week on commuting from a country town to a private clinic in Perth, WA's state capital, and expressed that she may have to discontinue services as the tyres of her vehicle were becoming unsafe and replacing them was financially prohibitive. Within the metropolitan area, a clinician described the difficulty faced by one of her client's families. Due to appointment times and the family’s care structure, the client took public transport to his appointments with his mother and several of his siblings. While the service they were attending had no direct financial cost, the family spaced appointments to allow them to save for the public transport fare to travel to the appointments.

Access to Transportation

The availability of transport options was presented as a resource that families used to access services. In Australia, the use of private vehicles is common (Australian Bureau of Statistics, 2013) and plays a key role in the lives of people with disabilities (Haning, Gazey, & Woolmer, 2012). While no data was collected directly around the use of transport, most descriptions of travel discussed or implied the use of a private vehicle. Caregivers who have access to their own private vehicle typically did not reflect on the use of their vehicle. However, clinician and caregiver participants discussed families who shared a private vehicle or who took public transport to services, as having to plan for transport. For families in which multiple caregivers shared a private vehicle, negotiations were made around the use of the vehicle either at different times, or for different priorities. While not necessarily difficult, this demonstrates that not all families who are accessing services have easy access to private transport. Furthermore, this demonstrates one way in which families with access to fewer resources experienced increased cognitive stress associated with planning for services. This notion of planning for services is explored more within Logistics.

Beyond public and private transport, some families had access to subsidised travel such as taxi vouchers. The programs that are in effect focus on supporting Aboriginal and Torres Strait Islander people in Western Australians to travel either to or from services. The participants who raised this form of subsidy were health practitioners who had worked or were working within a public health service. While discussions of this subsidy centred on recommending widening the client base to whom it applies, it is possible that other participants did not raise this as they were unaware that it exists. Participants shared that the main limitations of travel subsidies were that they only partially funded travel, in that they provided transport, typically as a bus service or taxi voucher, either to *or* from services for any given client, and that these services focussed on providing transport to Aboriginal clients. Hellen explained how taxi vouchers can enable access, but for some families are still insufficient support.

> One thing I guess is we're using more taxi vouchers now, so encouraging clients that if you can get to us we will give the taxi voucher home, so then it's all… or vice versa, we can give you the taxi voucher to get to us, and then make your

> own way home in your own time. <mhmm> So I think that has been really positive. (Hellen)

Participants also suggested that this subsidy be increased to cover more travel options including supporting transport both to *and* from appointments, making better use of public transport infrastructure, and to apply to a broader range of clients who experienced challenges with access to transport options. Later in an interview, Hellen recommends broadening the support to include families who may be in need of transport access but are ineligible for the scheme.

> I find that it’s sometimes quite hard, in that know some clients are getting driven to their appointments, and getting a taxi voucher, and then there's other clients bringing seven kids from the bus, and seven kids back to the bus to come for an assessment <yeah> and they're not eligible for transport. <mmm> So I find that quite hard. But in terms of a recommendation, I feel like then the simple thing is that the accessibility… or the transport accessibility is eligible for everyone who needs it. (Hellen)

Time

One of the key resources that families draw on to access services was time. As with financial cost, families experienced both direct and indirect time costs in their access of services. Direct time costs were linked to the time taken by the appointment, and in adhering to recommendations such as home practice outside of the clinic room. Indirect costs are broader, and were shared by the client and the caregiver. Caregivers indicated that for school-aged clients who had appointments that overlapped with the school day, there was an indirect time cost in the duration of not only the session, but of the travel, and the time taken to settle back into class work once returning to school. For the caregivers who were transporting their child to and from services, there is an indirect time cost not only in the child’s travel time but additionally in their own travel time between the child’s school and the caregiver’s place of occupation, typically their home or workplace. Within financial resources it was acknowledged that there is an indirect financial impact on caregivers who take time away from paid employment. However, it should be noted that indirect time costs impact caregivers’ occupations whether paid or unpaid. It is important to acknowledge that the occupations of caregivers go beyond paid employment, such as routine housework and shopping, and caregiving for household members, and non-household members (Veerle, 2011).

Adding to this indirect cost of travel time, is time spent preparing for travel, and supporting children with these changes in routine. Caregivers spent time, not only cognitively planning for the trip, but also preparing food and games, as well as ensuring children were prepared for the trip. Participants mentioned preparing afternoon tea or lunch as part of their routine of access to services, so that children could be alert and get the most out of the appointments. Participants with longer distances to travel shared that they spent time preparing playlists of music and games so that the child could better engage in therapy when they arrived.

Each of these indirect time costs contributed to the way that families engaged in services. Participants shared how families had moved between services so that they could reduce the amount of travel time, and that in doing so they also saved time in not having to prepare as much for travel between locations. Reducing these indirect time costs meant that caregivers had more time to give to occupations beyond speech pathology sessions. Participants recognised that any time saved in travel was saved within their routine, and so had a cumulative impact over the duration of services.

Logically, any time that families spent attending services could not be spent participating in other activities. In this way speech pathology services, like any activity, presented an opportunity cost. This opportunity cost presented in different ways depending on each family's structure and socioeconomic bracket. For some, attending services regularly meant that they were less able, or not able to participate in community sport or other after-school activity, either for the client or for another child in the family. For others, attending services for a block of time meant choosing to not go on a family holiday. In this case, the caregivers saw it was more beneficial to attend services and seek to improve their child's HRQL than to go on a family holiday and delay reaching success in intervention. In a contrasting incident within the dataset, one participant described telling her clinician that the family were planning on cancelling an overseas holiday as they needed to attend services. The clinician reassured the family that they could take a break from services by booking the next appointment after the holiday, and gave the family support to implement strategies while away on holiday. The clinician highlighted to the family that holidays are a good opportunity for children to broaden their language use by experiencing new things. This conversation shifted the caregiver from feeling that they needed to cancel their family holiday, to seeing the holiday as a positive experience that could support their child's communication. While there are different decisions around the opportunity cost to families, and each family's lifestyles and opportunities is different, these incidences show that clinicians can support families to reduce some aspects of opportunity cost if they are able to discuss these together.

Logistics

Participants shared a variety of factors that impacted the way in which they planned for services or used their resources. Within MASPS, the way in which families use and planned to use their resources for service access is reflected in the category of Logistics.

Service Provider and Workplace Policies

The policies of service providers varied and had a significant impact on the way that families accessed services for their children with communication needs. This section of the chapter seeks to demonstrate that workplace policies impact families' ability to access services, not to document each of the specific ways in which this appeared within the dataset. It is important that service designers and managers reflect on how policies may be experienced by a range of clients, and not focus only on the specific examples presented in this chapter.

Several service providers have a policy that only the client and a single caregiver can be in attendance within a session. This is with the intention that the clinician can make the most of the time they have with the client and caregiver. However, participants from both groups indicated that this can lead to families not accessing services as they do not have the ability to arrange care for the client's sibling/s. Participants indicated that they understood the reasoning for policy, but felt that it was unfair to implement this while also not providing a crèche or similar for families to use. Without a nearby available crèche, families with regular paid arrangements for care may also incur additional costs for care during service times, increasing the indirect financial cost of the service. Indirect costs for services may also be incurred through usage of nearly crèche facilities, if they had been available. Furthermore, caregivers who do not have regular care arrangements for their other children would have to either call on extended family for support, or wait in the service waiting room with their other children. This need for caregivers to stay in the waiting room while their child was seen by the clinician, and hence not attend the appointment directly, was seen as a lower quality service by both participant groups, especially for families with younger children. One caregiver, Kate explains how this impacted service access for her son while she also had a young daughter, and shares how this may complicate services for caregivers with more children.

> I had my little child as well so I couldn't actually be in the appointment lessons with him. Because there would be parts where he would be in an appointment and I would have to stay with my daughter in the waiting area, <right?> keep her occupied while he had the appointment. <Okay> You can kind of see how it might be hard for some people that have three kids under three or that kind of stuff. (Kate)

Policies from a client's broader context may also influence their ability to access services. For example, some schools have policies around which subjects or units of learning that students can miss, and which are mandatory, particularly on a repeating or regular basis. For primary school-aged children these are usually literacy and numeracy, which are typically taught in the morning, which in turn can limit the times available for a student to attend an appointment.

In some services, caregiver awareness of speech pathology scope of practice areas was held as an expectation either by clinicians and/or was written into the clinic's service policy. Service policies may require caregivers to make decisions around which area or practice they are seeking to access for their child, but these may not have been developed to ensure caregivers understand the full range of practice areas and how these may be linked to their child's needs. One caregiver described how she was reassured by a speech pathologist about her son's speech development after an assessment, but that when she was originally asked about her concerns, she had not been aware of the difference between speech and language as different range of practice areas.

> So there was very little communication or education of that within those first appointments that we had when he was two and a half or four. I think when people said, "His articulation's fine. It's very... You were like, "Okay, that's good," but then there's this whole other part that I wasn't aware of, and now I am. <mhmm> That's the part that matters for him. (Sarah)

Expectations of caregivers' awareness of range of practice areas was highlighted in descriptions by clinicians who worked for services that were implementing elements of family-centred practice. Family-centred practice is an approach to service design in which health professionals create plans that are considerate of families and their goals within interventions (J. R. Andrews & Andrews, 1986). Some clinician participants identified that at their workplaces they implemented *elements* of family-centred practice rather than applying family-centred practice as an overall service approach. Participants described workplaces having policies around clinicians asking the caregiver/s for their area of concern, and then only being able to provide intervention within that nominated area. Clinicians reported caregivers describing their concerns for their child's communication as 'speech', and consequently the clinician was only able to act within the speech pathology range of practice area 'speech'. Clinicians raised concerns that caregivers had been using 'speech' in place of 'communication' due to their level of awareness of the domains of communication. This may have limited the service options available to families who accessed services at some providers, as described above. Awareness also played a role in other ways, which is discussed further in Chapter 7.

Family Structure

Family structures impacted on service access in several ways. Families with a greater number of caregivers had more hours each day from which to share the care of their children. This resulted in either one parent working more consistently to enable the other caregiver to engage in a greater proportion of unpaid work, or each parent being able to take on more direct caregiving roles. Expanding on this, families called upon their extended family members to support when more resources were needed to access services. Within the dataset generally, participants indicated that caregivers who had a greater number of extended family members who lived nearby were better supported to do this, not only for a single instance but over time. This is not to say that all families who have extended family members who live nearby are able to call upon them for support, but rather that families without extended family members nearby are not able to call on those family members to support with transport or time resources.

Participants in both groups reflected on seeing grandparent carers (grand-carers) in waiting rooms and attending services in place of parents. Clinicians indicated that this is sometimes part of a formal fostering agreement, and that sometimes the grand-carer provides support by taking the client to services, but the carer to which the clinician usually reports is the client's parent as they have parental responsibility.

Participants shared that they felt services provided to clients and families are of an equal quality regardless of family structure. However, families with fewer adults to share the care of children may find accessing services more difficult, as there is less time available to provide care within the caregivers' combined workload.

Overall Workload

Service access is impacted by the overall workload of caregivers and clinicians. Clinicians’ availability is impacted not only by the total number of appointments they have available during work hours, but also by the hours in which they offer appointments. For families, availability of sessions was impacted by the hours they have available to attend sessions, and their ability to embed attendance into their routine.

Families with fewer caregivers have less total time to provide care for their children, including taking children to speech pathology appointments. This is particularly true of single parents, who may not be able to take time away from paid work if they want to both attend and pay for speech pathology services. This is not to say that single parents have insufficient time to provide care, nor to say that overall workload does not provide a challenge for families with multiple caregivers, but that some family structures impact more on the choices caregivers are able to make around their workload. One caregiver participant described herself as a part-time single mum, as her partner worked on a fly-in fly-out contract. The blocked nature of her partner’s work meant that for some weeks there were fewer caregivers in the home to contribute to care, while in other weeks there were more caregiver-hours to contribute to care and to the workload of the family’s life.

Participants describe clinics as predominantly offering services during business hours. This not only means that caregivers and clients are drawn away from their primary occupation to attend services, but places increased pressure on school-aged services between the end of the school day and the end of the business day. One clinician participant described that she could meet need by seeing all her clients within the two hours after school.

> If I could clone myself, that would be good, <*laughs*> and only work 2 hours a day, but there’s 5 of me at that time, that would be good. I think families understand too. Like we all have certain hours that we sort of have to work and services try to be as flexible as they can, <mmm> but you can’t always get what you want. (Isobel)

Other clinicians offer before school appointments to reduce pressure on the block of time after school. In smaller clinics, these decisions about service hours are usually the decision of each clinician within the scope of their employment contracts. Another clinician participant indicated that at her larger workplace it would be possible for speech pathology sessions to be offered before school, and for clinicians to work part-time every weekday afternoon, however this option was typically not taken up as it was not the established practice of the workplace nor indeed of the profession. Families demonstrated a preference for sessions at the end of the school-day, and at the start of the school/workday as these sessions reduce the secondary time cost away from their occupations. Caregivers whose work is unpaid were more available during business hours, but all participants made considerations for their child/client having time away from their occupation as a student. Most caregivers sought to address this through attending appointments in the gap between the end of the school day and end of the workday. Some caregivers use their child's school timetable to arrange services during subjects that they felt were lower priority areas given their child's needs. In some but not all cases, this timetable planning was done in negotiation with the client's school. One participant shared that their selection of high-school for their children was impacted by the potential school's willingness to negotiate time for services and/or work collaboratively with their children's healthcare providers.

After families had accessed their initial services, participants indicated that it was helpful to plan and access services in a consistent way within a regular family routine. This allowed families to integrate service access into the workload of their regular routine rather than viewing services as additional, and so having to access service in *addition* to their regular workload. Integrating services within the family's routine was helpful for clients and caregivers to prepare for and engage in services, and to negotiate service access in consideration of their occupations. Having a set routine was also emphasised as important for building clients' capacity to prepare for and engage in services. One participant shared how her son has difficulty changing routines, and that when there are changes to his intervention routine she was careful to explain it to him clearly and repeatedly so that he understands, as it would impact his planning for his day, and the classes he would attend at school. This participant's description highlights the importance of caregivers and clinicians being able to communicate changes to clients, so that they can change their expectations and planning about their own workload. Changes to routine can be challenging for children who have communication needs (Bishop, Whitehouse, Watt, & Line, 2008; Harvey & Spencer, 2019), and caregivers and clinicians cannot expect that a client has understood this change just because they have been told about it.

Workforce Participation

It is important to note that caregivers reflected how service access influenced their workforce participation. Clinicians and caregivers shared examples of how caregivers may lose income, or take leave from paid work in order to bring their child to services, or to attend services with their child. However, caregivers also shared experiences of electing to work fewer paid hours per week, turning down promotions, or selecting workplaces based on workplace policies based on how supportive the leave arrangements were. One caregiver described how the need to potentially re-commence service access for her child impacted her selection of employment opportunities, and how she considered the supports the role may provide/allow.

> In the past, we've had au pairs when I was working full-time up north. We had people that would support us and that was quite good, but it would require a lot of planning and extra help in order to access those services. It definitely would change how I'm going to go in the future in terms of whether or not I would return to a job where you are stuck behind a desk <mmm> Monday to Friday from 8:00 until 4:00, whatever. That was certainly my previous job in [removed]. I think people are becoming more flexible in their approach to employees, but it's still definitely something that sits in the back of my mind as to why I wouldn't necessarily go down that path [of full-time employment] <mmm> and just continue to try and contract work. (Sarah)

While impacts of services access on workforce participation have been discussed around the properties of Resources, it is also important to acknowledge here. Some caregivers indicated that they had shared experiences of short-term loss of income with their clinicians, but did not indicate the same for long-term loss of income or employment.

Speech Pathology as a Business

While available Financial Resources act as a barrier for families to access services, caregiver participants communicated that they felt speech pathologists were appropriately renumerated for their work, and that paying their therapists less would not be an appropriate solution to reducing the financial barrier. Clinician participants shared that part of maintaining communication services for the community was ensuring that individuals had access to services, and that the community had access to services in a sustainable way. Participants from both groups indicated that sustainability of access to speech pathology services within the broader community was related to ensuring that these services could be run as a business. In both the public and private sectors speech pathologists sought to meet targets of numbers of clients seen either set by their organisation or set by themselves as an income target. Clinician participants shared experiences of lowering the cost of sessions to meet the value of the CDM subsidy for certain clients so there was no gap to pay for the service. Some clinician participants indicated that practice leads were able to provide a certain balance of pro-bono services within a caseload of clients. While these strategies are helpful and supportive of individual families/clients accessing services, they require the clinician or service to have an understanding a family's financial situation. While this is possible, not all clinicians and caregivers have full discussions regarding the family's financial situation.

There are two key strategies that supported families experiencing financial insecurity to access services. Caregivers found it supportive to process payments via administrative staff members rather than with clinicians directly, so that the family's financial (in)security did not impact their therapeutic relationship with the clinician. This allows families to separate the relationship they have with the service as a business, from that with the clinician as a therapist. Secondly, families who were experiencing acute or ongoing financial insecurity found it helpful to be able to access services and pay for them with an agreed payment plan. Participants who discussed these strategies for supporting access to private services also noted that this informed their preference for larger clinics, as they felt that a larger business would be more able to absorb the loss of income from a client not paying immediately, compared to small clinic or sole-trader; and, that a sole-trader would be less likely to have administrative staff with whom they could discuss the financial aspects of their access to services.

In contrast to this, caregivers noted that they relied upon clinicians to have a knowledge of funding options, and to support families to access relevant funding programs. The level of support that individual clinicians gave to clients depended upon the support that they felt the family needed. Clinicians may not want to share information about multiple funding packages as they want caregivers to focus on the clinical strategies and recommendations. As such, some clinicians may only share information about funding packages with families that have communicated that the compounding barrier of financial cost was becoming prohibitive to accessing services. This may mean that some families who are eligible for, and in need of, a funding package may not be made aware of it.

Navigation

Connecting Resources and Logistics is the property Navigation. This property has been placed in this position in order to appreciate that there are a range of service options available, and that caregivers may choose among these options. Choices may be made independently or in collaboration with a clinician or service. A clinician participant described how she may initiate conversations around moving the location of services that were previously provided at the client's home as she observes the family's maintenance of services from her perspective.

> …to keep on track with the strategies, if that's been a bit tricky to do it at [the client's home] so say we've said "We're going to do these visits at home" and it's just not happening. We'll try to look at, or talk to them about alternative environments <yeah okay> and how we can do therapy somewhere else. (Isobel)

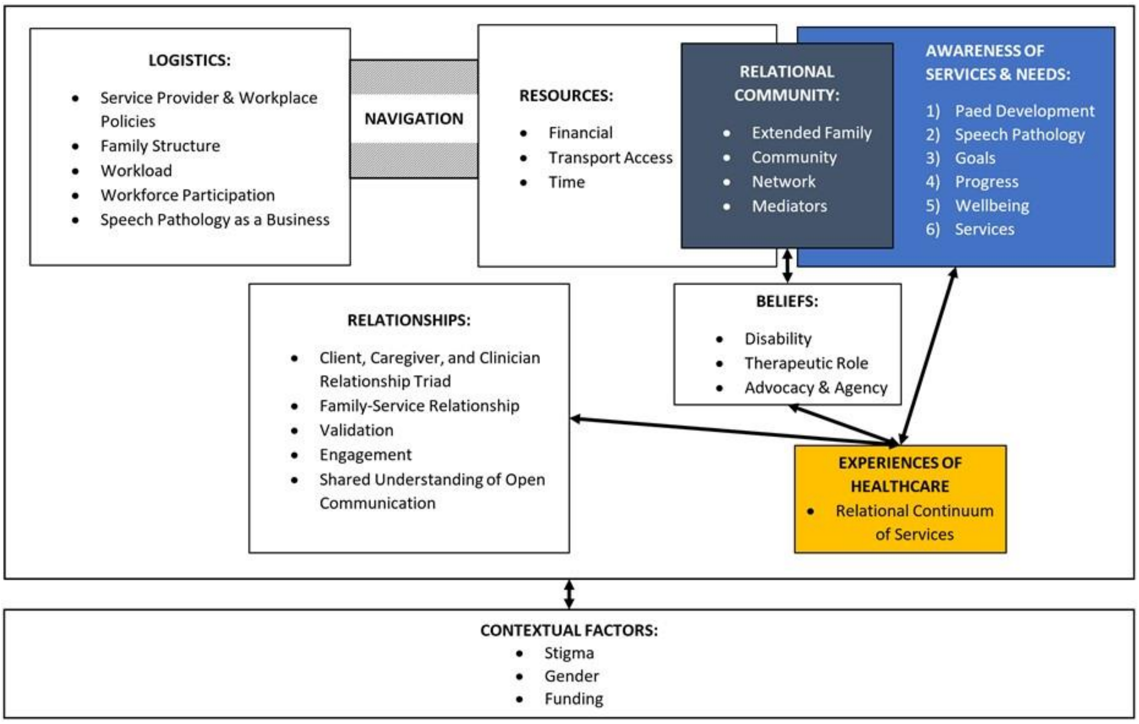
Within Navigation, caregivers make service decision by selecting the service that makes the most of the resources they have available to them, based on the logistics factors, and from the range of service of which they are aware. For example, families who have access to financial resources but limited access to time may choose to pay for home-based services. While there is typically a charge for the clinician to travel out to client's home, this choice alleviates the time cost of travel for the family. Conversely, a family that has available time but limited financial resources may choose to access a less expensive service that is further away. A family with several children may choose to select a clinic because it has a crèche or for its proximity to the family's day-care centre. There are aspects of Resources and Logistics that families may not have the ability to change, but the combination of properties over which they do have influence will in these ways be different for each family.

