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Research Article

Waiting list management: Professionals' perspectives and innovations

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Abstract.
BACKGROUND: Waiting lists for speech and language therapy exist when services do not meet demand. Waiting lists pose practical and ethical challenges for speech and language therapists (SLTs) and workplaces to manage, with potential flow on effects for children and families.
OBJECTIVE: The present study aimed to describe SLTs' perspectives about waiting lists for children with speech, language, and communication needs (SLCN) and explore waiting list management strategies.
METHODS: The present study reports on 187 SLTs' written responses to open-ended questions in a questionnaire. SLTs were from nine countries, had an average of 12 years' experience in the profession (range 0.2–45 years), and either currently or had previously worked with children. Data were analysed qualitatively using thematic analysis.
RESULTS: SLTs' feelings about their waiting lists centred on three themes: (1) negative (e.g., "overwhelmed", "stressed", "anxious", "embarrassed"); (2) neutral (e.g., "not too bad", "okay"); and (3) positive (e.g., "manageable", "proud"). Four themes related to waiting list management: (1) SLT service delivery (e.g., triage, use of technology in service provision); (2) workplace processes and policies (e.g., eligibility criteria, prioritisation); (3) SLT workforce (e.g., recruitment and retention of skilled SLTs); and (4) inaction (e.g., waiting list management was "out of my hands").
CONCLUSIONS: Waiting lists can have negative consequences and many SLTs take action to manage waiting lists; however, waiting list management strategies are not necessarily effective which can impact children's outcomes. There is a need to reimagine service delivery and identify effective actions for managing speech and language therapy waiting lists at a local and systemic level in order to optimise outcomes for children and families.

Keywords: Waiting list, service delivery, prioritisation, speech-language pathologist, speech and language therapist

1. Introduction

Waiting lists for speech and language therapy are common, particularly in countries with universal or government subsidised health care such as the United Kingdom, Ireland, and Australia. Access to speech and language therapy has been described as a "post-code lottery" where waiting times for services for children with speech and language needs are based on geographical location (I CAN and Royal College of Speech and Language Therapists [RCSLT], 2018). Children with speech and language needs must sometimes wait more than 12 months for assessment and therapy with a speech and language therapist (SLT) (I CAN and RCSLT, 2018; McGill, McLeod, Crowe et al., 2021; Ruggero et al., 2012). Waiting lists can have negative implications for consumers (e.g., parents, clients) and professionals (e.g., SLTs, doctors, educators), including psychological, physical, financial, and ethical burdens (McGill et al., 2020). Manage-

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ment of waiting lists and their negative consequences pose significant challenges for SLTs and workplaces to ensure quality of care is not compromised.

1.1. SLT workforce

The demand for speech and language therapy services often exceeds the capacity of current services which frequently have limited resources and staffing. The demand for speech and language therapy is projected to increase in the future (Commonwealth of Australia, 2014). Recruitment and retention of allied health professionals, including SLTs, is a significant issue (Long et al., 2018). SLT services often have limited funding, particularly in the public system, impacting their ability to recruit enough SLTs to cope with demand and capacity to offer long term employment contracts (Lincoln et al., 2014). Shortages of SLTs and subsequent gaps in service for children and families can result. SLTs engage in complex juggling acts to manage caseloads which are increasing in size and complexity while resources are not necessarily increasing to meet demand (Kenny & Lincoln, 2012). SLTs have reported feeling stressed, overwhelmed, frustrated, fatigued, and disillusioned when managing large client caseloads in under-resourced and under-staffed services, which can impact retention and affect their ability to provide evidence-based care for their clients (Edgar & Rosa-Lugo, 2007; McLaughlin et al., 2008). Poor job satisfaction for some SLTs may reflect "a mismatch between personal/professional values and the realities of providing healthcare" (Byng et al., 2002, p. 92). SLTs are often motivated by helping clients, making a difference, and having quality client relationships, and long waiting lists may conflict with these values, contribute to reduced job satisfaction, and therefore impact workforce retention (Byng et al., 2002).

Whilst waiting lists may contribute to workload, retention, and job satisfaction issues, limited research has specifically focused on SLTs' perspectives regarding waiting lists. Allied health professionals have reported feelings of frustration and embarrassment, and the inability to provide evidence-based and family-centred care due to waiting lists (Lincoln et al., 2014). Waiting lists have been reported to have negative implications for SLTs' psychological wellbeing (McGill et al., 2020); however, few studies have explored SLTs' perspectives about their waiting lists, whether there are implications for recruitment and retention, and any flow on effects to the children for which care is provided.