7. Results: Awareness & Experiences of Healthcare

This chapter focusses on presenting the properties of the categories of Awareness, and Experiences of Healthcare. Within discussion of Awareness, the dependent category of Relational Community will also be described, with links to the Resources category. This chapter will also outline how Awareness is informed by previous access of healthcare, and how these experiences are linked to the categories of Relationships, and Beliefs. The positioning of the Awareness, Relational Community, and Experiences of Healthcare categories is indicated in Figure 10 below.

Figure 10

Model of Access to Speech Pathology Services with Awareness, Relational Community, and Experiences of Healthcare Categories highlighted



Awareness of Service & Needs

Awareness is a key component of access. There is a clear lack of awareness of speech pathology; most caregiver participants indicated that they were not aware of speech pathology as a profession prior to seeking services, while those that were, had a limited knowledge of the breadth of the profession's scope of practice at that stage. Amongst clinician participants, discussion about gaps in caregivers' understanding of speech pathology and communication needs gave insight into the knowledge that clinicians expected caregivers to have when commencing services. In other Results chapters, properties of categories are presented in an ordinal manner, starting with the most impactful property from the data. In contrast, within this chapter the properties of awareness are presented in a hierarchical manner, where each property and sub-property build upwards upon the previous properties. This will start with awareness of general paediatric development through to awareness of speech pathology services

Awareness of Development

Participants highlighted the importance of a general Awareness of Paediatric Development as a base for the development of knowledge specific to the development of communication, and communication needs. Caregivers described how their understanding of paediatric development allowed them to identify differences between their child and their child’s peers. Identifying differences between children at similar ages was presented as a key skill: if not to identify specific needs, then to act as a catalyst for conversations within the caregivers’ peer group about the importance of these differences, and the need to act upon them. This understanding was linked in a complicated way to awareness of milestones. While caregivers used milestones as a general guide for the order of key developmental steps, some caregivers discussed receiving false reassurance from their community around broad developmental steps, and the notion of a wide range of expectations.

Beyond a general Awareness of Paediatric Development, participants noted that an awareness of communication specific milestones was important for their own identification of their child’s needs. Again, use of paediatric milestones was fraught with difficulty, just as for generic paediatric milestones. In some cases, caregivers provided descriptions of false reassurance for their concerns due to the understanding of milestones being broad, leading to families delaying access to services for their child.

> My firstborn son was three and a half when we first sought intervention. We noticed it before, but you think ‘things are developmental’ and you listen to other children, and it doesn't become that apparent. He was about three and a half when we both thought there is definitely something that we should probably investigate and look more into. (Nicole)

This awareness of communication milestones was linked to caregivers’ understanding of SLCNs. Speech pathologists held an expectation that caregivers commence services with an understanding of general paediatric development, if not of communication specific developmental milestones. This being said, clinicians did not expect caregivers to be able to identify or label specific communication needs or diagnoses.

Clinicians’ expectations of caregivers’ knowledge of communication development was evident in the way that clinicians described caregivers as having a poor understanding of the needs of their children. Using the World Health Organisation (WHO) International Classification of Functioning, Disability and Health (ICF) as a lens (Threats & Worrall, 2004), clinicians typically discussed intervention being structured around goals set to address functioning or capacity (Westby & Washington, 2017), while also reporting that caregivers shared concerns at the commencement of intervention that were phrased more around participation. This presented a key difference between the participant groups. Caregiver participants expressed that they had come to the speech pathologist as the 'expert' who could provide information and support for their concerns. While clinician participants appreciated that shaping goals was part of their role, they also shared that caregivers who commenced intervention with goals that were less specific, or related more to participation than function, were less informed. This difference in perspective on how intervention goals are formed and agreed upon is important as some caregivers indicated that they relied on the clinician to set goals and act as an expert, while clinicians did not report experiencing being relied upon in this way. The mismatch in perspective on goal setting from caregivers and clinicians may also contribute to complicating the goal setting process.

Awareness of Speech Pathology

Linked to an awareness of communication development and needs, was awareness of speech pathology as a profession. Most caregivers indicated that prior to their referral to speech pathology they were not aware that the profession existed. Those who did know about the profession either had a family member receive speech pathology service previously, or they held an allied health degree that had provided information outlining the roles of different health professionals. Participants in both groups suggested that awareness campaigns be run around speech pathology as a profession as this would also raise community awareness around communication needs.

Building on awareness of speech pathology as a profession, was the caregivers' awareness of the scope of practice in speech pathology. This awareness was in an informal sense referring to the profession's breadth of practice, but also to the range of practice areas encompassed within the profession's scope of practice (Speech Pathology Australia, 2016). Caregivers shared how their understanding developed as they interacted with the profession for different needs. Some participants indicated that they knew that speech pathologists worked on 'speech' as it was in the name, but were not initially aware of other areas of practice such as language, literacy, voice, or fluency. This highlights that understanding of the profession's scope of practice areas is low, but also tied to experiences of healthcare. One caregiver described how her understanding of Speech Pathology's range of practice areas differed now that she had been accessing services compared to when she first attended services.

> When he was two and a half, and we accessed speech for the first time, I thought speech pathology was just about how you pronounced your 't' and your 's's and your articulation. … A very narrow view, yeah. I had no idea it was about language, and I'd never heard of the terms expressive or receptive language probably only until like this year, which is frustrating. (Sarah)

Awareness of the range of practice of speech pathology both within and between services also played a role in service access. This is explored in more detail in the 'Service Provider and Workplace Policy section' in Chapter 6.

Awareness of Goals

The ability of a family to work with a clinician to establish goals is linked to their shared understanding of the communication needs of the child/client, and the ways in which the clinician can provide support. This is a property of Awareness as this type of awareness impacts the caregiver and client's sense of control over the intervention, and is related to their understanding of the progress. Each of these elements are related particularly to supporting maintenance of services, as an element of service access. While participants from both caregiver and clinician groups indicated that this would ideally be a collaborative process, the clinician may have a role to play in understanding and developing a caregiver/s' awareness of development, and of speech pathology as a profession to support this process. This is discussed further in Chapter 10. Using the WHO-ICF as a lens for understanding needs (Threats & Worrall, 2004) as in the Awareness of Development section above, caregivers with less experience of accessing speech pathology services typically phrased their concerns around limitations in their child's participation. One clinician described the diversity of goals that were indicated by caregivers, and how wording was important to the family understanding and recalling the goal long-term.

> Sometimes I've had kids who…they've come in because their kid is not walking because that's what they're worried about. And then the physio gradually sort of, does that work and helps them to see the other goals that we can help with. Because obviously… sometimes they're not that worried about the

> communication early on even though they could be, and they could access that service. <okay>
>
> … And then some are quite specific, they come with “This is my goal…”, “I need work on communication”, <yep> “I need a device” or “my kid can’t put their sentences together”. So it’s quite… it’s… it’s from both ends of the spectrum. <yep, okay>
>
> … we try to word the goals in their own words, <mhmm> so if [the families] review [the goal] in years to come, how they know that they’ll have made progress. Try to make it make sense to them. <yep> And the strategies that we will use to help them achieve that goal.

This is important to consider as clinicians typically create goals focussed on measurable functional outcomes drawing on psycholinguistic models, which focus on outlining an individual’s capacity for communication. As such there can be a discrepancy between how caregivers and clinicians understand a client’s goals. Despite this, both caregiver and clinician participants indicated that for therapy to be successful, a shared understanding of intervention goals was important. When discussing notions of achievement in therapy, clinicians typically focussed on achieving the final of a series of functional goals, while caregivers focussed on their child’s participation. These statements on participatory achievement were not always the same as the goals that the caregivers had commenced with, as some families had accessed years of intervention, but the focus on participation remained for long-term goals and their achievement. Neither approach to goal setting is inappropriate, however based on the dataset clinicians seem focussed on function goals, while caregivers generated goals in a range of ways that linked to participation. This may be related to the consistency required in training of speech pathologists as health professionals. If speech pathology as a profession intends to continue shaping goals focussed on measurable functional outcomes drawing on psycholinguistic models, then the burden of education would also be the responsibility of the profession and individual clinicians to support caregivers. Into the future, it will be important to acknowledge this discrepancy between goal understanding of clinicians and caregivers.

Awareness of Progress

Understanding of client progress by the caregiver and client is a key factor in maintenance of services. Caregiver participants indicated that they were more engaged in, and more likely to continue attending services when they understood the progress that had been made within or as a result of these services. Participants discussed the importance of the client understanding their progress regardless of their age. However, the way that progress is communicated would be considerate of their age and maturity. Caregiver and clinician participants identified that the two key factors that facilitated families continuing to access services was the awareness that the intervention was both worthwhile and justified. Families maintained services more easily when the intervention improved client communication, and when they understood that there was still more improvement to be had towards the overall goal. This balance of awareness within progress was tied closely to a family's maintenance of services. As such, it is important that clinicians assist families to be aware of a child's progression towards their longer-term goals, while also highlighting success in the shorter-term goals along the way. Supporting caregivers to understand the client's successes facilitates their engagement in services and recommendations, while supporting awareness of a remaining need for services facilitates families to return to the next service appointment as a step towards their long-term goal. In this way, awareness of progress towards a larger goal supports engagement in individual sessions, adherence to recommendations beyond the clinic room, and continued attendance at sessions.

Awareness of Wellbeing

Caregiver participants expressed that they were motivated to access services because they wanted the best for their child, and as part of this they wanted to reduce the impact of having a SLCN. This was also true for clients, in cases where they were aware of their SLCN they were observed by caregiver to be more motivated to participate in intervention.

> And I think also because [our eldest son] is a twin, so he has a twin sister who does not have a stutter, and I think he felt he wanted to improve on his speech because [his sister] would finish his sentences. She would bring out his words for him. <okay?> I think he had a very keen desire to work on this. (Nicole)

In line with this, caregivers typically held goals for intervention that were structured around the impact on their child's participation, as explored above. Caregiver and clinician participants shared how caregivers observed progress in part through observing changes in the client’s participation. Caregivers monitored their child’s wellbeing as part of maintaining services. This happened broadly in relation to their child’s overall wellbeing, and also with a specific focus on the impact of their child’s SLCN on their life.

> Seeing results. <yeah, okay> Yeah. Seeing him being able to communicate a bit better. He's having a better day at school, and him himself his spirits are a lot higher. <mhmm> That's what keeps me going, and makes me want to do it even more, is because I know it's only going to better him. (Dianne)

In this way, caregivers maintained services in a way that was considerate of their child’s HRQL (McCormack et al., 2012). This is explored in more detail within the Beliefs category.

Awareness of Services

Most caregiver participants described accessing several different types of services and more than one source of funding. Clinician participants indicated that they worked as part of a system of services within WA. No single service provided lifespan care across all range of practice areas. Few participants indicated in interviews that their service provided communication care across the lifespan, and those that did indicated that their service had a particular focus, such as physical or neurological disabilities. As such, caregivers used their knowledge of different services and funding packages to make decisions about which services to access for their children. These decisions were made both during initial access and in an ongoing manner. Caregivers used their knowledge of services and their child’s need to select the most appropriate service initially, and as their awareness of services and understanding of needs developed, they used this knowledge to change and select a more appropriate service for their child.

Caregivers used their knowledge of the network of services and funding pathways to seek access to speech pathology services. Caregiver’s knowledge was supplemented by their previous healthcare experiences. Some caregivers received information about funding or available services through informed members of their community or referring agents. One caregiver described her experience of being a non-medical health professional as informing her understanding that there would be a system that she could access.

> So, just knowing that the system… I had no idea of how the system works but <yep> but just know that there had to be a way in *laughs* <yeah, okay> and a way to navigate. (Amanda)

Once caregivers had gained access to a speech pathology service they relied on the clinician to build their knowledge of the network of services and funding pathways. Caregivers described that they perceived clinicians as having a greater knowledge of the network of services than they did, and that clinicians would identify relevant funding pathways to support a family. While clinicians saw identification of appropriate services and application for appropriate referral pathways as part of their advocacy for a client, they did not describe being *relied* upon by caregivers.

Awareness of Service Policy

In some incidences described in the dataset, caregivers were provided with mis-information, which impacted their access of services. One caregiver shared how she had been successfully maintaining services at a public clinic for her son's ongoing communication needs, and had been told that her son was required to move to an NDIS plan. The public clinic worked with the caregiver to successfully apply for NDIS funding, at which point her son was discharged from the government clinic. The family were unable to use their NDIS funding due to a lack of private service providers in their outer regional area. The government clinic had interpreted their own policy to mean that they were not able to provide services to a child who had an NDIS plan in place for the concerns that the NDIS plan was seeking to address. By discharging this client, the government clinic had left a child whom they had recognised as having ongoing needs without access to intervention services. Conversely, other participants described this same policy as applying to families who had *commenced* using their NDIS funding with a provider.

> When else would therapy end? Ahh, if a child receives a diagnosis of a disability. <mhmm> And then once they are picked up by their disability service provider, <mmm> so not just the minute they get the diagnosis, they *have to* be accessing a disability service. (Hellen)

While either description of this policy could be accurate, the inconsistency in the way the policy has been used as described by different participants, is concerning. Given that caregivers participants described that they relied upon clinicians to support their understanding of the network of available speech pathology services, it is important that individual clinicians understand the policies that impact on family's service access, and are able to either communicate the impact of these policies to caregivers as decision makers, or to advocate for appropriate treatment on their client's behalf.

Relational Community

Bryant and Charmaz (2007) indicate that sub-categories are possible within grounded theory work, as are properties that are dependent upon more than one category, such as Navigation within MASPS. In a similar theoretical sense, Relational Community is a dependent category between Awareness and Resources, as the community around a client's family both builds their awareness and acts a resource that they can rely upon to support their access to services. The properties of a family's Relational Community have impact within their resources and on their awareness, but are not wholly dependent on either category individually. There may be properties of Relational Community that exist without depending on either Awareness or Resources, but it is important to note here that the categories and properties are those identified within the data that relate to access of speech pathology services.

Relational Community within Awareness

The category Relational Community included each of the different spheres of community with whom the client, caregiver or family has a relationship. Three main spheres of the community were identified by participants: a clients' extended family; the family's social network; and, the family's professional network. This includes examples such as aunts and uncles, family friends from a community club, or health professionals such as the family GP. While logically proximity plays a role in relational community, communities within this category are based on relationships rather than locality. A visualisation of Relational Community can be seen in Figure 11.

Members of caregivers' relational communities develop awareness across any of the properties of the Awareness category, but play a unique role in awareness of communication development. When a caregiver has identified a concern related to a communication need, the relational community can act to validate this concern for

Figure 11

Visualisation of the Spheres of the Relational Community in the Model of Access to Speech Pathology Services

caregivers who then seek out services. Most caregiver participants indicated that they had concerns validated by members of their community at least the first time they accessed speech pathology services. When seeking validation some caregivers had their concerns allayed by members of the community with phrases such as ‘he’ll grow out of it’, ‘they’re too young for services’, or ‘wait until he’s at school’. One caregiver recalled her experience raising concerns about her son’s speech with the family GP and primary school:

> Well [the GP] discouraged me from putting him on a wait list. They immediately mentioned a wait list. <mmm> So the whole […] approach was, "You'll probably have to wait until he's in kindy <mmm> and then he'll get assessed at school and we'll see if there's a problem." And then the school – my kids go to the local public school but they have actually a speech pathologist there – was all like, "Just wait until he starts school". (Nicole)

There were caregiver participants who described having their concerns about their child’s communication allayed by members of their community, but who then persisted and accessed services anyway and had their concerns confirmed by a speech pathologist. While a number of participants in the study described these incidences of validation, there were also reports of families having delayed access to services by several years based on the recommendation of professionals in their network. The notion that families are being dissuaded from accessing timely services by their community, and in particular by other professionals, is concerning. This means that some clients can go years living with communication needs that are unaddressed. Understanding that caregivers seek validation of their concerns from their community highlights the critical importance of building awareness within the community around communication needs.

Beyond awareness of concerns, some caregivers described being supported to access speech pathology service by getting advice through their extended family or network, where they had links with allied health or speech pathology as a profession. The caregiver that was quoted in the Services sub-property above continues by saying:

> “My sister is also an occupational therapist, so I got her to kind of ask her speechy friends at the hospital what happens … just saying “What do we do?”, “Is it private, is it public?”, “What’s the pros, what’s the cons?”.” (Amanda)

Members of the relational community who take steps to facilitate a family or clients' access of speech pathology services have been labelled Mediators. Initially these community members were thought of as 'referring agents', however throughout the dataset Mediators act as catalysts for referral, but may not make the referral themselves. Mediators may encourage families to self-refer to services, or connect a family with another Mediator who is able to make a referral. Typically, Mediators were sought out by caregivers because of their experiences with paediatric development, either through professional or personal experiences.

The client's extended family are people with whom they have a direct or indirect kinship, sibship, or lineage relationships. Extended family members typically have a different place of residence to the client. Extended family members may act as a regular or semi-regular caregiver of the client. Members of a client's extended family may act as Mediators when they provide validation around a caregiver's concerns. Typically, this validation came from the caregiver's siblings (the client's aunts and uncles), or from the caregiver's parents (the client's grandparents). More broadly, a client's community consists of people with whom members of the client's family have an informal or social relationship that extends beyond their family unit. This can include friends and acquaintances of family members as well as indirect relationships, such as another mother at a parents' group, or members of a different family from school. Validation was seen within a community when caregivers shared concerns with other caregivers of children with a similar age. Any member of the broader community may also act as a Mediator by adding to validation of concerns by providing information about how the caregiver may choose to access speech pathology services. A client's network are those people and services with whom members of the client's family have a formal relationship beyond their family unit. These can include educators and health professionals, as well as other professionals and the services they work for, such as: occupational therapists, general practitioners, tutors, and teachers. Many caregivers described incidents of seeking validation from their network. General practitioners and classroom teachers were seen as common Mediators. While people in these professions were valued differently by caregivers (see the Discussion chapter), Mediators could be any member of the family's Network. Similarly, in the dataset some caregivers described instances where speech pathologists acted as Mediators to other allied health services by facilitating referral or access to services such as occupational therapy.

Each sphere of community included incidences of caregiver concerns being either validated or allayed. Some participants sought validation of concerns from a

Mediator within one sphere, and after having their concerns allayed, they sought validation from a Mediator within a different sphere.

Relational Community as a Resource

As outlined within Logistics, family structure impacts how caregivers plan for and access services. With this in mind, it is important to note that caregivers use their relational community as a resource in two key ways. Relational communities can be called upon by caregivers to alleviate pressure on the families' other resources or to address a logistic barrier to services, such as by providing care for a client's siblings during an intervention session. In addition to this, relational communities can also support by providing information to caregivers to build their awareness across any of the properties of awareness. While the relational community acts within the category of Awareness to validate caregivers' concerns, here the relational community is being seen as a resource in the way it holds information. Without validating an existing concern, the relational community can provide understanding to the caregiver to allow them to become aware of a need, or their child's improved communication, or about funding pathways or services previously unknown to the caregiver.