1.2. SLT service delivery

Speech and language therapy service delivery aims to provide person-centred, evidence-based care for all clients. Service delivery may vary according to geographical location, workplace setting/context, waiting list duration, or caseload size (Wright & Kersner, 2012). For years, many SLTs rationed their services to maximise the greater good for the greatest number. For instance, large waiting lists and caseloads can lead SLTs to provide different types or lower doses of therapy than children require, provide group therapy despite one-on-one therapy being more appropriate, or cancel sessions in an effort to manage their workload, all of which may impact children's speech and language outcomes (Chiang & Rylance, 2000). In contrast, for speech and language therapy to be effective, the intensity, or "quality and quantity of ... learning experiences" (Baker, 2012, p. 402), is important. Generally high doses, or high occurrence of learning experiences/practice trials per therapy session, are recommended (Baker, 2012; Glogowska et al., 2000; Law & Conti-Ramsden, 2000). Therefore, therapy outcomes may be compromised by service delivery decisions.

SLTs attempt to manage their limited resources, caseloads, and waiting lists using many different strategies and models of service delivery, including triage, screening, prioritisation, providing home programs and information to families, and offering group therapy (McCartney, 2000). Constraints within workplaces (e.g., limited funding and resources) may pressure SLTs to adopt service delivery models involving provision of a limited service for financial and efficiency reasons, rather than based on client needs (Wright & Kersner, 2012). For instance, pressure may be placed on SLTs to discharge clients from their caseloads in order to increase throughput and take on new clients from the waiting list, which has been described as "highly unsatisfactory" for SLTs (Hersh, 2010, p. 288). SLTs may also implement innovative strategies and service delivery models to improve their services and proactively manage their caseloads and waiting lists. Evidence regarding the effectiveness of innovative strategies may be limited or inconclusive, making decisions regarding service delivery and waiting list management strategies difficult (Petticrew, 2003). SLTs' decision-making regarding service delivery is not always made explicit to clients, which may be disempowering for families (Ruggero et al., 2012). Service delivery models do not always fit with families' expectations,

wants, and needs (Ruggero et al., 2012). Subsequently, there are challenges in balancing the need for cost and time efficiency, professional and personal values, evidence-based practice, and the needs of children and families.

Little is known about the types of support, if any, SLTs provide to children and families on waiting lists. Although waiting for speech and language therapy has traditionally been considered a passive stage of families' involvement with speech and language therapy services (Glogowska & Campbell, 2000), provision of information to families may empower them to be active while waiting and find strategies to reduce their waiting times (Fordham et al., 2012; McGill & McLeod, 2019). SLTs may provide information, strategies, or parent-led therapy programs to families on waiting lists, potentially encouraging active waiting and facilitating improvement in children's speech and language skills. However, the types of support provided to families on waiting lists and the efficacy of these strategies is unclear, particularly since direct parent training and high doses are recommended for parent-led therapy programs (Tosh et al., 2017). SLTs may also have innovative solutions for waiting list management and supporting children and families on waiting lists which have not yet been explored in published literature. Consequently, the aims of the current study were to describe: (1) SLTs' feelings and perspectives about waiting lists, and (2) SLTs' current and aspirational waiting list management strategies.

2. Method

The research aims were addressed using thematic analysis to explore SLTs' written responses to open-ended questions in a cross-sectional questionnaire. This method enabled broad insights to be obtained from many SLTs across multiple countries without limiting their ideas to pre-determined response options. This study received ethical approval from the Charles Sturt University Human Research Ethics Committee (Protocol number: H17181). The reporting of this study was informed by the Consensus-Based Checklist for Reporting of Survey Studies (CROSS; Sharma et al., 2021).