Mediators of Service Access as Members of the Relational Community

Specific members of a caregiver's Relational Community were described as being trusted by families for their knowledge about services or ability to provide a referral to services, these individuals have been labelled Mediators. Typically, in these incidences in the dataset, caregivers raised their concerns about their child's communication development with an education or health professional such as the child's classroom teacher, GP, or occupational therapist. Alternatively, a family's Network raised their own concerns about a child's communication development with their caregiver, raising Awareness of development or needs. In either case, the professionals within a family's Network typically proceeded to provide a referral to a speech pathologist. In this way members of a family's Network acted as Mediators of access to speech pathology services.

There were some commonalities in the actions that Mediators took to support families regardless of whether they sought to raise a caregiver/s awareness of needs, or were used by caregivers as a resource to access services for their child. When caregivers raised concerns, Mediators responded by either validating or allaying these concerns. Mediators that allayed caregivers' concerns typically provided reasoning related to the client's development, and why the communication features that the caregiver was concerned about were typical or within their expectations for the child's age.

Descriptions of the reasons to allay concerns that were given to caregiver participants were typically related to developmental stages being broad. In some cases, Mediators allayed caregiver concerns for service reasons linked to perceived challenges with accessing speech pathology services. In these instances, caregivers were occasionally told that they should not bother accessing services because waitlists were too long, or that their child was too young to benefit from speech pathology services. While waitlists do provide a real barrier to services, they are service specific. That is to say, that there is no one general waitlist for all speech pathology services across WA.

In most descriptions, mediators validated caregivers' concerns or raised concerns of their own with caregivers. Mediators typically then provided caregivers with a formal or informal referral to a speech pathology service. Formal referrals were typically provided by professionals within family's Network, either directly to a speech pathologist or via another Mediator such as a GP. Mediators also provided informal referrals, these referrals were drawn from a Mediator's own Family or Community rather than from their professional Networks. Similarly, members of a client's own Extended Family or Community acted as Mediators and were able to provide informal referrals. These referrals were typically to services that they had accessed either for themselves or their own children. The actions taken by Mediators are explored further in the Discussion.

Experiences of Healthcare

This section seeks to define Experiences of healthcare, outline how it links to other categories, and explore why it does not represent a subordinate category, intersect, or property of the categories to which it links.

Experiences of healthcare include an individual's previous interactions with healthcare providers and services which inform their schematic understanding of healthcare and health professions. In this research, this also refers more specifically to their understanding of speech pathology as a healthcare profession. While this category includes the way in which speech pathologists as clinicians understand the place of speech pathology within the wider healthcare system, it is important to acknowledge that such perceptions are significant and worthy of their own research, and as such are beyond the scope of this project (Tong, Roberts, Brewer, & Flavell, 2020).

Previous Experiences of Healthcare

Caregivers' previous Experiences of Healthcare inform the way in which they access speech pathology services. Caregivers' awareness of available allied health services and their funding pathways inform the services and funding they seek to gain initial access to the profession. For example, caregivers who had accessed allied health services for an older child described following the same pathway when they identified communication needs for their younger child, such as seeking out the advice of the same mediator. Caregivers who had accessed speech pathology previously, returned to the same clinician or service when seeking services regardless of whether it was for the same child or within the same area of practice. Caregivers shared how their understanding of the breadth of speech pathology practice increased as needs arose and changed for their child/ren. For example, one caregiver described how her experience of accessing services for her older child informed how she accessed services for her younger child.

> So in my case, we had one child and then five years later another child and I felt I was much better equipped to make that decision, and the resources that I needed, financially they were the same. It was much quicker for me to see whether or not the child was in the right place, and whether the therapy was working for him. So it goes back to again, understanding the interventions that we had for the first child. They weren't working for child number two so I was able to say “Oh, well actually no that's not working so we need to do something else.” I was much more of a player. (Nicole)

While this reinforces that caregivers’ understanding of a health profession develops with experience, it also indicates that there is a low level of community awareness of the profession’s range of practice areas. For example, one clinician described an incident where the caregiver of a client who had been working on articulation asked for a referral to a health professional that could support the client with literacy, not realising that literacy instruction is within the scope of practice for speech pathologists, and indeed an area of practice for that clinician.

Relational Continuum of Healthcare

Experiences of healthcare inform caregivers’ and clients’ understanding of speech pathology as a healthcare service. However, healthcare services are varied. Within allied healthcare some pieces of knowledge are transferable, such as the process for accessing funding within some schemes, while other experiences, such as the process of intervention are different. When discussing other health professions, clinician participants were more likely to compare speech pathology with other allied health professions, which may be because of their university training which supports categorisation of the healthcare system through grouping health professions in different ways. Conversely, caregiver participants were more likely to compare speech pathology more broadly with *any* other healthcare service or experience. Caregiver participants had varied previous healthcare experiences, but shared that their experiences of speech pathology were similar to psychology or occupational therapy. They also shared that while some key aspects of healthcare were similar across healthcare professions, their experiences of speech pathology were more different than accessing medical care or physiotherapy. This is true not only for the caregivers, but also for the clients for whom services are designed. One clinician shared a regular incident which she addressed within her large government clinic. The clinician indicated that the first part of her initial sessions is often working towards supporting her pre-school-aged clients to understand that they were going to play games and that playing with her as a therapist would not be a medical experience. The speech pathology department of this large government clinic shared a waiting room with the attached medical and nursing clinic. The clinician indicated that while the speech pathologists did not wear scrubs or lab coats, their professional attire was hospital-esque. When approaching some young clients she could see they were getting upset, and that they became more nervous as they then went to the clinic room. She perceived this as being related to the clients' previous experiences of accessing healthcare in this clinic, or in a similar environment. She described how many children in the local area would first be exposed to this clinic when they had their vaccinations, or if they had been to see the nurse when unwell. This participant perceived that this experience may have informed the clients' understanding that this clinic was associated with invasive procedures and sickness. This example highlights how clients' expectations of healthcare are informed by previous experiences, and part of this expectation is the relational or transactional model of healthcare.

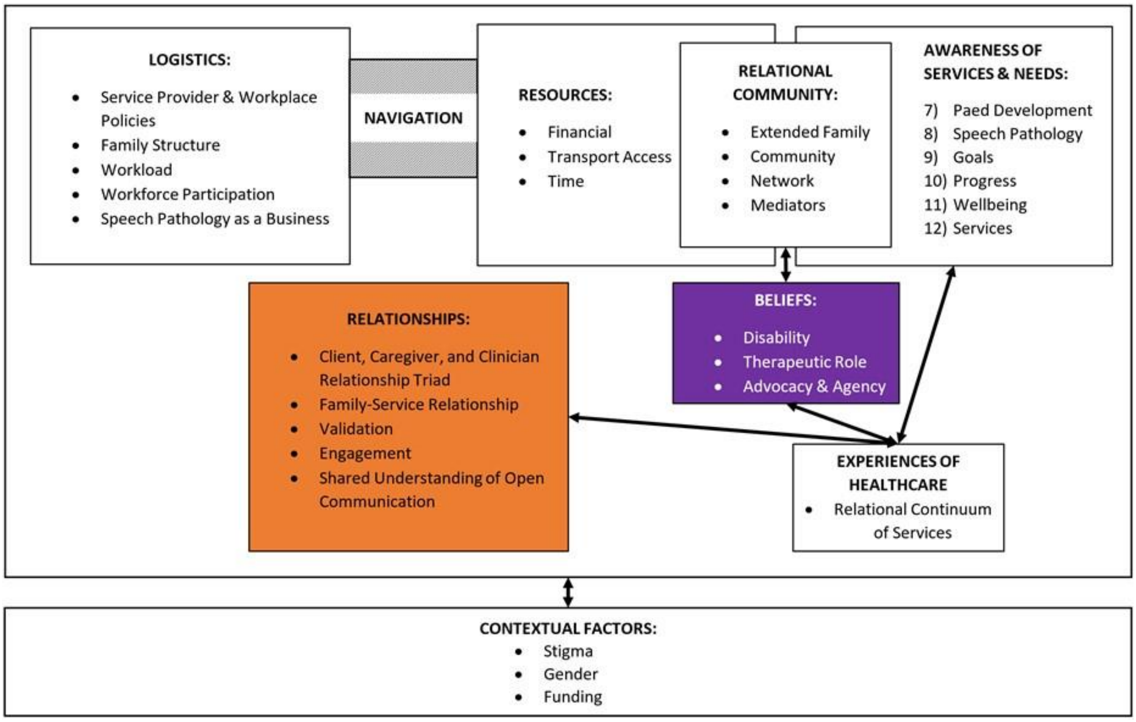
In this example, the client had viewed the clinic as a point of transactional healthcare where healthcare experiences are structured around the service being provided, such as a vaccine, rather than as a point of relational healthcare, where services are structured around the therapeutic relationship between the client and clinician, such as in speech pathology or occupational therapy. Previous literature (Porter, Mays, Shaw, Rosen, & Smith, 2013; Salisbury, 2020) has considered healthcare professions as being based in an ongoing relationship (relational) or tied to a medical model of healthcare (transactional). In a relational model, therapists focus on cultivating a relationship between themselves the client and/or other stakeholders (Salisbury, 2020). The work of the professional is client-focussed. In a transactional model, the professional seeks to provide care to address a specific issue or need (Salisbury, 2020). The care provided by the professional is condition-focused and transactional in nature. Participants identified similarities between speech pathology as it relates to other healthcare professions, with speech pathology being perceived as being more like other therapies such as psychology or occupational therapy, where the work of intervention is done by the client but guided by the therapist. Speech pathology was also perceived as less like nursing and general practice medicine, where the work of intervention is done by the professional, and sometimes perceived as being delivered *to* the client. The way in which participants described varying levels of similarity and difference between different health professions indicates that relational and transactional healthcare, may not be categorical, but exist more along a spectrum, with different healthcare services and experiences sitting along a line for transactional to relational. This theory acknowledges that each health profession includes elements of both relational and transactional healthcare, and that different experiences with the same health profession can exist at different points on this continuum. And as such, families' experiences with speech pathology and other health professions will inform their access of speech pathology services in different ways.

8. Results: Relationships and Beliefs

The aim of this chapter is to outline the properties of the categories of Relationship and Beliefs, and discuss how these are connected to Experiences of Healthcare. Within speech pathology, considerations of client factors and engagement with the client have been present for some time (J. R. Andrews & Andrews, 1986) in a way that focussed on making the most of client interactions within the intervention space (Westby & Washington, 2017). More recent work has considered how intervention can be supported through developing engagement within therapeutic relationships (Melvin, Meyer, & Scarinci, 2019). In this chapter I seek to explore how the relationships between individuals, and the beliefs held by those individuals, can impact on service access for families of children who have SLCNs. Given the focus on relationships in this chapter, it is important to note that each of the properties within the Relationships category can impact on experiences of healthcare, and on families' perceptions of speech pathology as a relational healthcare profession. This impact can occur at the level of individual service providers, and also of the profession. The positioning of the Relationships and Beliefs categories is indicated in Figure 12 below.

Figure 12

Model of Access to Speech Pathology Services with Relationships and Beliefs Categories highlighted



Relationships

This category outlines the factors which directly impact the relationships within intervention. Typically, participants spoke directly about relationships as being within the intervention period, but there was also data which suggest that the relationship between a caregiver/family and a service, or indeed speech pathology as a profession, was broader and more long lasting than individual therapeutic relationships. The properties below elaborate factors and features of these relationships as related to service access.

Relationship Triad

The Relationship Triad considers each of the relationships that exist within paediatric speech pathology services. These relationships are the connections made between the client, clinician, and caregiver/s. Each of these dyads have a relationship, and that relationship can be perceived by the third party. For example, the relationship between the clinician and the client can be perceived by the caregiver. While each of these relationships are important, the caregiver uses perceptions of the client-clinician relationship to inform their understanding of suitability of the clinician to the client. Caregivers then use this information to make decisions about proceeding and maintaining intervention.

The role of the caregiver changes with the maturity of the client. For younger clients, caregivers arranged services, transported clients to services, and attended the appointments. As discussed within the Logistics category, there were challenges for some caregivers taking part in clients' sessions. However, the fact that this was perceived as a challenge by participants indicates that caregiver participation was an expectation held by both caregivers and clinicians within services targeting younger clients. This expectation was in some cases part of the service provider's policy, and in others, a perceived non-explicit expectation that the caregiver held about the service. Part of this expectation was that caregivers adhere to recommendations from the clinician on the client's behalf, as the client is too young to take on strategies to implement independently between appointments. As the client became more mature, caregiver attendance within sessions became less common. Caregivers may still attend services, but participation was discussed less often. Caregivers of more mature clients commonly stayed in the waiting room while the client participated in therapy activities in the clinic room. A notion of handover was still described between the clinician and caregiver, but instead of recommendations being given to the caregiver to act on, the clinician shifted to giving recommendations and strategies directly to the client, with the caregiver receiving a copy, in part to keep the client accountable. As clients became more mature, caregivers received less detailed handovers, and there became an expectation that the client take greater ownership over their therapy. This first major shift in the balance of care within the Relationship Triad occurred when clients were already participating in intervention and were aged around 7 years, although participants noted that this shift was related more to the maturity and experience of the individual client than it was tied to their chronological age.

As clients became more mature, it became important that they understood that some parts of their intervention were not communicated to caregivers. This shift happened as clients became mature enough to not only have increased ownership/autonomy over their intervention, but also as they became emotionally mature and more able to express themselves within safe private environments. Stigma may play a role in this shift, as pre-/teenaged children become more self-conscious of the role that their SLCN plays in their life. As this shift happened, some caregivers ceased attending services, with clients using public transport to get to services, and then being collected by caregiver/s at the end of a session. This allowed a handover between the clinician and caregiver to happen, while shifting the responsibility for intervention further onto the client, and away from the caregiver. Either in line with this shift, or in cases where clients received intervention where the caregiver was not in attendance, such as some school-based services, caregivers typically received an e-mail or telephone call with a summary of the strategies and key points covered in an intervention session. The specific communication strategy for this handover was negotiated between caregivers and clients. While numerical data was not collected around the ages of clients in the experiences of either caregivers or clinicians, most participants shared experiences of services of children up to primary school-age, with some descriptions of high school-aged incidences. This may be a key area of further theoretical exploration, for families who are managing access while the client transitions from being a child to being a young person.

Throughout intervention caregivers experienced a range of emotional states. Most commonly, caregivers and clinicians described how caregivers experienced feeling grief around becoming aware that their child may require support through intervention, alongside relief that they were able to access those services. While incidences describing emotions throughout service access were included in the dataset, these descriptions are not consistent or widespread enough to identify a consistent pattern. For example, one caregiver described how she had experienced different emotions when identifying that each of her sons had a stutter. Her sons' needs were identified at different timepoints, which also impacted the timeliness with which services were sought.

> And for [our youngest son], I guess, even more it was heartbreaking because he had spoken so beautifully before whereas [our eldest son] had never spoken well. He just started speaking and he had a stutter, whereas [our youngest son] spoke and all of a sudden, he didn't speak without blockages, <yeah> which made it even more urgent for me. (Nicole)

Clinicians acknowledged that taking into account caregivers' and clients' emotions is important for the therapeutic relationship, which in turn contributes to how families access services. While clinicians identified grief as being important to acknowledge within therapeutic relationships, caregivers reported experiencing a wide range of emotions, sometimes even conflicting emotions simultaneously. Working to reduce this discrepancy between clinicians' perceptions and caregivers' experiences may strengthen therapeutic relationships and therefore be beneficial for access.

Family-Service Level Relationship

Just as clients and caregivers have a relationship with their clinician/s, families as a unit have a relationship with their service providers as organisations. When families sought to reinitiate services either for the same or different child, they typically did so by seeking services from the organisation that they had previously accessed. In some descriptions, the family sought services from the same service provider despite their previous clinician no longer being employed at that clinic. One caregiver described that her primary relationship with a service was with the administration staff member. She saw the administrative management of the clinic as valuable, and was happy to remain with the clinic after several changes in clinician due to ongoing difficulties with staff retention. The family ceased services with that clinic once the administration was shifted to be off site, and the caregiver felt that they no longer knew anyone at the clinic. Similarly, from the perspective of clinicians, some participants described working with several members of a family over several years, or even supporting families to identify communication needs for the siblings of the client for whom the family had initially sought services. In this way, the relationship that a family has with a service goes beyond individual clinicians, and the relationship that a clinician has with a family goes beyond an individual client.

Within interviews, participants described the importance of administrative staff in supporting the relationship of services with the family. Descriptions highlight that this is mainly done through administrative staff supporting the ease of attending services, and being a different individual with whom the family had a relationship for the financial management of services. As discussed in the ‘Speech Pathology as a Business’ property within the Logistics category, caregivers felt that working with administrative staff to manage payments and billing facilitated a positive relationship with their clinician, as it allowed that relationship to be focused on intervention, and not impacted if caregivers were having difficulty paying for services or if a payment plan was in place. Caregivers also described how administrative staff were able to provide support by letting families know when client’s funding packages were coming to an end, or needed input for management. This meant that caregivers could shift part of the responsibility of this management to the service, but this was only able to be done where caregivers trusted the service or administrative staff to do so. Caregivers did hold an expectation of this as part of the role of administration staff, however it facilitated access to services when it was present.

Families’ relationships with services were partly informed by their perceptions of speech pathology as a profession. Families’ previous experiences of healthcare, and specifically of speech pathology informed their understanding of the way speech pathology could support the client with their needs. Caregivers who had positive experiences with accessing services generally held a positive view of speech pathology as a profession and indicated that they would seek out services again if needed, from either the same or a different clinician. Some caregivers indicated having negative experiences with speech pathologists who either failed to develop a positive relationship with the client, or who the caregiver perceived was not individualising their intervention enough to warrant continuing services. Participants shared that having these negative experiences made them feel grateful for the positive experiences they had received in other situations, and were aware but wary of subsequently accessing services that they perceived as lower quality. After having a negative experience with speech pathology, some caregiver participants had ceased to access speech pathology services. Following a break, caregivers indicated that they had been encouraged to re-access speech pathology services, but typically did so with a different clinician or provider. At the time of her interview, one caregiver participant was accessing services for communication needs through a tutor. She shared that her family had ceased accessing speech pathology services after a negative experience with a clinician, and that they would not access services from a speech pathologist for as long as the tutor remained available. These experiences highlight that caregivers build a perception of how speech pathologists work based on their range of experiences with the profession. Caregivers with a greater breadth of experiences may attach negative experiences to individual clinicians or services, while caregivers with no or few previous positive experiences with speech pathology base their understanding of how the profession provides care in these negative experiences more broadly.

Validation

The way in which clinicians validated the concerns and perceptions of caregivers was identified as one of the key elements that contributes to their therapeutic relationship. Caregivers who had had their concerns falsely allayed by members of their Relational Community described feeling happy or vindicated when they persisted with accessing services, and a speech pathologist then validated their concerns. Caregivers retained feelings of worry or concern about their child’s communication development, but were happy to be reassured that they were on the right pathway to receive support, once their concerns were validated by a clinician. One caregiver shared how it felt good to have her concerns confirmed by a speech pathologist. She had acted by seeking services for her son for whom she had genuine communication concerns that had been repeatedly and incorrectly allayed by members of her community:

> Yeah really good. I was like, "Fuck you all." No. *laughs* <*laughs*> No, like it sucked, it sucked that I was right, <yeah, of course> and it sucked that he needed this, but it made me feel good that I had done my steps to get him in basically. <mmm, yep> (Kate)

For caregivers who did not share the same concerns as the referring agent who had referred the client to services, validation acted differently. Clinicians shared situations in which they did not want to emphasise the client’s communication needs in order to avoid putting the caregiver/s offside. Clinicians needed to balance communicating to caregiver the importance of intervention, without making achievement seem insurmountable, nor underplaying it. This was managed by clinicians in a similar way to communicating progress, by balancing information about need with the gains made by the client.