2.1. Participants

Two-hundred and seventy-six SLTs completed questionnaires. Two-hundred and sixty-four SLTs (95.7%) met the eligibility criterion by indicating they currently or had previously worked with children, and their responses to closed questions were analysed quantitatively and reported in McGill, McLeod, Crowe et al. (2021). A subset of 187 SLTs (70.8%) responded to at least one of the open-ended questions within the same questionnaire and these SLTs formed the participant sample for the present qualitative study. Of the 187 SLTs, 82.9% ($n = 155$) completed an online version of the questionnaire and the remainder completed a hard copy version. The number of valid responses varied for each question, so the percentage and number of respondents have been provided to enable calculation of the total valid responses. The SLTs' questionnaire responses related to workplaces based in Australia ($n = 101$, 65.2%) or other countries ($n = 54$, 34.8%). Most lived in Australia ($n = 131$, 71.2%), while others lived in the United States ($n = 25$, 13.6%), United Kingdom ($n = 11$, 6.0%), Canada ($n = 7$, 3.8%), New Zealand ($n = 4$, 2.2%), Republic of Ireland ($n = 3$, 1.6%), and one each from South Africa, China, and the Netherlands. Some SLTs ($n = 22$, 11.8%) spoke a language other than English at home, including French, Spanish, Dutch, Arabic, German, and Greek. SLTs were predominantly female ($n = 184$, 98.4%) and their level of experience ranged from less than one year (0.2 years) to 45 years ($M = 12.0$ years, $SD = 10.6$). The highest levels of education completed by SLTs were a doctoral degree (e.g., PhD; $n = 10$, 5.3%), master's degree ($n = 74$, 39.6%), graduate diploma/certificate ($n = 13$, 7.0%), and bachelor's degree ($n = 85$, 45.5%). Some SLTs ($n = 66$, 35.3%) had additional qualifications, including in arts, science, and education. SLTs' responses related to the following workplace contexts: community health centres ($n = 72$, 39.1%), private practices ($n = 33$, 17.9%), education settings (e.g., schools, nurseries/early childhood education centres; $n = 33$, 17.9%), hospitals ($n = 21$, 11.4%), disability services ($n = 18$, 9.8%), universities ($n = 2$, 1.1%), research settings ($n = 1$, 0.5%), or other ($n = 4$, 2.2%). SLTs most commonly reported their main areas of expertise (more than one response option was allowed) to be speech sound disorder ($n = 144$, 77.0%), developmental language disorder ($n = 140$, 74.9%), autism spectrum disorder ($n = 94$, 50.3%), literacy ($n = 71$, 38.0%), fluency/stuttering ($n = 61$, 32.6%), and childhood apraxia of speech ($n = 59$, 31.6%). SLTs

[1] SLTs in Australia, the United Kingdom, and New Zealand can practice with a bachelor's degree qualification.

reported having client caseloads ranging from 2 to 700 clients ($M = 63.5$, $SD = 66.7$). The mean duration of their waiting lists were 5.3 months between referral and assessment ($SD = 4.0$, range = 0–20 months) and 3.2 months between assessment and therapy ($SD = 3.8$, range = 0–22 months), with a combined duration of 8.4 months ($SD = 5.9$, range = 0–42 months) between referral and therapy for children.

2.2. Instrument

A questionnaire was developed to obtain SLTs' perspectives regarding speech and language therapy waiting lists for children. The questionnaire included information and consent forms at the beginning for SLTs to indicate their willingness to participate. Two versions of the questionnaire were developed: (1) a hard copy version to distribute in person; and (2) an online version to distribute internationally. Piloting of the questionnaire was undertaken with an independent paediatric SLT and members of the research team.

The questions were informed by research literature on service delivery, waiting lists, and prioritisation for health care services, including speech and language therapy (Glogowska & Campbell, 2000; Roulstone, 2007; Schooling et al., 2010). SLTs were asked to answer the questions based on a workplace they currently, or had recently, worked in with children. Closed questions about demographics, caseload size, waiting times, care pathways, and prioritisation parameters have been analysed separately and reported in McGill, McLeod, Crowe et al. (2021). Relating to the focus of the present paper, SLTs were asked a series of questions regarding their feelings about the waiting list in their workplace, services/service delivery models provided in their workplaces, and their ideas and strategies for waiting list management. Two questions analysed in the present paper were included in both the online and hard copy versions of the questionnaire, while the online version contained four additional questions relevant to the analysis of this paper, and minor formatting changes to enhance online usability. In both the online and hard copy versions, SLTs were asked "What strategies, policies or methods of service delivery do you use to help manage/address your waiting list?" and were also provided with a list of service delivery options and a free-text response box to identify the service delivery models used in their workplaces. In the online version of the questionnaire, SLTs were asked the following open-ended questions: "How do you feel about the waiting list at this [chosen] workplace?", "What do you think would help with managing paediatric speech-language pathology waiting lists? Please describe any ideas or solutions you have", and "Can you suggest any innovative ways to support children and their families and/or educators while they are waiting for speech-language pathology services?". Additionally, SLTs were asked to provide their opinion regarding how helpful and/or useful a website would be, containing information and ideas for things to do while children are waiting for speech and language services, to inform concurrent studies regarding development and evaluation of a technological waiting list management strategy (McGill & McLeod, 2019; McGill, McLeod, Ivory et al., 2021).

2.3. Procedure

Participant recruitment involved opportunity and snowball sampling via a two-stage approach. Stage 1 involved distribution of hard copy questionnaires to SLTs at the 2018 Speech Pathology Australia National Conference during a session and poster presentation. Interested SLTs completed the questionnaire anonymously and returned them to a bag by the door/poster board. Stage 2 involved distribution of an online version of the questionnaire via the following methods: emails to the authors' international professional networks, Speech Pathology Australia's e-News, international social media, and word of mouth. Participants were invited to share the online questionnaire link with other interested SLTs. Participants indicated their consent to participate in the study and have their results analysed by completing and returning their hard copy questionnaire to the first and second authors or clicking *continue* on the first page of the online questionnaire. The information sheet at the beginning of the online questionnaire advised participants that the questionnaire was anonymous and not to complete an online version if they had previously completed a hard copy version. Responses to hard copy questionnaires were manually entered into the online questionnaire form by a research assistant blinded to the aims of the study to enable data to be combined with the online responses. All questionnaire responses were compiled in the online questionnaire software and exported into SPSS (IBM, 2017), then into NVivo (QSR International, 2019).

2.4. Analysis

SLTs' responses to the waiting list management questions were combined and analysed together due to overlapping themes, whereas SLTs' responses regarding their feelings about waiting lists were analysed separately. Qualitative data analysis was based on the principles of thematic analysis using the six step procedure described by Braun and Clarke (2012) and insights from Lyons and McAllister (2019). Following familiarisation of the data (Step 1), the first and second authors read through the SLTs' responses and used a deductive approach and surface semantic coding to sort responses into a general service delivery framework, forming the initial coding structure (Step 2). A deeper inductive analysis using latent coding was then undertaken by the first author in NVivo (QSR International, 2019) that captured participants' underlying ideas, patterns, and assumptions. Codes were added when new content or ideas were identified. Codes were then grouped into themes (Step 3) and confirmed with the second author (Step 4). The author allowed time to elapse to give distance to the data, then collapsed and rearranged codes and modified the themes. Consensus with the second author was obtained regarding defining and naming the final themes (Steps 3 to 5). To enhance transferability of the findings, the authors used thick description through inclusion of verbatim quotes from SLTs when reporting the results (Step 6). The authors replaced other similar terms (e.g., speech pathologist) with "SLT".

3. Results and discussion

Responses to the question about SLTs' feelings were analysed and reported separately to SLTs' responses regarding waiting list management. Original participant identification numbers from the questionnaire have been retained and reported after SLTs' quotes.

3.1. SLTs' feelings about waiting lists

Three themes were identified in SLTs' written responses regarding feelings about their waiting lists: (1) negative; (2) neutral; and (3) positive feelings.

3.1.1. Negative feelings

Most SLTs' comments described negative feelings about their waiting lists. SLTs described feeling "bad" (28), "frustrated" (4), "anxious" (32), "overwhelmed" (164), "stressed" (250), "concerned" (260), and "embarrassed as a professional" (276) regarding their waiting lists. Most negative responses involved comments about waiting list duration, which SLTs felt was "far too long" (13). SLTs described their waiting lists as "enormous" (119), "horrendous" (16), and "a disgrace, but we can't speak about it" (10). Negative comments also related to being "understaffed" (172), "system level roadblocks" (4) and "business/money focused" organisations (166), or waiting lists being "poorly managed" (1). SLTs also described experiencing conflict between evidence-based practice and reality as their waiting lists went "against the intention of early intervention" (119) and that "if advocating the benefits of early intervention ... [I] should be able to 'walk the talk'" (276). SLTs described their waiting lists as "unethical" (181), particularly when they had "opened a duty of care to the clients" (220). The negative personal toll of waiting lists on SLTs was highlighted by comments about "feeling stressed ... because parents become anxious about waiting" (190), or feeling "a sense of having let others down" (260), meaning waiting lists had the "biggest negative impact upon ... job satisfaction" (260).