Engagement

A key property of the Relationships category within service access is Engagement. Engagement refers to both the way in which the client and family engage in intervention, and the way in which clinicians were able to engage client and caregivers in that intervention. By considering both perspectives of Engagement, we are able to see that access is not improved simply as a result of *whether* families engage in services or not, but also of *how* services and clinicians facilitate that engagement. Discussions of Engagement in the dataset centred on the way in which work was individualised for clients. Clinicians facilitated Engagement with clients by adjusting activities to the client's interest, beyond adjusting for each clients' goals, such as incorporating topics or activities of interest to the client. Clinicians also individualised recommendations beyond the clinic room in consideration of the client, caregiver, and the family as a unit. Caregivers perceived their children as individuals, and hence placed value on this individualisation when they observed that this had been conducted by clinicians. Caregivers reported that maintenance of services, as a phase of service access, was supported when they observed that their clinician was making an effort to individualise services, and when these modifications were able to make therapy a more enjoyable process for their child, the client. This was most clearly described in occasions where caregivers felt frustrated when the clinician altered activities to meet a client's goals but didn't take the client's preferences into account, or provided generic recommendations for implementation of strategies beyond the clinic room. One caregiver who accessed a government service felt that because her son was older than the average client at this service, the clinicians consequently had difficulty with delivering the intervention in a way that was appropriate for his age. The caregiver reflected that the clinician had explained the intervention and the caregiver had agreed that it was appropriate, but the way in which the intervention was delivered meant that the client and caregiver were less engaged in the therapy. The caregiver felt that the client would get less benefit out of a service that was not delivered appropriately, and therefore sought services elsewhere. Another caregiver had engaged with a clinician and was receiving a structured intervention program, but moved clinics as she felt that the first clinician's delivery was accurate but scripted. The family continued with the same intervention program with their new clinician, with whom they felt the client had a better connection. They continued intervention and achieved their goals with the second clinician. Another caregiver describes how a lack of engaging delivery of services, on the part of the clinician led to a feeling of the services being wasted.

> …just engaging the kid. We've been to 4 or 5 different speech pathologists for [my son]. <mmm> 3 privately and 2 through [government services], and I found

> that the [removed] one that just didn't click with [my son]. …she seemed quite new <yep> and very textbook. <okay> You know, she seemed to… if I took my son away she could continue reading and no one would know any different sometimes <mmm> and that lack of engagement. I felt that that service was wasted, that session was wasted. (Amanda)

Caregivers shared a perception that both the engagement and individualisation of intervention contributed to the progress that was being made within intervention. When caregivers perceived services to be delivered in a way that was not considerate of their child as an individual they typically sought out services from a different speech pathologist. Consequently, a lack of engagement or individualisation within services would not be seen as a limitation of access to individual clinicians or service providers, although it may act as a limitation for access to the profession only in situations where these behaviours formed a negative perception of the profession as a whole. As discussed within Awareness, the observation or perception of progress was the most important factor that contributed to the maintenance of services.

Shared Understanding of Open Communication

Open communication was included as a property of the therapeutic relationship by participants from both participant groups. In contrast to consent, definitions of open communication varied between participants, and were inconsistent within participant groups. Definitions included elements of honesty, and the sharing of all information relevant to the care of the client between the caregiver and clinician. It is not clear from the descriptions whether the intention was for the client to have an awareness of the information that was shared between the caregiver and clinician, however this may also be dependent on the client's maturity or perceived maturity. Participants in both groups had difficulty when asked to provide clarity around what constituted 'information relevant to the client's care'. Some participants indicated that services had agreements that were used within initial appointments around what information was appropriate to share with clinicians, or that clinicians may request of caregivers or client. However, this was not always the case. The key part of open communication that seemed to be important was that there was agreement within triads on what information was relevant to the client's care, and should therefore be shared.

Informed Consent within the Relationship Triad.

Informed consent was identified as a property of Open Communication (being a sub-property of Relationships). An understanding of informed consent that has been drawn from the dataset is discussed below. This is important as it exists as a property of the Shared Understanding of Open Communication, which was important for therapeutic relationships within the Relationship Triad. Participants noted the importance of communication between caregivers and clinicians, as well as between clinicians and clients based on the client's maturity. Several participants labelled this as 'open communication', however definitions of 'open communication' varied between participants. As outlined within discussions of the relationship triad, communication between key stakeholders involved in intervention changes over time and with the maturity of the client. However key components of communication described by participants were informed consent, and agreement within the Relationship Triad on open communication.

Descriptions of informed consent for communication were consistent within the data set. The general description for inter-organisation communications was that clinicians would only be able to contact another organisation regarding the client if they had express permission from the client's legal guardian, who was typically the caregiver; and, when the communication was focussed on improving the care of the client from the perspective of either professional. Conversely, participants indicated that consent for intra-organisation communication was implied by the family's access of the organisation. This is to say that both caregivers and clinicians described not needing express permission from a caregiver/legal guardian for the clinician to contact another professional about the client if the professional worked within the same organisation.

The notion that communication should be focussed on improving care for the client for either professional was present for both inter- and intra-organisation communication. Descriptions differed around the frequency with which clinicians checked that they still had permission to make inter-organisation contact. In most descriptions, clinicians contacted caregivers prior to each instance of contact with a professional from another organisation. Caregiver participants perceived this as a courtesy call to keep the caregiver 'in the loop', however clinicians perceived this as both a courtesy, and as providing caregivers with an opportunity to withdraw consent for the inter-organisation contact. Caregiver participants indicated that they were not aware that these courtesy calls function in-part to allow the caregiver to withdraw permission. In contrast to the use of courtesy calls, some participants described how their service policy was to check for consent to contact other health and education organisations relevant to the client on a regular basis, usually annually. Clinicians whose workplace used this policy perceived this as meeting the legal requirement for consent around inter-organisation contact. Clinicians whose workplaces had a policy such as this in place indicated that this was the minimum requirement, and that contacting caregivers about this more regularly was at the discretion of individual clinicians. Caregiver participants described incidences where they had given ‘standing’ permission for the clinician to make inter-organisational contact with some professionals, as they felt the courtesy calls were an interruption for both themselves as caregivers, as well as for the clinician. In these descriptions caregivers expressed that inter-organisation communication was part of the core role of their child’s clinician, and therefore they did not want to re-provide permission at every instance of inter-organisation contact.

Clinician participants provided definitions of consent for inter- and intra-organisation communication that were in line with Speech Pathology Australia’s (2020a) Code of Ethics, and/or service specific policies. Clinicians described following these policies to the best of their ability. Some clinician participants also discussed disclosing information between organisations without informed consent when they felt that doing so was in the interests of the welfare of their client. Some clinician participants indicated that service policies allowed them to do this on such grounds, while others did not clarify if this was the case.

Beliefs

This section seeks to outline the properties of the category of Beliefs that caregivers and clinicians hold in relation to accessing speech pathology intervention for clients. Experiences and perceptions shared in interviews identified three key properties of Beliefs, each of which have sub-properties. Beliefs around Disability, Therapeutic Role, as well as Advocacy and Agency each contributed to the construction of this category.

Disability

Caregivers’ and clinicians’ beliefs around disability were important to understanding how services were accessed. Caregivers shared experiences of identifying communication needs for their children, and then being cautioned by members of their relational community that they would not be able to change their child’s diagnosis regardless of whether they accessed services. Caregivers perceived speech pathology intervention, and by extension speech pathologists, as being able to support their child to improve their communication, despite the lifelong nature of some diagnoses.

Within the dataset, caregivers described a variety of relationships between SLCNs and disability. Participants described perceiving communication needs: as not being related to a disability; as being part of a broader and/or more complex disability, such as Autism; or, as being a disability in and of their own right, irrespective of the presence of a diagnosis. Participants noted that their perception of disability informed their view of SLCN as something that could improve over time with support from a clinician, regardless of which perception of disability they held. This may be because the caregivers who participated in this research had all sought, or were seeking services. Some caregivers shared that they had been told by members of their community that SLCNs were not a disability, or that their child's disability would not improve regardless of intervention. Each of the caregiver participants in this study described how they had ignored these points of view that discouraged their access of services, and sought services anyway. Regardless this data indicates that, at times, caregivers are being told by their communities that they do not need to, or should not bother, accessing support for their children with SLCNs. Marie describes how she was encouraged not to seek support as it could identify her children as having a disability, but that she persisted through this by viewing services as support, rather than an implicit label.

> No, no one. It was a very long road, and very lonely as well. <yeah> And nobody was there. And when went to that part, everybody asked me not to go there. Because I'll tell you… in [our family's] culture <mmm> and in from where I'm from, it's kind of still a taboo, not to tell people that you're <mhmm> kids got something, autism or any sort of disability. So, I was asked not to go <mmm>…but I did it myself. I thought "If there's help available, why not? Then they should take it." Already they are suffering so much, I didn't want them to not take help just because of what people said. <mmm, okay> (Marie)

Considering this broadly, it is worth noting that some caregivers may therefore have their concerns about their child's needs incorrectly allayed, or not see speech pathology as able to support their child's needs, and hence not seek services. This could leave clients living with the impact of unsupported SLCNs. In contrast to this, clinicians perceived SLCN as something with which clients could be supported, regardless of whether they perceived SLCN as a disability or not.

Therapeutic Role

Caregivers and clinicians each held perceptions about their own and each other's roles in intervention. Caregiver participants saw themselves as having an active role in intervention. Caregivers act as experts on their children and in doing so seek to give clinicians the information that they need to provide the best care possible. Some caregivers indicated that this process is one that develops over time, as when accessing services initially caregivers are unsure what information is relevant, but that this skill increases with their experiences with healthcare services. Caregivers of young children used clinical sessions to take on information and strategies to support the client outside of the clinic room. Where discrete home practice was given, the caregiver acted as a therapy assistant in delivering the intervention at the advised dosage. One participant described having to shift between roles as a mother and as a therapy assistant. Caregivers also took on an active role in integrating communication strategies into the home life of clients. Caregivers described doing this regardless of whether they had been given discrete tasks, or strategies to implement. The caregiver who was mainly responsible for arranging and attending services also often supported other family members, such as client's siblings and other caregivers, to implement strategies. In some cases, this was a coordinated effort with specific family members having a specific Therapeutic Role, while in other cases, recommendations were taken on by all family members in a more integrated or shared approach.

Advocacy & Agency

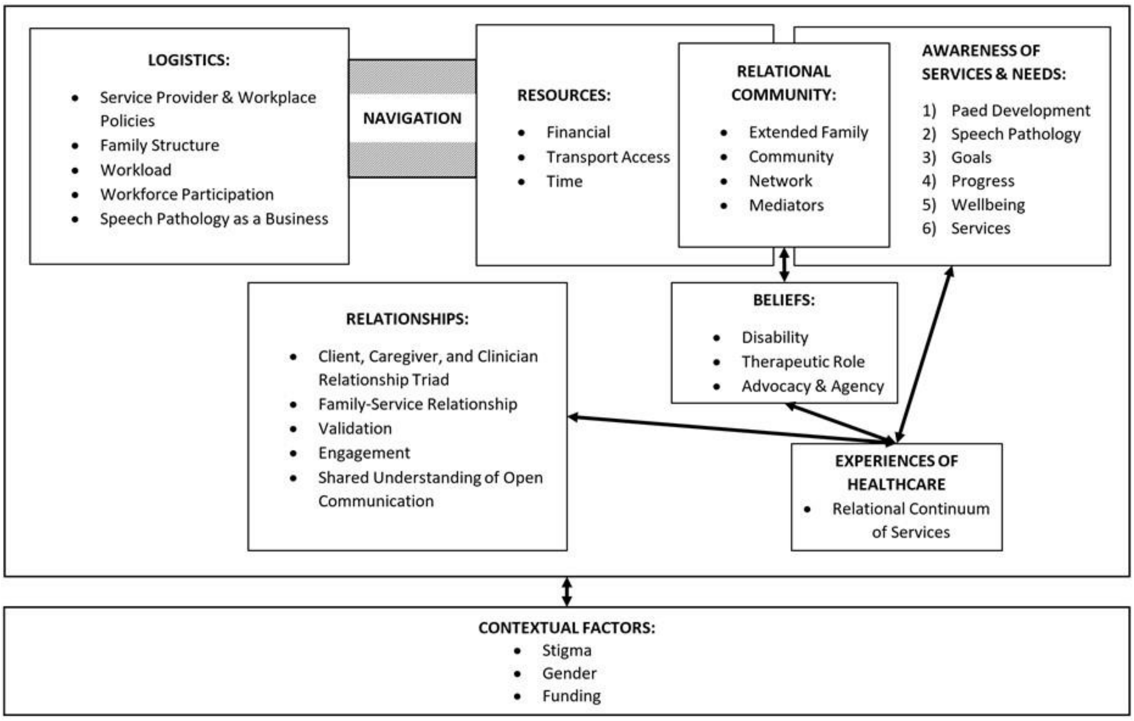
Caregivers also acted as their child's advocate across settings. This role was understood by clinicians, and there was agreement among participants from both groups that caregivers advocate for the client beyond the clinical setting. This may include passing on information to the client's classroom teacher/s, or following up with the school to see which strategies had been implemented at school. Caregivers also acted as advocates for their child as a person when negotiating strategies that were to be implemented. Clinicians experienced this with caregivers who would discuss the type or dosage of strategies outlined in the clinician's recommendations. However, caregivers also acted as an advocate in this sense outside of the clinic room. This type of advocacy beyond the clinic room was not discussed by clinician participants, which may reflect that clinicians have a limited awareness of how caregiver act as advocates for their children in other contexts. Caregivers saw their child as a whole person, and consequently balanced the delivery of strategies and adherence to clinician communication with the client's wellbeing and participation in other occupations of their life. For example, one caregiver described doing structured home practice activities to support their child's articulation needs, but not pushing for additional trials when the child was sick or tired. Here the caregiver was ensuring that the client, their child, did not develop a negative association with adhering to speech pathology recommendations while completing home practice tasks. Caregivers also described ensuring that the child had time off each day, as well as larger breaks each week, and ensuring that they could take time to participate in social activities such as community sport. In this way caregivers adhered to recommendations from their speech pathology sessions in a manner that was integrated with their lifestyle and considerate of their child's overall wellbeing and social participation. Given that caregivers' access of services is motivated by their concerns for their child's participation, as identified in the Awareness category, it is logical that caregivers balance their child's intervention with their overall wellbeing and social participation.

9. Results: Contextual Factors

In this chapter I will outline the Contextual Factors that arose through analysis of the dataset. These factors shown under the heading Contextual Factors in the lower section of Figure 13 below. They are not included in the model as a category, but clustered together in a list for convenience. Each of these properties were identified as influential across a range of categories of the model. I will seek to outline key examples of how these properties have broad influence over the model, and where appropriate will outline how the categories of the model also influence these contextualising factors. It is important to note that Stigma, Gender, and Funding each have an independent influence on the categories across the model, and so their order of presentation here is not intended to be meaningful.

Figure 13

Model of Access to Speech Pathology Service



Stigma

Within the dataset, a minority of caregiver participants shared that they felt there was a stigma around SLCNs and accessing speech pathology services, but that they experienced this stigma in different ways. It is worth noting that both caregivers that discussed Stigma in an in-depth manner also shared within other parts of their interview that they had migrated to Australia as adults, and perceived that health access operated differently in Australia than those in their country of origin. It may be that caregivers perceive Stigma as linked to their cultural background, and as such caregivers who grew up outside Australia are better placed to observe stigma in the community because they perceived themselves to be part of a non-dominant culture. Considerations of Stigma being located in dominant or non-dominant culture are important, but beyond the scope of this research. It is perhaps more important that service decision makers using MASPS acknowledge that some families do experience stigma, it can be present in many forms, and may be linked to cultural expectations. One caregiver described how she felt Stigma because accessing services was an implicit admission that her children had SLCNs. It is for this reason that she had been discouraged from accessing services for her sons by her extended family. This caregiver shared that she felt judged by her extended family for seeking services, as they felt that this reflected a lack of support within the immediate family. This was most clearly captured by a clinician who summarised:

> Yes, [there is] definitely [stigma]. I think it depends on what your cultural background maybe is that would dictate that, … it's typically [viewed as] the kid's mum's fault. It seems to be mum's fault, if that's the case. (Joanne)

Another caregiver described how she did not feel Stigma around her child having a SLCN. In contrast, she observed that she would feel judged by other parents if they felt that she had not done *enough* to support her children. Stigma was judged differently in these examples, for either accessing or for *not* accessing services. Of note, in both examples, caregivers were pressured by feeling as if they were seen to be not doing enough to support their children. As such, they shared experiences of being encouraged to act in a way to minimise the visibility of their child’s SLCNs: one by being encouraged not to seek services so as not to draw attention to her children’s needs; and in contrast, the other being encouraged to seek services to reduce the impact of her son’s SLCN.

Culture

Throughout the dataset there were incidences where participants shared perspectives on service access being impacted by caregivers’ culture, where the participant’s background was that of a non-dominant culture in WA. While logically the construct of ‘access’ is impacted by Culture, it is impacted by the Culture of the *whole* community rather than only by members with non-dominant cultural backgrounds. This being said, the Cultural elements of social constructs are perhaps more easily observed when including perspectives of people from non-dominant cultures.

A few caregiver and clinician participants across metropolitan and non-metropolitan settings shared descriptions of how Aboriginal families and clients more frequently have specific supports in place. Examples within the dataset were particularly focussed on Resources such as travel.

> I think they're doing a really good job, like the Aboriginal [descriptor removed] team is doing a really good job at allowing Aboriginal clients to access our service easier with the transport offers <mmm> and things like that. So I think that's great. If that wasn't in place that was definitely something I would recommend. (Hellen)

Some clinicians also described that some larger government services facilitated access for Aboriginal clients by having teams comprised partially or entirely by Aboriginal people whose role was to work with the Aboriginal communities.

It is important to note that access to healthcare services by and for Aboriginal Australians is impacted by ongoing racism both within and surrounding healthcare services as a direct result of the ongoing impact of colonisation (Hollinsworth, 2013; McDermott, 2019). There are services and schemes which seek to positively discriminate in order to support Aboriginal people to access health services, such as the follow-up allied health services within the Medicare benefits schedule for people of Aboriginal and Torres Strait Islander descent[3] (Department of Health, 2017b), or the transport offers described by Hellen in the quote above. However, it is important for clinicians and service designers to reflect on the way/s in which the experience of service access may be more difficult for Aboriginal families and clients, and to seek to address these differences in experience (Hollinsworth, 2013; McDermott, 2019).

Beyond this, both caregiver and clinician participants shared examples of how access to speech pathology services was experienced differently by people from specific cultural or immigrant groups within WA. Given that these descriptions were focussed on only a few of the many cultural backgrounds that make up Australia’s complex multicultural society, it would be an unfair overgeneralisation to present these as examples of how non-dominant cultural groups differ in their access of speech pathology services. With reference to Aboriginal cultural groups within WA, it is worth noting that this study did not set out to specifically recruit Aboriginal caregivers or

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[3] Here reference to Aboriginal and Torres Strait Islander peoples appears differently than in other sections of the thesis, as this instance refers to a Medicare benefits schedule item (Department of Health, 2017b)

clinicians within WA, however descriptions of access to speech pathology services by Aboriginal people were provided by participants in their interviews, and so are included in the dataset.

MASPS is a model which provides a visual structure to the interpretive theory of the social construct of speech pathology service access in WA around the time of data collection. Researchers may choose to use this model as a theoretical basis for investigations into how service access operates from a cultural perspective, or indeed with reference to specific cultural groups access speech pathology services. However, these specific differences are beyond the scope of this research. Future directions of research related to MASPS with reference to specific cultural groups is explored further in the Discussion.

Gender

While recruiting I noted that I was only contacted about research participation for either participant group by women. I created a memo on this topic and considered conducting maximum variation sampling of male caregivers of children who have SLCNs. Ultimately, I proceeded with recruitment without a gendered aspect, and monitored the gender balance of participants. No participants identified as male, however at the point that this had been established it was no longer practical to recruit and interview additional participants based on the overall timeline of the project.

In discussions around the caregiver's role in intervention, caregiver participants typically reflected on their experience as 'Mothers' rather than more generally as caregivers. In some interviews participants in both groups used the word 'Mothers' when talking about other caregivers. In this way Gender was not only a feature of recruitment, but was also demonstrated that service access and discussions of service access are gendered. Some caregiver participants shared that they felt they were more aware of their child's communication than their male partners.