Similar negative feelings have previously been reported with regards to SLTs' management of large caseloads in services with resource constraints, which had negative implications for workforce retention and the care provided to clients (Edgar & Rosa-Lugo, 2007; Kenny & Lincoln, 2012; McLaughlin et al., 2008). Conflict between practice and professional/personal values or ethics has also been found to impact job satisfaction and retention within the workforce (Byng et al., 2002; Lincoln et al., 2014). Key ethical principles guiding SLTs' practice include beneficence (doing good for others), nonmaleficence (doing no harm), and justice (fair and equitable access to care) (Fletcher et al., 1997). Waiting lists can delay provision of care for clients who would benefit from support, and factors associated with the practice context (e.g., resource limitations, organisational policies) may contribute to service delivery decisions that conflict with best practice recommendations or clients' needs, for instance, regarding the timing, type, and intensity of intervention (Hoffman et al., 2017). The findings may illustrate the moral and ethical challenges for SLTs posed by a "philosophical conflict between desired and allowable practices" (Byng et al., 2002, p. 90). More must be done to address the constraints facing SLTs in their practice

contexts, and support and retain SLTs in the workforce to enhance quality and continuity of care for clients.

3.1.2. Neutral feelings

There were also neutral responses from SLTs about their waiting lists. Some SLTs indicated they had "mixed feelings about the waiting list" (234) or felt their waiting list was "not too bad" (137), "okay" (169), or "adequate" (238). Others felt that although their waiting list "could be better . . . prioritising helps get in more urgent patients" (178). Some SLTs displayed a sense of acceptance that "long waiting lists seem to be the nature of community health" (163) with "no available alternative" (246) and "it is unfortunate to have a waitlist; however, it is necessary" (244). These perspectives are consistent with previous research indicating that health professionals view waiting lists as a "normalized" aspect of health care "culture" (Rittenmeyer et al., 2014, p. 194).

3.1.3. Positive feelings

Some SLTs reported positive feelings, including feeling "generally OK" (26), "fortunate" (184), or "good" (204) about their waiting lists. Most positive responses involved comparisons with waiting lists in other organisations or reflections on how their waiting list had changed over time. For instance, some SLTs described their waiting list as "a big improvement" (212) or "better than it was" (58), while another felt "a shorter waiting list would be better but compared to other public services it isn't that bad" (182). These perspectives may indicate that some form of waiting list management strategy had been in place within the workplaces. Some SLTs felt their waiting list was "manageable" (251) and felt "proud that we can respond to requests for service in a timely way" (154). Being proactive by "actively working towards NOT having a waiting list" (176) may have provided a more positive perspective for SLTs regarding their waiting lists, perhaps due to feeling like they were doing something to address the issue.

SLTs' feelings may have reflected caseload size, which can contribute to perceptions of caseload manageability – a construct interconnected to job satisfaction (Katz et al., 2010). SLTs who expressed neutral or positive views may have had smaller caseloads than those who reported negative feelings. Caseloads exceeding 55 clients have been reported by school-based SLTs to be unmanageable (Katz et al., 2010).

3.2. SLTs' perspectives regarding waiting list management strategies

Four overarching themes were identified in SLTs' responses regarding their waiting list management practices, ideas, and innovations (Appendix): (1) SLT service delivery; (2) workplace processes and policies; (3) SLT workforce; and (4) inaction.

3.2.1. SLT service delivery

Many SLTs described existing or aspirational service delivery strategies in their workplaces to manage waiting lists and support those who are waiting for speech and language therapy. SLTs described assessment practices such as screening, intake/triage, single session models, and drop-in services. An SLT emphasised the importance of families receiving a timely assessment, even if they subsequently waited for therapy: "I believe that assessment is the greatest priority . . . Assessments take away parental anxiety when no problems are found. Even if therapy cannot be offered for a long time, processes are 'in motion' once an assessment is done" (160). In a recent community-based randomised controlled trial (RCT), provision of an assessment following referral to families on a speech and language therapy waiting list led to similar improvements in child outcomes and caregiver satisfaction to those who received both an assessment and access to an evidence-based speech and language website while waiting (McGill, McLeod, Ivory et al., 2021). However, Ruggero et al. (2012) found that parents were dissatisfied with long waits between assessment and commencing therapy.

SLTs described providing group therapy, intensive therapy programs, and therapy blocks, including "shorter block therapy sessions followed by home program and review" (195). Group therapy was described by many SLTs as a way to "decrease waiting times" (193) by seeing multiple clients at once with "similar needs" (60) and offering "places . . . to children on the wait list" (1), as well as encouraging active waiting by offering "group [therapy] while waiting for individual [therapy]" (255). However, a study by Ruggero et al. (2012) found that most parents preferred one-on-one therapy for their children instead of group therapy and few preferred home programs or parent training. Alternatives to one-on-one therapy were considered acceptable to "fill a gap" (p. 346) rather than replace direct face-to-face support; however, it is possible that greater transparency between SLTs and families regarding service delivery

options may alter these perspectives (Ruggero et al., 2012).

SLTs also identified the need for a greater focus on prevention through health promotion or embedding speech and language therapy services within universal services (e.g., nurseries/early childhood education centres, child health services, playgroups), such as having SLTs as "part of mothers' groups so early fundamental language teaching can be taught" (33). Historically speech and language services have aligned with a rehabilitative framework and services have typically been provided in one-on-one, clinic-based settings with children diagnosed with speech and language disorders (Law et al., 2013). However, there is an increasing awareness of the social and environmental influences on children's speech and language development, and a growing focus on and need for prevention, health promotion, and whole population approaches (Law et al., 2013). Such approaches may enable SLTs to expand their reach and provide support earlier to greater numbers of children, both with existing speech and language difficulties and those who are at risk.

SLTs also discussed the use of technology in service delivery, such as "using teletherapy to provide services" (43) or as a way of disseminating information and training to families through "webinars" (1), "moderated online support groups" (1), "SMS messages with tips" (237), a "parent coaching app" (232), "a website to direct them to with appropriate strategies" (273), and "online parental videos for support strategies family can use in interim until they are able to seek help" (64), which have shown promise in other research studies (e.g., Wales et al., 2017). Many technology-based strategies were innovative ideas that SLTs aspired to implement in their workplaces, and fewer SLTs were already using such strategies.

SLTs also described collaboration with parents and professionals as a common strategy. Many SLTs reported providing advice and training to parents, with some providing "phone support" (36), "parent training programs" (207) or "one-off advice sessions to families at time of referral" (196) or soon after intake to "provide parent education to support active waiting while on the wait list for an initial assessment" (215). Some SLTs provided home programs, "general information" (103), and "'harm-free' resources to parents" (104), which have been implemented by SLTs for many years. Others were not currently offering these supports but suggested ways that services could support families on waiting lists, such as providing "parent friendly resources" (167) for "parents to use during wait times or for mild diagnoses" (165), "[an] accessible website for families to use, including some video clips on how to put these [strategies] into practice at home" (206), an "information package for families or . . . a parent information group to present generic strategies for communication support that could be used while waiting" (182). It was unclear whether the parent education strategies implemented by SLTs involved direct parent training and high doses, which has been recommended for home therapy programs (Tosh et al., 2017). McLeod et al. (2020) conducted an RCT to evaluate provision of three types of support to children aged 3–6 years on a speech and language therapy waiting list: (1) 12 sessions of immediate face-to-face therapy; (2) a tailored advice session; and (3) provision of a purpose-built website containing information and parent-friendly strategies for stimulating children's speech and language skills. The results indicated that provision of advice sessions or a website to caregivers were not as effective as face-to-face therapy for improving children's speech production or caregivers' satisfaction, but there was little difference in outcomes across groups regarding children's intelligibility, language, and early literacy, and caregivers' feelings of empowerment (McLeod et al., 2020). A concurrent RCT by McGill, McLeod, Ivory et al. (2021) compared two waiting list conditions: (1) provision of the same purpose-built website to caregivers; and (2) a control group involving provision of assessments only. The findings indicated that provision of a website was no more effective at improving children's and caregivers' outcomes than receiving an assessment only while waiting, suggesting families may require more than a generic website alone while waiting (McGill, McLeod, Ivory et al., 2021).

SLTs suggested "strong links and sharing of knowledge" (65) with other health and education professionals would assist with managing speech and language therapy waiting lists and supporting those on waiting lists through "training of health visitors [regarding] appropriate referrals" (146), training "educators and . . . early childhood providers . . . in providing language rich environments and in strategies for modelling and eliciting language" (123), and implementing "school/preschool based programs" (21). Interprofessional collaborative practice can enhance access to health care and coordination of services, improve clients' outcomes, and increase clients' and caregivers' satisfaction with care (World Health Organization, 2010). Collaboration between

professionals, such as in education settings, can have many benefits for children's communication development (Hadley et al., 2000). For children with disabilities, interprofessional collaborative practice can enhance progress toward goals and provide "more seamless care" (Sylvester et al., 2017, p. 206). However, collaboration can be time consuming and has been associated with SLTs' perceiving their caseload to be unmanageable (Katz et al., 2010), potentially impacting their work with children and, subsequently, the outcomes of children and families.