> My husband probably would've waited a bit longer… (Nicole)

> …it's [generally] the mums who drive this earlier and the husbands seem to think, "He'll be fine. Let's just wait until he's in school and see what the teacher says." (Nicole)

In follow-up interviews, caregivers and clinicians were asked directly about the gendered aspect of service access. Both participant groups reflected that they had mainly observed mothers arranging services for clients, but that it was dependent on family structure, and was not the role of the client's 'mother' per se but rather of the client’s ‘primary caregiver’. Caregiver and clinician participants described that arranging services was typically the role of the caregiver who acted as primary carer for the family’s child/ren. Participants indicated that in WA this role typically fell to the family’s mother, as families in WA are perceived to typically follow a nuclear matrifocal structure, however, this role *could* be adopted by a father or other caregiver. Participants described this primary caregiver role as typically adopted by the caregiver with fewer paid work commitments. It is in this way that the Gender disparity in the workforce impacts upon the way in which services are accessed for children with SLCNs.

> I would just say that we [mothers] are the ones that are getting time off, either stay-at-home mums, or the dads are obviously in a higher paying job. So if anyone can take the time off, it's most likely going to be me, or single mum kind of thing. (Kate)

Caregivers also shared how accessing services for their children impacted upon their decisions to participate in the workforce. This has been explored above in the Workforce Participation section of Chapter 6. Given that mothers typically adopted the role of primary caregiver, it is important for the reader to consider that upholding existing stereotypes of service access may also influence gender disparity within workforce participation more broadly.

When asked directly about different family structures, both caregiver and clinician participants shared that they felt that the services received by the client would not differ based on a family’s structure or their gender of their caregivers. This is to say that services for the client would be delivered similarly regard*less* of their family structure. One clinician clarified by describing that she tailored her services to be considerate of families’ various structures. She intentionally delivered services that were regard*ful* of her clients’ family and care structure.

Funding

Funding has been included as a contextualising factor of the model, as participants of both groups expressed beliefs around funding that were intertwined with a range of categories of the model. It seems obvious funding is related to a family’s resources, however participants noted that most funding packages either subsidise or reimburse families for the financial cost of service access. Participants expressed that some families have difficulty with this model: a subsidy model leaves families with a level of financial cost for services; and, a reimbursement model leaves families having to pay for services up front and wait to be reimbursed. Participants described how not all families who qualify for funding schemes were in the position to be able to afford either subsidy or reimbursement approaches.

There are funding schemes that can cover an agreed amount of a client's intervention upfront, such as the NDIS stated supports (National Disability Insurance Agency, 2021) or charitable donation, however even funding of this type requires that families or clients meet certain criteria to be eligible. Some families were required to attend and pay for services so that the client could be assessed in the first instance. Even in the case of successful applications to a funding scheme, families typically paid for these initial assessment services. It is also worth considering that direct financial costs are not the only costs to families for attending services (see Chapter 6). Participants also shared their perspectives of demographic-based funding schemes that sought to support particular segments of the community. Clinician participants recommended broadening funding schemes, such as for travel to services based on need, rather than on demographic information, such as a person's Indigenous status. However, clinicians also shared that they felt that means-testing for such a service would be complicated.

> But also I think that sometimes there's other families that aren't Aboriginal that are just as disadvantaged, <mmm> that would be eligible for a service like that as well, or should be eligible for a service like that as well. But unfortunately they're not. … I feel like then the simple thing is that … transport accessibility is eligible for everyone who needs it, but then at the same time I don't know how you police that within a service of saying "Well you're eligible…but, can we check your bank?" "Do you have a car. Let me look at your car" "Yeah okay. No, you're not eligible". (Hellen)

One caregiver participant highlighted how access to these different types of funding schemes have a requirement that families pay for services in some way. Indeed this may be by design, as some clinician participants shared how they had observed families spending funds more cautiously when they were private savings compared to money obtained through a funding scheme. This perspective may also be shared by those responsible for designing funding schemes, however people in these roles were not interviewed within this research. Having considered that, the perspective shared by these participants highlights that there is a belief held within the community that families demonstrate that they are financially committed to services before receiving financial support.

Access to funding schemes is a large and complex area that is beyond the scope of this research. Within MASPS, it is important for service designers and decision makers to consider that these schemes have their own factors that impact access, and that not all funding schemes may be accessible or appropriate for all people. Providing fully financially supported access to speech pathology services may not be realistic, however Australia has means-testing linked with healthcare beyond allied health access, such as through the Healthcare Card programme (Services Australia, 2021). While complex, it may be appropriate to consider how health funding can be used to best facilitate service access for families in a way that is considerate of their contexts and needs.

10. Discussion

While the results chapters have been structured around the categories and properties of MASPS, it is important for the reader to note that they should consider the model as a whole if they are using it as a framework to design or review service access. While each category can be discussed separately, the relationships between categories are also important. Furthermore, what is important to one family or service, may be less important to another. For example, participants tended to only discuss Transport when it presented a difficulty for them. Those families that did not have difficulty with Transport for accessing services mentioned it less often. However, for families who did mention transport planning or access, it was an important factor in their access of speech pathology services. Considering Transport in this way demonstrates that not every property is equally important for each family, nor at any given time. However, each category is important for the overall access of speech pathology services within the community.

The quotes and incidences described in the Results chapters were chosen because they were illustrative of individual properties or categories. However, the lives of service users may not be as easily dissected in each of the categories of MASPS. Quotes and descriptions used within this discussion chapter draw on transcript segments and coding (Bryant & Charmaz, 2007). In a similar way to the quotes and incidences used in the Results chapters, the quotes and incidences used here have been selected to illustrate to the reader how categories are related and/or what steps could be taken to improve service access. This discussion has been structured around key points of recommendations that arose through data analysis. However, individual service providers should use MASPS to reflect on their services individually. There will be more of a focus on the application of MASPS in the Conclusion and Future Directions sections below.

Interpretation and Application of MASPS

Travel as an indirect property of MASPS

At the outset of this data collection, Travel was seen as a possible area of interest as it is mentioned throughout the literature (Mesidor et al., 2011; Raatz et al., 2021; Ruggero et al., 2012; Scheer et al., 2003). However, analysis of descriptions of Travel identified that it was an indirect cost of service access. Travel was often discussed by participants in close proximity to Resources, not because it was a resource that service users could 'have', but because Travel was burdensome on a family's Resources. Travelling requires families or clinicians to have available Time, Financial

Resources, and access to suitable Transport. When families are travelling to *and* from services, they need to have the time to travel between their place of occupation and the clinic where services are provided, either directly or via the client's school/day-care. There were available alternatives, as discussed in the results Chapter 6, such as the clinician providing home-, school-, or community-based services, but in this case the clinician was then required to have the time available to Travel, and the financial and labour cost of this Travel was in some cases charged to the family. While this was an appropriate solution for some families, non-clinic-based services place increased burden on the use of Financial Resources needed for accessing services.

The Funding source holds Control

It is worth noting that while families use the Resources that are available to them to access services, there may be restrictions placed on the way in which resources can be used to navigate service access if they are subsidised or supported by an organisation or scheme. With specific reference to Financial Resources, often the organisation that is supporting services places restrictions on the way in which funding is used in terms of where and up to how much financial support is available for any one occasion of service. Financial subsidies for services provided through the Medicare Benefits Schedule, such as CDM Plans, can only be used with a health professional who is an eligible and recognised by Medicare services (Department of Health, 2017a). Similarly, if services are being paid for by an organisation rather than service users, the organisation directs the way in which services are carried out.

> …our primary school has a speech therapist who comes in, and now that [my younger son]'s in Pre-primary I was going to speak to the school about that …in Kindy the teacher sort of didn't think there was anything too much to worry about. And then interestingly, his Pre-primary teacher now, she's mentioned something to me at the beginning of the year, said "Oh [my younger son]'s got a bit of a problem with his words sometimes." And I said "Yeah, there's a longer story." And I need to bring that up with them… (Nicole)

While Nicole's son's needs are ongoing, access to the school speech pathologist in Kindergarten was not a possibility as the client's classroom teacher did not have a concern about his communication. This quote demonstrates how within the client's school, access to the speech pathologist who is employed by the school is mediated by the school staff, namely here by the classroom teacher. This is not inherently a positive or negative factor of service access, but illustrates how decisions about service provision can be made by the organisation that is providing financial support for services. It is also worth noting that in a situation such as the one described here, the accuracy of the referral relies on the teacher's Awareness of communication development, speech pathology scope of practice, and the family and child's needs. The impact on service access of educators' awareness of communication needs has been explored in previous research (Harrison et al., 2017; McLeod, 2006).

Workplace Participation

The results within the property of Workplace Participation have acknowledged that there are both short- and long-term impacts on Workforce Participation for caregivers of children with communication needs. Interview data also suggests that the impact of a child's SLCN on the caregiver is discussed infrequently with clinicians, if at all. While it is not within the scope of practice of the speech pathologist to support the wellbeing of a client's caregiver, it may contribute to the maintenance of services for clinicians to be considerate of the caregiver's wellbeing. This includes recognising that some caregivers may have reduced their Workforce Participation in order to facilitate access to services for their child. Given the focus on Workforce Participation as an economic indicator within Australia (Australian Government, 2017), it may be important in the future for services and funding providers to be considerate of the indirect costs of service access for families. As discussed in results, there was also a gendered element to caregiving within families of children with communication needs. The gender balance of caregiving seen in this research may be linked to gendered expectations of Workforce Participation currently held within Australia (Australian Government, 2017).

Application of Family-Centred Practice

Participants from both groups described incidences of accessing services where clinicians were restricted by only being able to provide services to clients within the range of practice area/s identified by caregivers. This was explored within the Policy property of the Logistics category in Chapter 6. It is worth noting that some of the services discussed had taken this approach in order to provide family-centred care. While definitions vary between service contexts, generally family-centred care is defined as care that is driven by the needs of the family (J. R. Andrews & Andrews, 1986). Family-centred care is an appropriate form of service design, however it is important that it is conducted in an informed way. Some caregiver participants indicated that they were not aware of the various speech pathology range of practice areas when they first commenced accessing services for their child. As in the examples used in Chapter 7, one parent had raised concerns about her child's communication, but had used 'speech' as an umbrella term. However, their clinician had understood 'speech' to refer to the client articulation of speech sounds. The caregiver's son was assessed as having articulation within the normal range for his age, but did not have his need relating to language development identified until further assessment was done years later. In failing to recognise the role that Awareness plays in family-centred practice, some service providers are failing to provide a model of informed healthcare. In this way mis-application of practice design, such as family-centred practice, present not only a Logistical and Awareness issue for service access, but also an ethical one. Here both the profession and individual clinicians have responsibilities to ensure that care provided to families addresses the family's needs in an informed way (Speech Pathology Australia, 2020a). Examples such as this highlight the impact of low Awareness of speech pathology services within the community. The speech pathology profession, which is to say clinicians, organisations as service providers, and professional bodies, have a collective responsibility to raise awareness of speech pathology in the community (Speech Pathology Australia, 2016, 2020a, 2020b) so that families understand communication development and needs (Speech Pathology Australia, 2020a, 2020b). Additionally, individual clinicians bear a responsibility to each of their clients, to ensure that needs and goals and intervention are discussed in an informed manner (Speech Pathology Australia, 2020a). It is important that each clinician works with their clients to ensure that they hold a shared understanding of key terms that have implications for the access of services at any given service provider. Individual clinicians may or may not have the power within their workplace to change the policy of their service provider, but may be able to work towards developing an understanding and implementation of professional policy obligations within their workplace. However, it is recommended that individual clinicians ensure that their clients and families are able to make informed decisions around their healthcare, as this is part of the profession's code of ethics (Speech Pathology Australia, 2020a). Greater community understanding of speech pathology services, supported by informed healthcare can in turn improve service access through improving Awareness.

Beyond family-centred care, McDermott (2019) highlights how models of cultural safety can guide speech pathologists to work with families in a way that is considerate, or regard*ful* of the client, their family, and their community. These ways of working enhance cultural safety by focussing on the needs of individual clients and seeking to discover approaches that go beyond approaching each client regard*less* of their culture and Experiences of Healthcare (McDermott, 2019; Speech Pathology Australia, 2016). For clinicians and service providers, ‘regardful’ or considerate practice includes reflecting upon the possible previous Experiences of Healthcare of individual clients, families, and communities, and considering what impact this may have on future access. While McDermott’s (2019) considerations for culturally safe practice are embedded within discussions of service access for Aboriginal and Torres Strait Islander peoples, the principles may also apply more broadly to a range of clients, families, and communities.

Collaborative Goal Setting

While speech pathologists have a role in raising awareness of communication development and needs, caregiver participants indicated that they preferred clinicians who worked *with* the family to set and monitor goals. As mentioned in Chapter 7, using the WHO-ICF as a lens (Westby & Washington, 2017), clinicians typically generated goals that sought shorter-term improvements and focused on communication functioning, while families typically created goals that were long-term and participation focused. Because of this, participation goals may therefore be considered by clinicians to be longer-term goals. While there is a place for a variety of goals in intervention, service access is supported when caregivers and clinicians agree on and have a mutual understanding of the intervention goals. Intervention goals are sometimes broken into short- and long-term goals, with a series of short-term goals stepping the client towards their long-term goal. Based on the caregiver preference for collaborative goal setting, it is important for clinicians to ensure that caregivers understand short-term function-based goals, and how these relate to the long(er)-term participation goal (McCauley & Fey, 2013). Conversely it is important that caregivers ensure that clinicians understand their long-term goals for intervention, as these guide the creation of clinical goals.

Within initial analysis, it was identified that clinicians have a role to play in supporting caregivers to understand short-term functional goals. While this is true, analysis of discussion around achievement of goals from caregivers indicated that it is also important that clinicians remain focussed on long-term participation goals, as these are the goals that families are typically seeking to address. Caregivers indicated that being able to observe improvement on goals was one of the strongest supports of service maintenance. For this reason, clinicians need to be able to report on Progress towards the client’s achievement of goals that are related to their successful participation. Clinicians may do this by clearly explaining to caregivers how short- and long-term goals are related, and by setting long-term goals that use wording from the caregivers' or clients' concerns. Analysis of transcripts suggests that caregivers may be less likely to maintain services when they perceived that clinician's goals for the client were not aligned to their own. Caregivers described differences in goals for the client as being one of the reasons they consider changing clinics/clinicians or discontinuing services. Just as clinicians can support caregivers to understand short-term goals, caregivers have a role to play in supporting their clinicians to sustain focus on the client's long-term goals.

Caregivers described how their understanding of speech pathology intervention and scope of practice increased over time as they had different healthcare experiences with speech pathologists. Furthermore, several caregivers described that they were seeking the services of a speech pathologist as an expert, and so had intentionally attended initial services with a broad goal in mind. These caregivers had seen the clinical shaping of goals as the clinician's responsibility. However, clinicians indicated that they perceived caregivers who focussed on long-term participation goals as being less well informed about their child's intervention. Within these descriptions of caregivers being perceived as less well informed, clinicians did not describe taking a caregivers' previous Experiences of Healthcare into account. For this reason, it is recommended that clinicians recognise that even if they are seeking to work collaboratively with caregivers, their ability to set short-term goals is seen as a clinical skill. As such, it may be beneficial for clinicians to not *expect* caregivers to attend initial services with short-term or function-based goals prepared, and to be open to working with families in a collaborative way based on their concerns.

When monitoring and reporting on the progress of long-term goals, it is important for clinicians to consider that caregivers' and clients' understanding of the goals they seek to achieve also changes over time and in relation to their experiences of healthcare. The way caregivers and clients express their goals may change as they gain an understanding of speech pathology intervention relevant to their initial concerns. Moreover, for clients with long-term/ongoing needs, their goals may change relevant to the client's current progress, and the communication demands of different contexts on the client, for example shifts between home, primary school, and high school. This highlights that conversations between clinicians and families about goals should be ongoing throughout their relationship, and not a one-off discussion. Participants from both groups discussed the benefit of returning to goal discussions at regular intervals both during service access and in follow-up conversations after direct intervention had ceased.

Sunk Cost Fallacy

The sunk cost fallacy is the tendency for consumers to see previously incurred costs as ‘investment’ in a particular pattern of consumption, and to resultantly resist changing their investment or consumption pattern due to the previously incurred costs, regardless of future outcome (Haita-Falah, 2017). There were instances in the dataset where caregivers spoke about not wanting to change between clinicians and/or therapeutic approaches as they were wary of losing the progress that their child had made in their intervention up to that point. In some cases, this was related to the Financial investment of services, and at other times with regard to the cumulative resources that had been invested in the child’s progress towards their goals. Families did not explore new intervention approaches as they sought to avoid discovering that either the new or current approach were less efficient, but in doing so were not able to discover if there were intervention approaches that were *more* efficient. In this way some families were impacted by the Sunk Cost Fallacy (McCabe, 2018). While it is understandable that families do not want to risk losing progress and/or using resources unnecessarily, in shifting approaches and/or service providers, they may discover an approach that has a more efficient rate of progress for their child, or that is less burdensome on resources. It may be advisable for caregivers to discuss trialling different approaches to intervention with their clinician, or vice versa, in order to discover the approach that is most suitable for the client.

Awareness of the Speech Pathology’s Range of Practice Areas

Each caregiver participant indicated they did not know the about the breadth of services provided by a speech pathologist prior to accessing services. Most participants indicated that they knew speech pathologists worked with children on articulation because ‘speech’ was part of the profession’s title. Some caregiver participants indicated that they did not know that speech pathology existed as a profession prior to being referred for services. One clinician participant indicated that they had been asked by a caregiver for referral to another health professional to work on literacy, not realising that those services could also be provided by a speech pathologist, and in fact by the participant herself. This information within the dataset reinforces that caregivers’ knowledge of health services changes based on their own experiences, but also highlights that there is a low level of awareness of speech pathology within the community. Given that some caregivers understand speech pathology because of its title, it may be important to reflect on the use of ‘speech pathology’ as the label of the profession. Considerations of the profession’s title are included in Speech Pathology Australia’s long-term planning document (2016). However, given that some caregivers were unaware of the existence of speech pathology it is suggested that regardless of the outcome of changes to the profession’s title, that awareness campaigns are run within WA to raise the community’s understanding of the supports that are available to them.

Building upon this, some participants indicated that the descriptions for other health professions were clear, and helped them to understand what services the profession was able to address, but that this not the case with speech pathology. Some participants shared that they understood that people could have difficulty with articulation because of the profession’s title in WA being ‘*speech* pathologist’, but that they were unaware that people could have difficulties with other areas of communication such as language or voice. Some caregiver participants shared that they knew that children could have developmental needs related to communication and that adults could have communication difficulties related to acquired disorders, but that they were unaware that these broader communication needs could be supported by a *speech* pathologist. However, in reflecting on the profession’s scope of practice (Speech Pathology Australia, 2015), there may not be a title that suitably captures the breadth of areas of service provision. As such, concerns around the profession’s title may be less related to the way in which the title is descriptive, but rather be related to how the profession raises awareness of itself, and how the profession places value on the role that speech pathologists play within the community.

The profession of speech pathology has an awareness issue, at least for paediatric services in WA. This issue is in part related to the labelling of the profession, but also related to broader awareness of the profession’s scope of practice. The need for speech pathologists to act in a way that raises Awareness of the profession and its scope of practice is included within the MASPS model. Indeed, professional advocacy of this sort is part of Speech Pathology Australia’s (2020a, 2020b) professional standards for speech pathologists, however these examples highlight just how low awareness of speech pathology is among some segments of the WA population.

Caregiver reliance on Clinician for support with Service Navigation

Within the dataset, interviews with caregivers included discussion of caregivers relying on clinicians to support their Navigation of service access. In some cases, this was directly mentioned, where caregivers described that once they were accessing a service, they took direction about accessing other services and/or funding programs from their clinician. In other cases, it was indirect, where caregivers described that they felt they had relatively little knowledge of the network of speech pathology service compared to their clinicians, who they saw as members of this system. In these indirect descriptions, caregivers described clinicians as having some form of an ‘insider view’ of health services. While clinicians discussed times when they had referred clients on to different services, or made recommendations about funding packages, their interviews did not include descriptions of caregivers having *relied* upon them for service navigation.

Caregiver descriptions of having relied upon clinicians for service navigation was related to caregiver’s experiences of healthcare. Caregivers who had previously accessed allied health services, and in some cases speech pathology services, knew of some of the services and funding options that were available. In contrast, caregivers described relying on clinicians more so when they had fewer Experiences of Healthcare related to accessing services. In this way speech pathologists become a part of a family’s Network within their Relational Community. Just as other health professionals support families to access funding and speech pathology services, speech pathologists reciprocate this support. Into the future, it may be important for clinicians to recognise that they play a role within a family’s Network, so that they can be more intentional about how they provide support to clients and families around not only other allied health services, but the network of speech pathology services.

Building on an earlier recommendation that the speech pathology profession work to increase community awareness, it may be important that as part of this, individual organisations focus on raising awareness of the services that they provide. This form of awareness raising would not only develop community awareness of speech pathology, but also Awareness of the organisations within the broader network of services. Service maps, such as the one I created to aid in my own understanding during analysis of this research (Appendix F) may be an appropriate resource that would make it possible to support caregivers to understand how they can seek initial services that are appropriate for any concerns they may have.

Mediators within a Family’s Relational Community Network

As outlined in the results Chapter 7, Mediators are community members within a family’s Relational Community who are perceived as being able to facilitate access to speech pathology services. Mediators either raised concerns with a child’s caregiver, or were sought out by caregivers to validate their concerns. While the actions of most Mediators were described in a similar way, GPs and teachers were described by caregivers in slightly different ways. Referrals via a GP were common, and were typically motivated by the ability of GPs to provide access to Funding such as Medicare's CDM Plans (Department of Health, 2017a). In this way, GPs and other medical specialists acted as gatekeepers to Funding, and for some families this resulted in GPs acting as gatekeepers to services. Not all families require access to Funding in order to be able to access services, however some do. Classroom teachers were frequently described as Mediators within caregiver interviews. Teachers were described as working closely with speech pathologists, and as being able to make informed referrals. Caregiver participants held teachers' opinions in high regard, and described often having taken their concerns to their child's classroom teacher. Drawing on my own background working as a speech pathologist in education, I have experienced working alongside teachers who often know which speech pathologists are providing particular types of care for current or former students, and can therefore make an informed referral. However, there is nuance to consider here. I have worked alongside experienced teachers who specifically work with children who have Developmental Language Disorder, so their ability to monitor and make referrals may be different to the broader population of teachers. Furthermore, within the dataset clinician participants described receiving mass referrals from teachers who were well known and local to their clinics. So, while referrals from classroom teachers were commonly perceived to be well-informed and specific by caregivers, this may not always be the case.

It is worth noting that the quality of referral made by any particular Mediator was not the focus of this study, and these points about the way in which referrals are made are grounded in the data that was shared in participant interviews. There may be more information to consider about the process by which Mediators provide referrals, and the quality of referrals. Given the frequency with which caregiver participants described teachers as Mediators, there may be scope to explore this area specifically.

In most cases Mediators acted to supports services access, however in some cases Mediators were trusted people within a caregiver's Network who were sought out for validation and/or information by the caregiver, but the Mediator allayed the caregiver's concerns. Mediators typically allayed caregivers' concerns about their child's SLCN when they perceived the child to be too young to receive services. With reference to this, into the future it may be important for awareness to be raised within the community, and specifically awareness of speech pathology providing communication and mealtime support from birth and across the lifespan.

Just as the dataset included descriptions of clinicians raising concerns with caregivers, Mediators were also described as raising their concerns with caregivers. Caregivers described child health nurses and classroom teachers raising concerns about a child's communication development. Clinician participants described working with families who were seeking services because of a concern raised by a member of the clients Relational Community, typically their classroom teacher. Clinician participants described how these families often commenced services with less awareness of communication needs than families who had identified their child's needs themselves. Clinicians described focusing on initially raising awareness of paediatric development, communication needs, and the speech pathology profession in cases where a Mediator had raised the initial concern rather than the client's caregiver. For this reason, it may be beneficial for the speech pathology profession to have awareness campaigns structured around these topics. Doing so would reduce the workload on the clinician within initial services, and may also increase the proportion of caregivers who identify communication concerns for their own children. As such, a greater proportion of families would be acting to have their concerns validated, rather than relying on Mediators to raise concerns with caregivers.

Preference for Multidisciplinary Service Providers

Caregiver participants described having a preference for accessing services at a multidisciplinary provider when their children were receiving support from multiple health professionals. Caregivers of children who were accessing multiple health professionals described that accessing services at fewer providers made it easier to build and maintain a service-level Relationship. Caregivers also shared that this reduced the cognitive planning aspect of the workload needed for services in two ways. Firstly, caregivers indicated that accessing multi-disciplinary services supported inter-disciplinary communication. Inter- and intra-organisation communication was described as being handled differently. In some cases of inter-organisation, caregivers were asked to pass information between different health professionals. While caregivers indicated that they still wanted to be informed about their child's care, they described multidisciplinary service providers as reducing the Workload of having to pass information between different service providers. Secondly, when different health services were provided at the same location, planning for attending services was streamlined for caregivers. Additionally, caregivers described working with one administrative team to make bookings and payments as more convenient.

One clinician also described families being able to access interdisciplinary sessions as a benefit of her practice having multiple service providers at the same location. In this incident, the participant described how a caregiver was experiencing difficulty in Navigating attending services for both of her children who were accessing services from multiple health professionals. Once this was identified, the participant's service was able to offer longer interdisciplinary sessions for the family where both children could receive services in parallel in the same clinic room. This solution had a sizeable impact on service access for the family. It meant that fewer services needed to be booked, planned for, and attended, and that neither child needed to be cared for or wait outside the clinic room while their sibling received intervention. Arguably there was less of an impact on the caregiver's and clients' occupations due to attending intervention.

Role of Administrative Staff in Service Access

Examples from participants in both groups have highlighted the importance of good administrative staff. As outlined in Chapter 7 on Relationships, families have a relationship with a service provider as an organisation, in addition to clinicians, and administrative staff play a role in building and maintaining this family-service relationship. One caregiver described how there had been high staff turnover of clinicians at her son's speech pathology clinic, but that they had continued to access services there because there was a paucity of options in their regional town, and the administrative support was strong. She described how a particular administrative staff member had supported the family's service access by being proactive about the family's appointment bookings, and by notifying the family when funding packages were coming to an end, or needed renewal. When the clinic notified the caregiver that this particular administrative staff member was leaving the clinic, the family discontinued their services there, as they felt they were losing their last ongoing connection with the services as a whole. While the example described here was not common within the dataset, it is illustrative of the impact that administrative staff can have on families' relationships with the service for which they work.

> I mean, they had an awesome admin there for a year. She was onto it. She was great. But when she left to [removed]… and it just all went to hell.
>
> It was a pain. All the funding was up to date when the admin left there. <okay> She was great with all of that. Yeah. The admin side of things made a massive difference, to why we continued going there. (Hazel)

It is important to note here that people in administrative roles were not recruited directly as part of this research. Researchers may wish to consider the specific role of administrative staff in service access as an area of further investigation.

Magnification of Rurality

At the outset of this research project, some literature had outlined that living outside major cities may be a factor which impacts service access (Dew et al., 2013; Jones, McAllister, & Lyle, 2018; Warwick, LeLievre, Seear, Atkinson, & Marley, 2021). Conversely McAllister et al. (2011) proposed that within Australia living in a non-metropolitan area did not pose a separate challenge in accessing services, but rather magnified the challenges experienced within other factors of service access. The point made by McAllister et al. (2011) was supported by the dataset of this research. Descriptions of service access by caregivers who were living in a non-metropolitan area did not include different factors than those descriptions by participants who were living in a metropolitan area. However, some non-metropolitan caregivers described how they perceived there to be a paucity of services in their regions, and that distances to clinic were greater than they would be in a metropolitan area. Some clinician participants that had shared experiences of providing services in both metropolitan and non-metropolitan areas were asked about these experiences. These participants indicated that they had not perceived there to be different factors impacting service access between metropolitan and non-metropolitan areas, but that the scale of the factors impacting service access was magnified. There are some factors that clearly relate to this magnification, such as Resources as they related to travel. However other factors such as Relational Community were also discussed by participants. While non-metropolitan participants described their towns as having strong communities, of which they were a part, they also indicated that caregivers who lived outside town might face difficulties in accessing their geographical community, and this would impact the development of their Relational Community. Considering the role of Relational Community in MASPS, this could in turn impact a caregivers' Resources and Awareness of Needs and Services.

The Relational Continuum of Health Services

Participants were asked how accessing speech pathology services compared to other allied health professions in order to understand if there were profession specific differences in service access. This highlighted two key points. Firstly, caregivers perceive speech pathology as a health profession, rather than specifically an *allied* health profession, such as medical and allied health professions. Indeed, some caregivers indicated that they were not aware that health service professions could be organised into sub-categories. Secondly, participants perceived speech pathology to be more closely related to some health professions such as psychology and occupational therapy, and less related to other health professions such as physiotherapy and general practice medicine. When discussing the similarities between these professions, caregiver participants' descriptions focussed on the professions as having elements of transactional and relational healthcare, with speech pathology including transaction elements, but being mostly relational in nature. The descriptions by participants in this dataset indicate that each health profession includes elements of transactional and relational healthcare, but in a different balance. In this way, analysis of interviews indicates that caregivers perceived different health professions as being within a Relational Continuum of Health Services, rather than as categorically transactional *or* relational. The Relational Continuum of Health Services property sits within the Relationships category, as the type of relationship that each caregiver had with their clinician was informed by their understanding of speech pathology as a profession. In this way, the Relational Continuum of Health Services is also related to an individuals' Experiences of Healthcare. Caregiver participants had predominantly accessed speech pathology services that they felt were relational in nature, however some caregivers had heard of or accessed speech pathology services that they felt were more focussed on the delivery of dosage within a specific program, and that these services were therefore more transactional in nature. It may be important for clinicians and service designers to understand that families' perceptions of speech pathology as a relational health service is dependent on their previous Experiences of Healthcare. Some clinician participants shared experiences where caregivers had interacted with them in a transactional manner. In these cases, clinicians described how caregivers attended appointments but did not engage in activities. Clinician participants described perceiving that this may be because the caregivers saw the intervention as being limited to within the clinic room and delivered by the clinician. However, caregivers within the dataset did not describe these experiences. It is unclear if this difference in experiences results from a difference in perspective, or was a feature of recruitment as caregivers who are less engaged in speech pathology intervention may be less likely to volunteer to be a participant of a research about speech pathology services. Potentially, caregivers who view speech pathology as a transactional health service may have been less likely to participate in research related to the profession. In this way, it is important to acknowledge that the Relational Continuum of Health Services exists within MASPS as an interpretative model, and so further investigation may seek to focus on setting and investigating hypotheses which have been created with MASPS in mind. Such research from a deductive standpoint may be warranted in order to further shape an understanding of how MASPS and speech pathology service access operates.

Caregivers take on Multiple Roles

Most caregivers indicated that they saw their role in intervention as a significant and active one. Caregivers described taking on multiple roles within intervention, as both caregiver/mother and a role similar to a therapy assistant. As indicated earlier in the Wellbeing property of Awareness of Services and Needs in Chapter 7, caregivers described monitoring both the wellbeing of their child in relation to intervention, and the relationship between the clinician and their child. A caregivers' Awareness of their child's Wellbeing, existing Beliefs about their Therapeutic Role, and Relationship to the clinician and service impacted their role in intervention. Most caregivers described being responsible for integrating home practice of strategies into their daily life. Alternatively, some caregivers described how they acted to complete home practice set by their child's clinician, or to ensure that their child complete the home practice independently. These notions of caregivers balancing roles, while also adhering to health advice in consideration of their child's wellbeing is similar to my own experiences as a child with significant health needs. Whether caregiver participants were describing integrating strategies, or ensuring home practice was complete, their descriptions included elements of switching roles between acting as a caregiver or a therapy assistant. Switching between roles is common for people who act as carers (Nzinga, McKnight, Jepkosgei, & English, 2019), so it is not surprising to see this as part of caregiving for children with SLCNs.

When considering the multiple roles that caregivers take on as part of intervention, it is important to understand that caregivers described using their knowledge of their child to inform their therapeutic role. While caregivers shifted between tasks as a parent to their child or therapy assistant to the clinician, they integrated knowledge about both roles into the way they acted. For example, some caregivers described monitoring their child's target communication behaviours in day-to-day interactions. These parents had integrated their skills as an interventionist into the way that they gave care. Other caregivers described how they monitored their child's wellbeing during therapeutic activities, and in this way advocated for their child's overall wellbeing as a priority over completing any individual piece of home practice set by the clinician. Some caregivers described a mix of these behaviours. The act of having a qualified professional train a non-professional in specific tasks for the care of the client exists within the literature as ‘task shifting’ (Nzinga et al., 2019), though is typically focussed on different professionals sharing or developing skills rather than clinicians developing the skills of caregivers to work with their own children.

Descriptions of task shifting in the dataset give some insight into the way that caregivers take on therapeutic roles within intervention. However, it is important to note that clinicians did not discuss considerations that they make for caregivers as having therapeutic roles. Given that caregivers are a part of the therapeutic triad relationship, and they are service decision makers, it may be important into the future for speech pathologists to recognise and be considerate of the explicit or implicit expectations on caregivers to act as both parents and therapist.

Contribution of MASPS to existing models of health access

MASPS offers a unique contribution to existing understandings regarding service access. A particular point of distinction is that MASPS can be used by providers to identify factors that impact service access for families and carers. Other models of service access, offer a different focus. For example, Tanahashi (1978) can be used to evaluate the coverage of a specific health service (e.g., general medical practices, vaccine clinics) for a target population, and, classify the relationship between the service capacity and service utilisation, by identifying several types of coverage, including in areas such as awareness of available services. Practically, this means Tanahashi’s (1978) model can be used to identify if low service utilisation is impacted by factors such as availability or acceptability of the service. Notably, Tanahashi’s (1978) model is typically used for provision of transactional healthcare services. This provisional focus marks a conceptual distinction from MASPS. MASPS was constructed based on the experiences of speech pathology service consumers and providers, which participants have identified as a predominantly relational healthcare service. Building on this distinction between transactional and relational healthcare, this notion is explored in the Relational Continuum of Health Services section. One of the key contributions of MASPS, is a clearer understanding of the experience of transactional and relational healthcare by providers and consumers, within service access. More specifically, the relational continuum of health services was identified as a novel property as part of the broader construction of MASPS as a grounded theory. While relational and transactional healthcare have been previously explored in the literature (Gray et al., 2018; Reeve-Johnson, 2016; Salisbury, 2020), these discussions are often focussed on health services falling into either relational *or* transactional categories (Reeve-Johnson, 2016) rather than considering both relational and transactional elements of healthcare practice.

MASPS and Worldview

Western health design has adopted a transactional design to healthcare provision, even though a binary of transactional and relational healthcare has been established (Gray et al., 2018; Reeve-Johnson, 2016). MASPS identifies two key issues for consumers within this focus on transactional healthcare design. Firstly, MASPS identifies that service access exists on a continuum beyond the binary between transactional and relational health care. Secondly, providing relational healthcare services through a system designed for transactional healthcare introduces challenges for healthcare consumers. Given the relational nature of speech pathology services, I identified that some service providers are delivering speech pathology services using a transactional healthcare approach which is creating additional complications and barriers to consumers in accessing this healthcare. An extreme example of this is discussed in the Service Provider and Workplace Policies section in chapter 6, where a service provider was solely relying caregivers to identify the area of concern, without taking into consideration the caregiver's awareness or understanding of labels such as 'communication', 'speech', and 'language', and the differences between these terms.

This incongruence between the approach of the service provider and the needs of the service consumer appears to reflect a difference in worldview. Pepper (1970) presents the World Hypothesis, which outlines how different worldviews are formed, corroborated, and subsequently have impact on constructed systems (Berry, 1984). The World Hypothesis considers the difference between the way that worldviews interact with branches of philosophy (Berry, 1984; Pepper, 1970), but here I apply the World Hypotheses as an analysis of patterns of behaviour within health service designs. Pepper (1970) presents four adequate core world hypotheses which serve as the basis for philosophy. Of these, two are seen as relevant here: mechanism, and contextualism (Berry, 1984; Pepper, 1970). Mechanism assumes a cause-and-effect process of operating, wherein a system can be observed as comprised of its functional acts, and these acts lead to consistent and somewhat predictable outcomes that are specified by these acts (Berry, 1984). Contextualism assumes that processes operate within a context, and that acts within a system are individual, and influenced by the broader context within and beyond the specific system (Berry, 1984; Pepper, 1970).

Applying the world hypotheses (Pepper, 1970) to service design and access, I observe that the Health Service Coverage Model (Tanahashi, 1978) reflects a mechanistic hypothesis, while MASPS represents more contextual hypothesis. While neither worldview is incongruent with the provision of health services, it may be important for theoretical exploration in this area to consider the benefit of mechanistic or contextualised approach to service design. Given that speech pathology was identified by participants as a mostly relational health care service, it is important for service access design to be considered using a model, such a MASPS, which has a complementary contextualist worldview. Arguably, more congruent alignment of worldview may support a more appropriate delivery of services. As such, a mechanistic worldview is not inappropriate, but is perhaps better suited to the provision of services through a transactional healthcare model. It has been identified that consumers approach speech pathology services with a worldview that is consistent with transactional healthcare, and this is incongruent with experiences that participants described as ideal, which is to say speech pathology as a relational health care service.

The contribution of MASPS to the existing models of health access is therefore to provide a model that is grounded in a contextualist worldview. As stated above, existing models that reflect a mechanistic worldview are not incorrect, but perhaps better suited to transactional healthcare services. Therein, MASPS also draws attention to the differences in systems of transactional and relational healthcare services, and contributes a novel element in the Relational Continuum of Health Services property.

Conclusions

By considering service access as a whole, and integrating the perspectives and experiences of both clinicians and caregivers, MASPS has been created in way that considers the factors within the WA community. This is a key point of difference from the existing service access literature, which has sought to identify factors of service access through the comparison of communities (Lim et al., 2017; McAllister et al., 2011; Raatz et al., 2021) with a more mechanistic approach (Berry, 1984), the exploration of particular diagnostic groups (Jessup et al., 2008), or the perspectives of either caregivers (McAllister et al., 2011) or clinicians (Lim et al., 2017) separately.

Conducting CGT has identified that the categories and properties that hold meaning within the construct of paediatric speech pathology service access have impact across a family's experience of accessing services. While phases of services access such as seeking services, initial services, maintenance, attendance, adherence, and discharge are mentioned throughout this thesis, they do not form the basis of the construct of service access, as was previously considered in the proto-categories of the temporal model (See Figure 4). While families may move among these phases as they utilise services, MASPS demonstrates that the meaningful aspects to consider when reflecting on services are not bound to an individual phase. This is not to say that MASPS cannot or should not be considered in relation to such phases, but that based on the current dataset, MASPS applies to, and can be applied in analysis of, services at each and all of these phases. MASPS can be used by service designers or clinicians who are currently providing services to reflect on their design of service provision to families within their community. In doing so it is hoped that services providers will be able to more strategically improve and adapt service access to their community's needs.

To enable knowledge translation, an important next step may be for health services to review their service provision according to a contextualist worldview, and for speech pathology as a profession to be able to move forward with the consumer using shared definitions of access, that is considerate of services as they operate within a broader context. MASPS provides such a contextualist framework for service designers to be able to review their provision of services within their community, and in doing so, to be considerate of the consumers within their communities. Service access can be improved within localised communities through service providers adopting a framework that seeks to provide relational healthcare services.

As MASPS integrates the perspectives of speech pathology service providers and caregivers as service decision makers, the model can be used to align service design with the worldview of consumers. By adopting a design that is considerate of consumers' view of speech pathology as a predominantly relational healthcare service, providers can seek to work in a way that is consideration of their communities, beyond providing services to their communities in a transaction sense.

MASPS can be used at the level of the profession or of individual service providers to move beyond a transactional healthcare framework and into a relational one. Clinically, MASPS can be used as a reflective prompt by those designing speech pathology services to reflect upon the way in which their service provision supports or limits the ability of their consumer base to access their services, therein improving service access.