Additionally, relying on non-SLTs in service delivery was suggested, including "recruiting AHAs [allied health assistants] to do the bulk of group work" (166) to "allow the SLTs to see the higher priority clients" (166). Speech and language therapy assistants or allied health assistants work with children and families under the supervision and guidance of SLTs, carrying out therapy plans, completing routine-based tasks, or preparing resources and materials (SPA, 2014). Speech and language therapy assistants may assist with reducing SLTs' workloads and free up time for other non-delegable complex tasks such as assessment and therapy planning; however, training and supervising assistants also takes time and resources (Goldberg et al., 2002).

3.2.2. Workplace processes and policies

The second theme related to workplace processes and policies. SLTs' responses related to funding, administrative strategies, referral processes, organisational strategies, and evidence-based practice. With regards to funding, many SLTs indicated that "increased funding" (126) would help with management of waiting lists as "funding is the main issue" (229). However, researchers have recommended that provision of additional resources and funding occurs in combination with other initiatives for effective long-term management of waiting lists (Sanmartin et al., 2000). Many comments about funding were linked with the ability to "increase staffing levels" (165) among the SLT workforce. Others described a need for "bulk funding for health promotion/carer training" (129), "primary health care initiatives" (131), and "communication workshops and training" (129) for early childhood education services. Some SLTs made use of alternative funding models to manage their waiting lists, including encouraging families to access government rebates for private services, or making referrals to disability/medical insurance schemes. However, such funding is not available in all countries. In countries where funding and government subsidised sessions are available, not all children are eligible, and children who are eligible often require more than their allocated amount of support to make significant improvements in speech and language (Law & Conti-Ramsden, 2000). Privately-funded services were not an affordable option for many families (McGill et al., 2020).

SLTs also reported implementing administrative strategies such as failure to attend policies, cancellation lists, registration forms, limits on advertising, waiting list audits, and templates for documentation to increase efficiency. Some SLTs used scheduling to manage their waiting lists by "reserving assessment appointments to ensure that new referrals are assessed promptly" (212) "regardless of the number of discharges to ensure throughput of clients" (260), and keeping "a full schedule" to "see as many kids as possible" (241). SLTs also suggested strategic caseload allocation processes could help, including having "allocated teams, within current staffing, to manage each priority level" (237) of clients.

SLTs also described strategies involving referral policies to assist with waiting list management. Some SLTs preferred to "refer excess clients on to others and will not accept clients if they have to wait more than 2-3 weeks" (176) while others referred potentially eligible children to other services to access alternative funding (e.g., disability insurance schemes) as it "is the only way most of these children will access regular and ongoing . . . intervention" (163). Referrals were a way to "assist in starting processes for further assessment" (113) as well as encourage active waiting through linking families with other "adjunct services . . . community-based group programs . . . parent courses and parent support groups" (176) while waiting for speech and language therapy.

Organisational strategies for waiting list management related to both standards and restrictions imposed on services. Some SLTs described having "state mandated timelines" (238) for seeing clients and "strict benchmarks for different ages to be assessed by" (165). Benchmarking is consistent with recommendations from Rvachew and Rafaat (2014). There were many restrictions imposed on the services provided by SLTs, including closing the books, discharge protocols, "strict criteria for acceptance onto waiting lists" (126), and "strict caps on session numbers to help reduce wait times for other clients" (165), which have implications for continuity of care, client satisfaction, and efficacy of interventions

(Law & Conti-Ramsden, 2000; Ruggero et al., 2012).

SLTs reported "prioritisation based on outcome evidence" (190) to be an effective waiting list management strategy. Many SLTs used prioritisation to ration the services provided based on factors such as "age, disorder type" (21), "severity, impact on education . . . impact on daily functioning" (225), or "vulnerable" (149) and "disadvantaged groups" (167). Some SLTs described formal prioritisation guidelines in their workplaces such as a "clinical prioritisation tool" (167), while others described "a vague prioritisation policy which is not consistently implemented" (206) and thought that "a clear pathway for prioritisation" (206) with greater "consensus" (187) was needed to help manage waiting lists. Prioritisation of children for services based on child and service factors is consistent with previous research (McCartney, 2000; McGill, McLeod, Crowe et al., 2021; Roulstone, 2007). Prioritisation can be problematic as some children considered low priority may never receive support, despite the ability to benefit from therapy (McCartney, 2000).