Limitations and Future Directions

In the first part of this chapter, MASPS was labelled as an interpretative model because of its grounding in a specific population, which is to say paediatric speech pathology services that seek to address children's SLCNs, between July 2017 and early 2021, within WA as a health district. For this reason, a few key limitations as well as next steps are related to refining and/or confirming the way that MASPS reflects the social construct of access within either broader, or different service settings.

Limitations

It may be worthwhile for the reader to note that the presented model, as a constructivist grounded theory (Charmaz, 2012) is a co-construction between researchers and participants based on the data within dataset. As such additional data may have led to MASPS having been constructed in a different way, but the way in which this would impact construction will remain unknowable. The below limitations are reflections that stem from having conducted a GCT methodology, and so are themselves informed by the constructed grounded theory. In this vein it would have been ideal to have had time within my candidature to recruit and talk to a wider range of stakeholders.

Firstly, Caregivers in this research had all at some point been successful in accessing speech pathology services. While not all participants were successful immediately, no participants held a perspective that was from an experience of having never, or not yet, accessed services. While more complicated to recruit, perspectives of these caregivers would be important to consider in future research.

Secondly, more recent research has identified the merit in including client voice (Lyons, Carroll, Gallagher, Merrick, & Tancredi, 2022). In hindsight, the recruitment of clients, which is to say children with SLCNs, would have been included had this research commenced more recently.

Thirdly, cultural background was identified within the later stages of analysis as playing a role in speech pathology service access. Cultural demographics were not collected as part of the demographics survey, but were non-systematically mentioned by participates in their interviews. This data collection strategy is important as it allows participants to share information that they feel is relevant to the topic of investigation. However, given that some data was shared around a cultural basis for policies, such as additional allied health sessions subsidies Aboriginal and Torres Strait Islander peoples (Department of Health, 2017b), it may have been beneficial to have been able to observe patterns in interview data based on participants' individual backgrounds, or alternatively to have been able to conduct maximum variation sampling regarding this property of MASPS.

Lastly, given that gender played a role in participation in the research, it would have been beneficial to have conducted maximum variation sampling for participants of a range of genders. This was not identified as necessary within considerations of sampling from theoretical early in data collection, but was identified as a possible area of interest in analysis of later interviews. While the data collected on this topic was sufficient for discussion, direct interviews would have been beneficial, had time been available to do so. Such interviews would have allowed insight into whether the experiences of caregivers from other genders were aligned with the perspectives shared within the existing dataset. Similarly, it would have been ideal to have recruited participants who were seeking to access services while part of a non-traditional family structures. This area was not identified as an area of interest within theoretical sampling, however reflecting on my own positionality as a member of a non-traditional family structure, it may have been best to have recruited caregiver participants with experience in accessing services from this point of view.

Future Directions

While the label speech pathology is embedded within title of ‘MASPS’, there are only a few points within the model that are speech pathology specific. These appear in Logistics: Speech Pathology as a Business, and Awareness of Services & Needs: Speech Pathology. While awareness of services and the ability of service providers to operate in a sustainable way are important for speech pathology service access, it is logical that at least some of the concepts within these properties are not limited to speech pathology services. It is worth noting that participants shared concerns around speech pathology having a notably low level of awareness within the community compared to other health services, but this does not discount the possibility that other health professions may still need to address awareness of their services and related needs within the community. For this reason, a logical next step may be to conduct research that considers the application of MASPS to other health professions within WA. This process may confirm the categories and properties of MASPS as being applicable more broadly, however in doing so further research may also refine the structure of MASPS, and this would be appropriate.

As noted above, this research also focussed on WA as a health district. Researchers may wish to broaden the application of MASPS by investigating its applicability to speech pathology services beyond WA. This may mean investigating speech pathology service access concerned with children’s SLCNs across Australia, or indeed in other nations. It would be advisable for researchers to keep the relatedness or similarity between health districts and their populations in mind when seeking to investigate the applicability of MASPS to other health districts. Interpretative models that have been constructed using grounded theory methods, such as MASPS, are sensitive to the time and place in which they have been constructed (Liamputtong, 2013), which is to say the data within which they are grounded (Charmaz, 2012). MASPS is applicable to speech pathology services in WA, however the factors impacting service access for families of children with SLCNs may be similar in other states and territories of Australia, as there are commonalities and similarities between these health systems.

In a similar vein, this research focussed on speech pathology services that sought to support children with SLCNs. It may be appropriate for future investigations to remain within the speech pathology profession but to extend to include services related to feeding and mealtime management across the lifespan, in order to take on a broader profession specific focus. Alternatively, further research may consider and refine the application of MASPS with specific populations of children within WA. Within participant interviews there were specific discussions around the way service access is perceived by families of a non-dominant cultural background, and discussions of services specific to some families, such as funding and services for Aboriginal or Torres Strait Islander peoples. There may also be other specific populations within WA whose service access researchers may wish to investigate using MASPS as a theoretical structure.

In addition to using MASPS to guide investigations of various populations of consumers, researchers may also seek to confirm or shape these specific constructs or properties from within MASPS. Specific properties may be of interest to researchers, such as: the Relational Continuum of Health Services; the impact of service access on caregivers' Workforce Participation; speech pathologists' perception of their own profession within the network of broader health services; the impact of funding scheme design; or, the way in which Mediators act to support service access.

MASPS is an interpretative model based on theory generated using an inductive and abductive (Charmaz, 2012) CGT approach. The aim of this research was to investigate the factors of access to paediatric speech pathology services that seek to address the needs of children with SLCNs in WA. In addressing this a grounded theory was co-constructed with participants. This model of service access can be used by service providers and users of paediatric speech pathology services to reflect upon and improve service access within WA. Beyond this, by generating such a model using a CGT approach which makes use inductive, and abductive reasoning, MASPS also provides a theoretical framework that researchers can use to guide their investigations of services access in a theoretical manner, whether these investigations are focussed on service access broadly or on specific properties of service access.

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Appendices

Appendix A: Demographic Questionnaires

Table 5

Caregiver Demographic Questionnaire

Question	Responses/Response Type
• Do you live in a metropolitan, regional or rural area?	Please choose one: ○ Metropolitan ○ Regional ○ Rural ○ Other – Please specify
• What is your residential address?	Open Residential addresses will be used to determine remoteness using 2011 ASGC ratings and socio-economic area rating using 2011 SEIFA ratings
• What type of socioeconomic group do you consider your family to be in?	Open
• What is the highest level of education that you have completed?	Are you currently studying? ○ Yes ○ No Please select the highest level that you have completed/are completing: ○ Primary School ○ High School (Year 10) ○ High School (Year 12) ○ Certificate I ○ Certificate II ○ Certificate III ○ Certificate IV ○ Diploma ○ Advanced Diploma/Associate Degree ○ Bachelor Degree ○ Bachelor Degree with Honours/Graduate Diploma/Graduate Certificate ○ Masters Degree ○ Doctoral Degree
• What is your relationship to the child/ren who is/are accessing speech pathology services?	Open e.g.: Mother; Father; Grandmother; Uncle; Brother
• How many people share the care of your child/ren?	Please indicate
• Who are the members of your immediate family? i.e. Who	Open e.g.: Mum, Dad, Grandma, and two sons.

lives in your home or shares care of your child/ren?	
• How many children are in your family?	Please indicate
• What other services, in addition to speech pathology, do you access, and for which children?	Please indicate services for the eldest child: ☐ Speech Pathology ☐ Occupational Therapy ☐ Physiotherapy ☐ Psychology ☐ Social Work ☐ Academic tutoring – Please specify the topic ☐ Other – Please specify Please indicate service for the youngest child: ☐ Speech Pathology ☐ Occupational Therapy ☐ Physiotherapy ☐ Psychology ☐ Social Work ☐ Academic tutoring – Please specify the topic ☐ Other – Please specify
• In which areas does your child have communication needs? • Does your child have, or do you think your child has, a particular diagnosed communication need? If so, please state.	Indicate all that apply: ☐ Speech ☐ Language ☐ Voice ☐ Fluency ☐ Multimodal Communication (AAC) ☐ Hearing Please describe the nature of your child's communication needs: Open
• Which services are you accessing/attempting to access?	Please select all that apply: ☐ Child Development Service ☐ WA Country Health Service ☐ Non- Government Organisation ☐ Private Services ☐ Other –please specify/describe
• For the first service you indicated. Have you been successful in seeking these services?	Please select one: ○ Yes ○ Yes, but I have been unsuccessful in the past ○ No ○ No, but I have been successful in the past
• For the second service you indicated. Have you been successful in seeking these services?	Please select one: ○ Yes ○ Yes, but I have been unsuccessful in the past

	○ No ○ No, but I have been successful in the past
• What type of funding pays for the services you are accessing/seeking access to?	Select all that apply: ☐ Government (CDS, PMH or WACHS) ☐ Chronic Disease Management (CDM) Plan subsidy plus private funds ☐ Chronic Disease Management (CDM) only ☐ NDIS ☐ Disability Services Commission (DSC) Funding ☐ Helping Children with Autism funding (HCWA) ☐ Better Start Funding ☐ Community grant (e.g. Rotary, Lions' Club) ☐ Private Funds ☐ Health Insurance/fund rebate ☐ Other (please provide details)
• What type of appointments do you access?	Please select all that apply: ☐ Individual (one-on-one) ☐ Group sessions ☐ Telehealth ☐ Other – please specify/describe
• How regularly do you attend appointments	Please select the best description: ○ More than once per week ○ Once per week ○ Once per fortnight ○ Once per month ○ Less than once per month ○ Other – please describe
• In general, how would you describe your attendance?	Please select the best description: ○ Regular (come to all sessions as planned) ○ Occasionally miss a session (miss/reschedule few sessions) ○ Irregular (miss/reschedule about half of appointments) ○ Usually have to reschedule appointments (miss/reschedule more than half of all appointments) ○ Have not been able to attend

Table 6

Clinician Demographic Questionnaire

Question	Responses/Response Type
• Do you work at one, or multiple workplaces? • Do you practice full-time or part-time?	Please indicate the number of workplaces that you currently work at: ○ 1 ○ 2 ○ Other – Please specify Please select the best description ○ Full-time ○ Part-time ○ Full-time equivalent (Part-time across multiple roles) If you indicated Full-time equivalent, or Part-time, what is your FTE balance? Open
• For how many years have you been practicing?	Please indicate
• Do you consider yourself a new-graduate, or senior clinician?	Please select one: ○ New-graduate ○ Early career ○ Senior ○ None ○ Other – please specify
• For which type of service do you work?	Please indicate all that apply: ☐ Child Development Service ☐ WA Country Health Service ☐ Non- Government Organisation ☐ Private Sector ☐ Other – Please Specify
• Have you worked for other services in the past? If so for which types of services have you previously worked?	Please indicate all that apply: ☐ Child Development Service ☐ WA Country Health Service ☐ Non- Government Organisation ☐ Private Services ☐ Other – Please Specify
• What types of services do you provide?	Please indicate all that apply: ☐ Individual ☐ Group ☐ Telehealth ☐ Other – Please specify
• Where do you provide services?	Please indicate all that apply: ☐ Clinic-based services (clients come to you)

	☐ In-school services (where parents are present) ☐ In-school services (where parents are not present, but have arranged for the visit) ☐ In-home services ☐ Telehealth ☐ Other – Please specify
How regularly do clients attend your appointments/appointments at your service?	Please indicate overall for all clients on your caseload: ○ More than once per week ○ Once per week ○ Once per fortnight ○ Once per month ○ Less than once per month ○ Other – Please describe
Ignoring the reason for not attending an appointment, how would you describe your clients’ attendance?	Please indicate overall for all clients on your caseload: ○ Regular (come to all sessions as planned) ○ Occasionally miss a session (miss/reschedule few sessions) ○ Irregular (miss/reschedule about half of appointments) ○ Usually have to reschedule appointments (miss/reschedule more than half of all appointments) ○ Other – Please describe
What is the address of the clinic that you operate? AND/OR In what districts do you provide services?	Open – Address Open – Postcodes and/or indicated on map of WA Residential addresses will be used to determine remoteness using 2011 ASGC ratings and socio-economic area rating using 2011 SEIFA ratings
In which areas of WA do your clients reside?	Open – Postcodes and/or indicated on map of WA Residential addresses will be used to determine remoteness using 2011 ASGC ratings and socio-economic area rating using 2011 SEIFA ratings
What type of funding pays for the services that you provide?	Select all that apply: ☐ Government (CDS, PMH or WACHS)

	☐ Chronic Disease Management (CDM) Plan subsidy plus private funds ☐ Chronic Disease Management (CDM) only ☐ NDIS ☐ Disability Services Commission (DSC) Funding ☐ Helping Children with Autism funding (HCWA) ☐ Better Start Funding ☐ Community grant (e.g. Rotary, Lions' Club) ☐ Private Funds ☐ Other – Please specify
• What type of socioeconomic group do you consider your clients to be in?	Open
• In which areas do you provide services (you, not your service as a whole)?	Indicate all that apply: ☐ Speech ☐ Language ☐ Voice ☐ Fluency ☐ Multimodal Communication (AAC) ☐ Hearing

Appendix B: Initial Interview Guides

Initial Caregiver Interview Guide

- Thanks & thanks for filling out the survey
- Questions for me, or about the information sheet/consent form?
- An hour for today
- Follow up interviews (telephone & Skype)
- Record and make some notes to discuss

Open ended questions	Targeted Probes	Notes
• Tell me about going to see a SP	a) How identified SLCN o Who? b) What was your reaction? c) Did you know about SP? d) Was there anyone who supported you? o How so?	
• What stood in your way?	a) As compared to other caregivers?	
• What made it easier?	a) As compared to other caregivers?	
• Finished intervention?	a) Yes a. How did this happen? b. Why? c. Reaction to ending? d. Goals? b) No – Considered end?	
• Recommendations for the profession?	a) How would you support other caregivers? b) What can SP do?	
• Anything else to discuss? • Any questions for me?		

- Thanks
- Updates are available
- Gift card

Initial Clinician Interview Guide

- Thanks & thanks for filling out the survey
- Questions for me, or about the information sheet/consent form?
- An hour for today
- Follow up interviews (telephone & Skype)
- Record and make some notes to discuss

Open ended questions	Targeted Probes	Notes
• Tell me about how parents come to see you. Start with when you become aware that they be added to your caseload	a) Referral intake style meeting or similar? b) Patterns in referrals? i. Particular people? ii. Parents? c) Parent awareness of SP? d) Parent awareness of goals/referral?	
• What makes it harder for the families?	a) As compared to parents at other services? b) Your service addressing this?	
• What makes it easier for the families?	a) As compared to parents at other services?	
• What makes maintenance difficult?	a) As compared to parents at other services? b) Your service addressing this?	
• What makes maintenance easier?	a) As compared to parents at other services?	
• How does therapy end? • Do you discuss end of therapy?	a) For what reasons does intervention end? i. Is it goal directed?	
• Recommendations for the profession?	a) What’s happening now? b) Parents suggested changes? c) Changes for profession/government	
• Anything else to discuss? • Any questions for me?		

- Thanks
- Updates are available
- Gift card

Appendix C: Updated Interview Guides

Updated Caregiver Interview Guide

- Thanks & thanks for filling out the survey
- Questions for me, or about the information sheet/consent form?
- An hour for today
- Follow up interviews (telephone & Skype)
- Record and make some notes to discuss

Open ended questions	Targeted Probes	Notes
• Tell me about going to see a SP	e) What prompted you to seek services for your child? o Who? f) What was your reaction? g) Did you know about SP? h) Was there anyone who supported you? o How so? i) Did you know that you can ‘self’-refer to speech pathology? o How did you know that?	
• What stood in your way when you started to access services?	b) As compared to other caregivers? c) Did availability of clinician impact on your access? How?	
• What made it easier to start accessing services?	b) As compared to other caregivers? c) Would having information on speech pathology be helpful?	
• Other initial access factors	a) What impact did having to wait for services have on your access? b) Did you know what to expect when you went to your first few appointments? a. How did you know what to expect? b. Did not knowing put you off? c) How would you describe the severity of child’s difficulty? Does this impact? d) How did you choose the service that you’re going/went to?	
• What make continuing services difficult?	a) As compared to other caregivers? b) How do you make going to speech pathology work in your life/routine? a. What impact does that have on your life?	
• What helped you to continue going to services?	a) As compared to other caregivers? b) Have you discussed alternate arrangements (location/time) for Ix? Whit who? Who suggested it? c) Have you considered telehealth? d) How do you see your role in the therapeutic process?	

• Have you discussed funding with your clinic/ian?	a) Would you like to have a conversation about funding? b) Why/Why not?
• Finished intervention?	c) Yes a. How did this happen? b. Why? c. Reaction to ending? d. Goals? d) No – Considered end?
• Recommendations for the profession?	c) How does accessing speech pathology compare to accessing other health services? d) How would you support other caregivers? e) What can SP do?
• Anything else to discuss? • Any questions for me?	• What should we ask caregivers? other SPs? ○ What would be your answer to that question/s?

- Thanks
- Updates are available
- Gift card

Updated Clinician Interview Guide

- Thanks & thanks for filling out the survey
- Questions for me, or about the information sheet/consent form?
- An hour for today
- Follow up interviews (telephone & Skype)
- Record and make some notes to discuss

Open ended questions	Targeted Probes	Notes
• What keeps you being a SP?	e) What motivates you to keep being a speech pathologist?	
• Tell me about how parents come to see you. Start with when you become aware that they be added to your caseload	a) Referral intake style meeting or similar? b) Parent awareness of SP? c) Parent awareness of goals/referral?	
• Do you receive referrals from other healthcare or education services/providers?	a) Are referrals managed differently for interprofessional v caregiver?	
• Do you have interprofessional links?	b) Tell me about the purpose of the interprofessional links you have? i. Are interprofessional links aimed to benefit the profession, or your service?	
• What makes it harder for the families?	c) As compared to parents at other services? d) Your service addressing this?	
• What makes it easier for the families?	b) As compared to parents at other services?	
• What makes maintenance difficult?	c) As compared to parents at other services? d) Your service addressing this?	
• What makes maintenance easier?	b) As compared to parents at other services? c) Have you used breaks for families in their maintenance? For what reason (reprieve or consolidation)? d) Have you considered telehealth as a strategy to support access?	
• When a family come to your service, do they stay on one type of funding or does it change?	e) (How) Do you support families to seek funding?	

• How does therapy end? • Do you discuss end of therapy?	b) For what reasons does intervention end? i. Is it goal directed?
• Are their tension is the running of you service/business? In what way?	c) Do you feel you have to balance services that you offer with the viability of the service as a business or the guidelines/processes of your service? d) Are their service/approach you would like to provide if you there were no external constraints?
• Recommendations for the profession?	d) What’s happening now? e) Parents suggested changes? f) Changes for profession/government
• Anything else to discuss? • Any questions for me?	• What should we ask caregivers? other SPs? o What would be your answer to that question/s?

- Thanks
- Updates are available
- Gift card

Appendix D: Follow-up Interview Guides

Follow-up Caregiver Interview Guide

- Thanks
- Questions for me, or about the information sheet/consent form?
- Record and make some notes to discuss

Context	Question	Notes:
	How have other families that you know identified their child as a communication need?	
Some families talked about being directed to different services at different times	Do you feel you've been directed to right SP service for your needs? • What helps, or might help families to get into the right services at the right time?	
We've found that people need different resources, like time or money to get into services	What resources do families need to be able to find appropriate services? What resources do families need or use to start and maintain their services? • Is this similar for initial services and maintenance?	
A few participants mentioned stigma around communication needs or services	Do you feel that there's a stigma around accessing speech pathology/SLCN services? • If so, what does this look like?	
Some people share a lot about their lives with their speech pathologists, while others choose not to	Is open communication important in <u>your</u> relationship with <u>your</u> clinician? • Does this open communication extend to the clinic/service broadly (ie. To other staff – not just the clinician)? • How do/would you feel about having such open communication with your SP?	
Some participants have discussed gaol setting as part of their intervention	What impact does goal setting have on therapy?	
Some families have talked about home practice impacting how they maintain services.	What impact does home practice have on going to services?	
	How did/will you know that you're done with therapy?	

	What role do you think that review appointment/calls/ assessments play in services heading towards discharge? • Expectation vs. driving it as a caregiver
We’ve seen that predominantly its mother’s bringing children to services	Is this what you’ve seen? Do you have a reflection on why this is? Do you feel that service differs for families where the someone else manages access, or where the family has a non-nuclear structure?
Some parents have talked about making sure they go to a clinician that is trained in a particular program	Do you feel that your clinician was appropriately qualified and equipped to provide you with the services you wanted?
Have you accessed school-based services?	How do to they change how you access?
When a child is seeing a speech pathologist, sometimes they are asked to share information with the child’s school or another health professional	How do you see this sort of information sharing (ie. core or on top)? Do you expect that the clinician gets permission for this? • Do you expect that information sharing with schools works in the same way? • Has your experience been in line with your expectations?
	How has the professions recent move to telehealth impacted on your access of services? Do you feel that this will change how you might access long-term?

- Thanks

Follow-up Clinician Interview Guide

- Thanks
- Questions for me, or about the information sheet/consent form?
- Record and make some notes to discuss

Context	Question	Notes:
Some speech pathologists told us that they take queries from families and then advise if they family should access service, with that in mind…	How do you tell the difference between families that should seek services, and those that don’t need to seek services?	
Some families contact a speech pathologist with clear needs, and others are ore vague	What do you think supports families to identify their child communication need?	
We’ve found that people need different resources, like time or money to get into services	What currently supports, or can support families to get into the right services for them? • What resources do families need to be able to find appropriate services? • What resources to families need or use to **start** and **maintain** their services? ○ Is this similar for initial services and maintenance?	
A few participants mentioned stigma around communication needs or services	Do you feel that there’s a stigma around accessing speech pathology/SLCN services? • If so, what does this look like?	
During the interviews some people have had really positive positions on open communication, but we wanted to explore your experiences further:	What do you think the role of open communication is between a clinician and client? • And should this extend to the services as well?	
Some participants have discussed goal setting as part of their intervention	What impact does goal setting have on therapy?	
Some families have talked about home practice	What impact does home practice have on going to services?	

impacting how they maintain services.	
	What role do you think that review appointment/calls/assessments play in end-of-service planning?
We've seen that predominantly its mothers' bringing children to services.	Is this what you've seen? Do you have a reflection on why this is? Do you feel that service differs for families where the someone else manages access, or where the family has a non-nuclear structure? How do you communicate to your clients that you're qualified and able to deliver the services that you do
Some clinicians talked about advocacy, and so I wanted to ask directly	Do you see yourself as having a role to advocate for you clients? • If so, how do you do this?
We've heard that caregivers who have accessed services in the past are more forthcoming with home practice:	Do you think that caregivers that have accessed more therapy are more forthcoming with asking for home practice, or with *doing* home practice?
Have you provided school-based services?	• What impact do they have on access?
When a child is seeing a speech pathologist, sometimes they are asked to share information with the child's school or another health professional	How do you manage information sharing about a client? ○ How do you give them opportunities to withdraw consent? ○ Is this time limited? • Do you explain this to your clients?
	How has the professions recent move to telehealth impacted on your provision of services? How do you think it has impacted client's access of services? Do you feel that this will change how you might access long-term?

- Thanks

Appendix E: Follow-up e-mail to participants

Dear [Participant],

Attached is a document with our interview typed up word-for-word. Because it was a conversation, it will have grammatical errors and fillers (umms and uhhs) typical of informal oral language. For the purpose of the study, could you please check over the document to see if you are happy with the content of the interview and the ideas and information you presented.

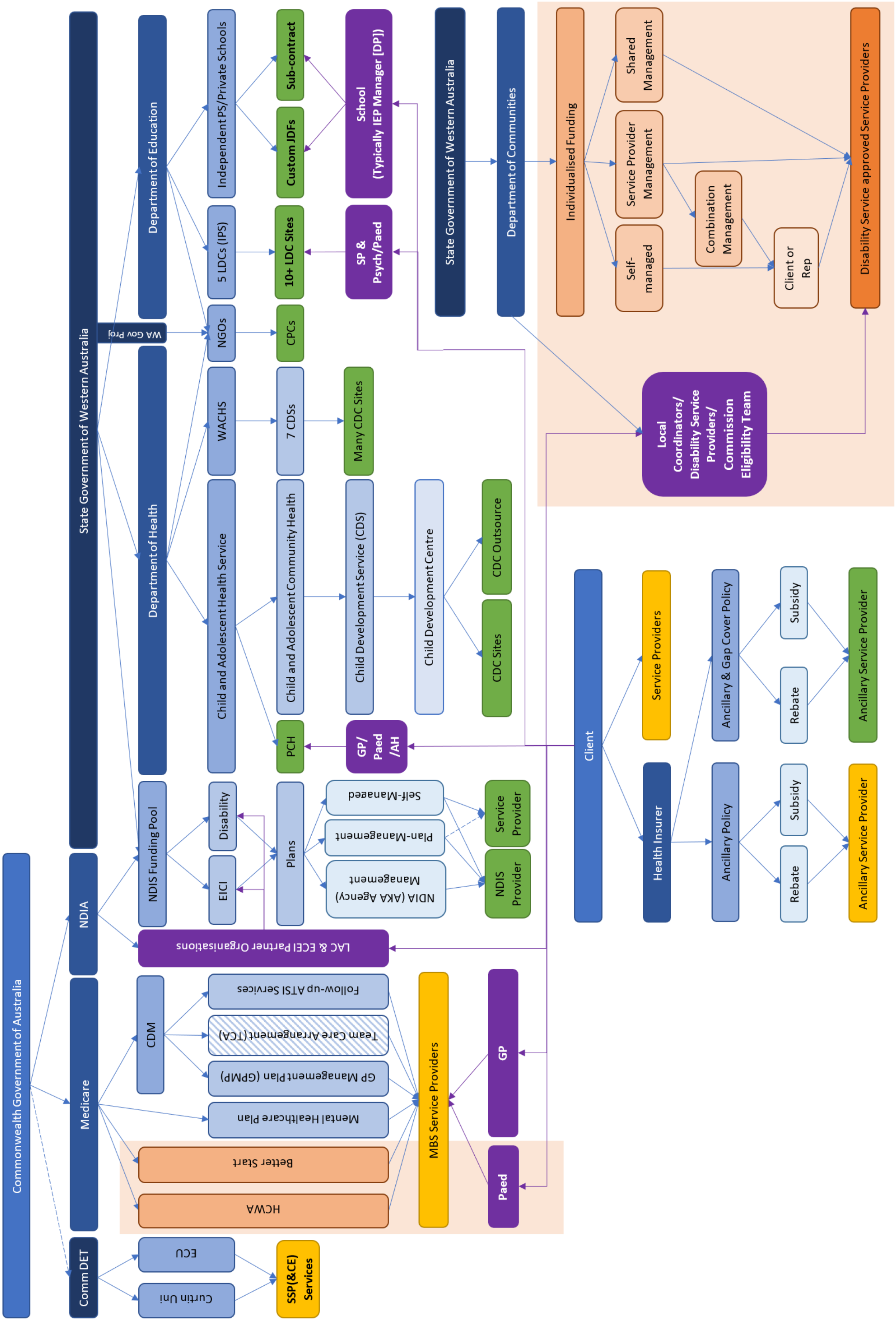
You are welcome to edit and change the interview, and then attach it to your reply; please use track changes or highlight any changes that you do make, so we are aware of the revisions. If you are happy with the interview as it is, please send me a quick line to let me know. If you want your transcript to be withdrawn from the study, please let me know within 3 weeks. It cannot be withdrawn after this time because of the type of analysis we're doing. Once you have approved the transcript, all identifying information will be removed for the remainder of the study.

Once again, thank you so much for being willing to be part of the study.
Your insights are greatly appreciated,
Robert Wells

Appendix F: Speech Pathology Services Map

Figure 14

Speech Pathology Services Map



Appendix G: Case Study 2: Barriers and facilitators of access to paediatric speech pathology services

The following case study excerpt was written as part of chapter 4 of the book *Constant comparative analysis*, which I co-authored with Clare Carroll and Deborah Harding (Clare Carroll, Harding, & Wells, 2022). J&R Press© are the copyright holder of this material, and it is used here with permission. In this appendix additional expanded contractions are included for ease of reading.

Introduction

In my PhD research (supervised by Assoc Prof Suze Leitão, Dr Mary Claessen, and Dr Peta Dzidic) I sought to establish a model of speech pathology service access for children with Speech, Language, and Communication Needs (SLCNs) within Western Australia. In seeking to generate theory from qualitative data, I was guided towards Constructivist Grounded Theory (CGT; Creswell, 2012; Liamputtong, 2013). In considering the literature I found that most existing studies reported on either caregivers' or clinicians' experiences and perspectives of accessing SLT (Speech-Language Therapy) services. I felt that the construct of 'access' (to speech SLT services) was central to the inter-related experiences and perspectives of both stakeholder groups, and so sought strategies to investigate this central concept. Through viewing access in this way, and through having sought to co-construct understanding with participants, I selected a CGT (Charmaz, 2014) approach to data collection and analysis. Charmaz (2014) describes grounded theory as a cluster of methods. I chose to use CCA (Constant Comparative Analysis) as part of my decision to adopt a CGT approach. Within CGT, the use of CCA facilitates researchers' reflection on data. This includes comparison of two or more pieces of data with one another: data with category, or data with concept. CCA is an ongoing process throughout several of CGT's overlapping phases (Tweed & Charmaz, 2012).

My research made use of in-depth semi-structured interviews with caregivers of children with SLCNs and SLTs who provide services to children with SLCNs. Throughout the overlapping phases of data analysis (Tweed & Charmaz, 2012). I used CCA as a strategy to identify meaning within interview transcripts, which was then noted using codes or memos depending on the nature of the comparison. Charmaz (2014) encourages researchers to immerse themselves in their data, and to identify nuance and novel understanding within new pieces of data, as comparted to an existing dataset. Immersion and CCA appeared throughout the phases of my research in different ways.

Data analysis

After completing each interview, I actively reflected on how the interview went, and the key sentiments that were shared. I also considered the key sentiments considering the other data that had been collected up to that point, both within and between participant groups. Within the initial coding phase I used line-by-line and incident-with-incident coding to label experiences that were shared within interviews. This labelling can be seen in Table **4.6**
Coding and Memo Data Sample.6. Using CCA within coding allowed me to create initial descriptive codes that exist as line-by-line and incident-with-incident, but that were also situated within the surrounding codes. Where the comparison of two or more initial codes led to a new way to describe the data, I would create a new initial code that was attached to the relevant section of the transcript, often sandwiched between the relevant/neighbouring codes in the transcript table.

CCA plays a key role in focused coding, as Charmaz (2014) encourages researchers to compare initial codes with the transcript, and initial codes between transcripts in order to identify meaning that can then be noted in focused codes (see Table **4.6**
Coding and Memo Data Sample.6). In coding the transcripts for meaning it became increasingly important to use CCA to explore the differences between participant groups. By actively looking at the different ways that caregivers and SLTs discussed access, we were able to focus on the meaning being expressed, rather than the terminology used by either group within their interviews. It is worth noting here CCA in this phase was facilitated by the ‘distance’ created between the transcript and its interpretation through descriptive initial coding.

In categorizing data, I sought to group the focused codes based on meaning into increasingly theoretically saturated groups. Through this process I used CCA to support the sorting of codes through reflecting on whether the meanings shared were the same or different.

Throughout data analysis I worked to ensure that the data being collected within interviews was moving categories towards theoretical saturation. The analysis of interviews raised further questions, sometimes about an unexplored area and sometimes about a nuanced experience that had been shared. When questions were raised, I used CCA to first seek understanding from existing data. This was helpful, as often these questions represented a new perspective of an experience, and so some data had already been collected but not analyzed with that perspective or understanding. This process allowed me to not only identify new insights, but to shape further data collection towards theoretical saturation.

Throughout the research I also generated memos when I reflected on data as a whole and sought to immerse myself in the data. For me, CCA became a part of this immersion as I mulled over different pieces of interview data or my own coding. Sometimes this was an active process wherein I had reviewed a line of a participant’s interview and was not sure how it related to other interviews or codes, as described above. At other times it was a passive process where a comparison would spring to mind while I was doing something unrelated. In either case, it was important that I was aware of my data and codes, and sought to construct meaning through analysis including comparative analysis.

In the example in Table .6, in separate interviews a caregiver and a SLT are discussing travel as an aspect of access to services, but from their own perspectives. The caregiver is discussing travel as an investment in intervention, while the SLT is discussing the need for financial investment by families in order to receive services at home. In both cases the participants are discussing the need for resources (time or financial) to address the barrier to access presented by travel. However, it was the comparison of focused codes arising from analysis of these passages that enabled me to see the broader concept of ‘resource allocation’ here, as reflected in the memo below.

Table 4.6

Coding and Memo Data Sample

Caregiver: Catriona (pseudonym)			
Speaker	Transcript	Initial Codes	Focussed Codes
Robert	Is there anything that you think made it more difficult or that was frustrating in the way that you maintained services?		
Catriona	Could my maintenance have been better? Hmm. If [the SLT] didn't live so far away, yes. So sometimes that was a pain because a I guess a half-hour session turned into kind of a two-hour round trip. So driving half an hour to get there, half an hour for therapy,	Describing how maintenance could be improved through reduced travel time to and from the clinic	Overcoming distance as a barrier through viewing travel as an investment in intervention

	half an hour back to daycare, and then another sort of half an hour back to work.		
	So that was a big investment.	Describing travel time as a big investment	
	So I think for other caregivers who don't see how important [intervention] is, I can see how barriers such as distance and time could make a really big difference in whether you continue going or not.	Linking a lack of investment from families to their observing of the importance of the intervention	Investment in intuition is justified by observing its importance
Speech-Language Therapist: Caroline (pseudonym)			
Speaker	Transcript	Initial Codes	Focussed Codes
Robert	What makes it harder for families to access your service?		
Caroline	But we do also offer site visits. So people don’t have to come to our clinic. We can go and do a home-visit or a school-visit.	Indicating that there is an option for home visiting, but that they attract a financial cost	Community visits are offered to address location access difficulties; however this comes with an additional travel cost, that may or may not be covered by funding package/s
	There is a travel charge, …		
	…sometimes that’s covered by funding.	Indicating that travel charges may be covered by funding packages	
Memo comparing coding of Catriona & Caroline’s interviews			
Both caregivers and SLTs have spoken about the barrier presented by travel and/or distance from clinical services. Catriona and other caregivers discuss time as a resource to address distance through seeing travel as addressing distance – though			

travel can present its own challenges for a family. Caroline and other SLTs have presented home- or community-based services as addressing travel and/or family distance from clinical services. Discussions by SLTs have typically looked at addressing travel through a cost or charge that is passed on to the family or occasionally the funding source.

While both are seeking solutions to clinical services being distal from families, they are addressing this using different resources, either time or money. In either case families are required to have resources to invest into the intervention to address their distance from the clinical services.

Challenges in Analysis

CCA can be challenging. Within my research I found it difficult being so immersed in my data, and having to be conscious of my position as a SLT while interviewing both caregivers and SLTs. It can feel overwhelming to be immersed in your project's data. With respect to CCA it can be difficult to decide which pieces of data to compare. With the knowledge that I was aiming to create meaning from my data, I focused on making comparisons that were meaningful and contributed – in part or whole – to my understanding of access to paediatric speech pathology services within Western Australia. At certain times throughout my research when I felt overwhelmed by my data it was important for me to reflect on why I was feeling overwhelmed, note/memo it, and then reflect on the whole dataset. Through stopping and documenting my reflection I was able go from looking at an individual piece of data (see the tree) to seeing the dataset as a whole (the forest). Often this process allowed me to identify something that was not sitting well with me, which then informed CCA and/or theoretical sampling.

Coming at this research as a SLT, I brought a clinical understanding and commonality to data co-generated with SLTs, and I had to seek to show equal respect by giving equal weight to data co-generated with each participant. A core part of the investigative approach within my research was viewing 'access' as not having a true and whole form in either the caregiver or the SLT, but having an existence that is held wholly by the relationship and combined experiences and perspectives of caregivers and SLTs. And as such I worked with all participants to co-create meaning, not with each group separately. This awareness was important when using CCA as I sought to draw comparisons between groups to identify a clearer understanding of access to speech pathology services, and to avoid comparisons placing participant groups in opposition to one another. In my project it was important for me to acknowledge my positioning as a SLT, and to seek to treat data that was co-generated with SLTs and caregivers with equal rigour and respect.

Appendix H: Full Page Model of Access to Speech Pathology Services (MASPS)

Figure 15

Colour Full-Page Model of Access to Speech Pathology Services (MASPS)

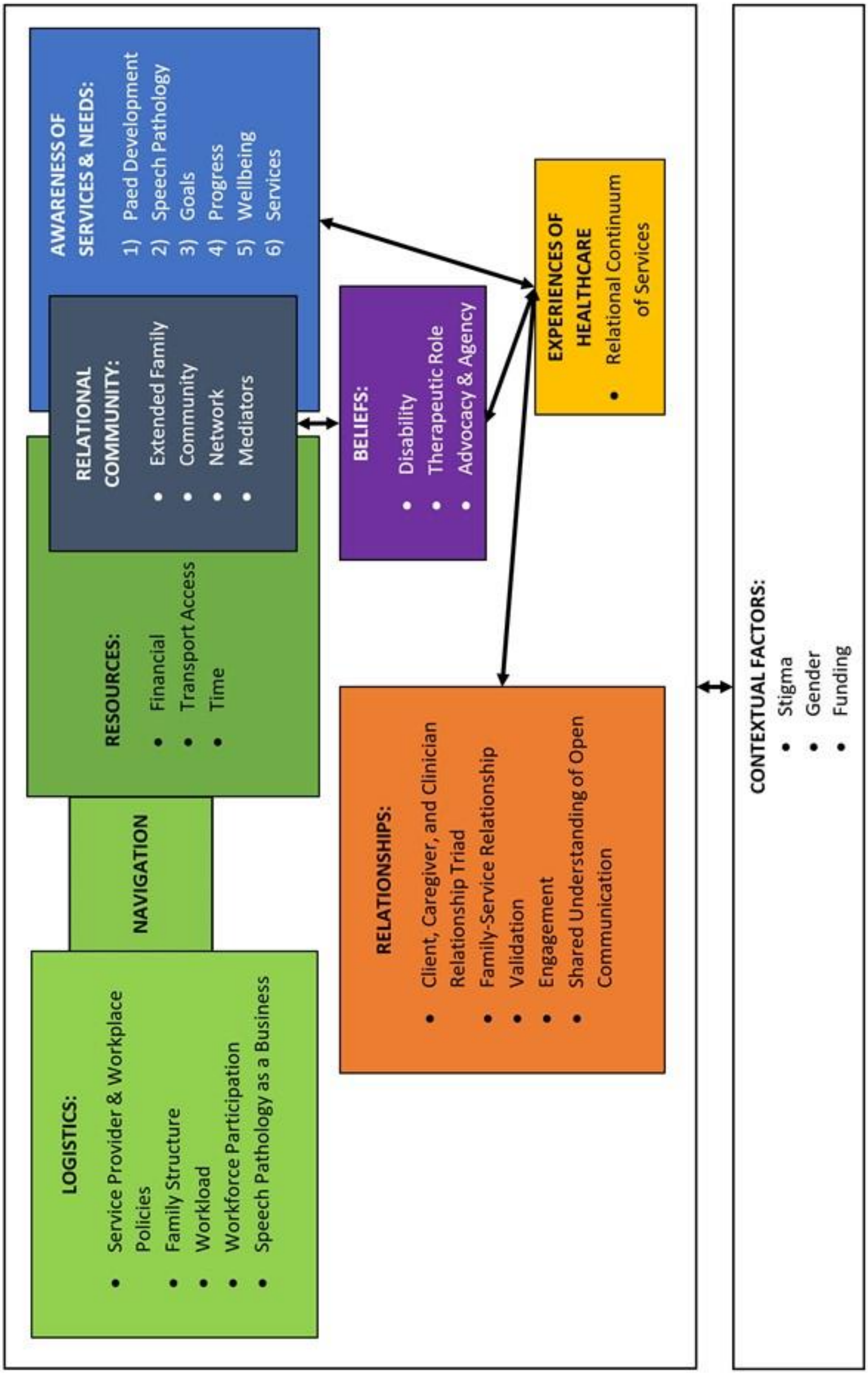


Figure 16

Black and White Full-Page Model of Access to Speech Pathology Services (MASPS)