SLTs' responses also commonly related to evidence-based practice. Some SLTs experienced feelings of conflict regarding their current waiting list management strategies as they felt they were "unable to offer best practice" (250) and were "not providing a good service for children" (126) which was "not good for the reputation of the SLT profession" (126). Speech and language therapy should be evidence-based and person-centred in order to promote optimal outcomes for children, which involves integration of evidence from research literature, clinical experience and expertise, client values and preferences, and the practice context (Hoffman et al., 2017). Incongruency between strategies implemented in services and evidence-based practice is consistent with prior studies (Hersh, 2010; Ruggero et al., 2012). Although the practice context is important to consider in professional practice, the SLTs' responses may highlight a heavily service-centred focus within their workplaces, rather than achieving balance between the constraints of practice contexts and a person-centred focus. SLTs' responses also suggested a lack of control or autonomy over the decision-making processes regarding some aspects of client care. This could conflict with SLTs' professional and ethical values, ultimately impacting children's care (Keane et al., 2012).

Being able to "empower" families "to do proper research" (240) was another innovative solution identified. SLTs suggested "evidence making" (141) through "more research into group service delivery" (149) and the "most effective time to treat particular disorders" (149) would help with waiting list management. SLTs identified a need for "evaluation of 'while you are waiting' resources" (129) "that are easy to integrate into home routines" (60). Some SLTs acknowledged that although they were "yet to explore" if the resources provided to families to encourage active waiting have "an impact on the referral condition," it "allows parents to have heard the information before when I start to introduce it all during the assessment" (192). Development and evaluation of resources and information for supporting children and families on waiting lists were often identified as aspirational solutions rather than strategies the SLTs were already implementing in practice, and are consistent with recent research (McGill & McLeod, 2019; McGill, McLeod, Ivory et al., 2021). People on waiting lists have been found to "long for information" but seldom receive it from health care services (Rittenmeyer et al., 2014, p. 218).

3.2.3. SLT workforce

The third theme identified in SLTs' responses about waiting list management related to the SLT workforce. SLTs described strategies related to recruitment, stating that more publicly funded SLT positions were "desperately" (119, 164) needed since there are "not enough positions to meet demands" (26). For some workplaces, there had been "no increase in staffing in almost 20 years despite marked growth in population" (164). One SLT described spending "40 years coping with waiting lists" and reported: "There are not enough SLTs in the public health system. Not then; not now . . . So much angst. So much discussion. So many years. Employ more SLTs - that is how we can manage paediatric waiting lists" (160). Despite trying "many strategies", SLTs reported "the only factor that has helped is when we have had periods of increased staffing, but when this ceases, the waiting lists grow again" (167). Recruiting "casual" SLTs to "conduct additional assessments when the waitlist starts to grow too quickly" (224) was reportedly effective in some workplaces. SLTs described the need for not only increased numbers of SLTs and positions, but for recruitment and retention of "skilled" (131), "well-trained" (39) SLTs "with experience" (225). Whilst many SLTs suggested recruitment and retention of SLTs were key wait-

ing list management solutions, few identified specific strategies to recruit and retain skilled SLTs in the workforce such as "more training" (127) and "ongoing professional development opportunities" (184). The shortage of SLTs and other health professionals is a well-documented issue impacting children's access to services (Keane et al., 2012; Lincoln et al., 2014).

Traditionally, speech and language therapy services for children have been provided on weekdays and most often within clinics. However, flexibility of the SLT was another waiting list management strategy identified by SLTs, which included "being flexible with work hours" (102), "scheduling options" (251), and "location options for service delivery" (176). Increased flexibility of service delivery, including location and session times, was one of the most common suggestions from parents for improving speech and language therapy services (Ruggero et al., 2012).

Increasing managerial support for the SLT workforce was identified as an aspirational idea which would help manage waiting lists, as "the worst examples of large waiting lists ... are where there is chronic understaffing, appalling management support ... and unreasonable workloads" leading to "subsequent staff retention issues" (184). SLTs who felt "overworked, overwhelmed and unsupported" with "little time or energy for inspirational ideas" just kept "continuing on with mostly the same processes and programs", rather than feeling supported to implement innovative actions to manage their waiting lists (250). Employees require a positive workplace environment in order to "flourish" and be innovative, which includes managerial support, provision of resources, enhanced autonomy, and reduced workloads (Colligan & Higgins, 2006, p. 95).

Changes to SLT higher education were also suggested to help manage waiting lists. These included an "increase" in "the number of spaces in graduate programs" (227), and having a "better understanding of workforce need" (40) by teaching "aspects of managing a caseload, prioritisation and how to explain these to others" (270) as well as "service delivery models ... taking into consideration telehealth" (270). SLTs also described implementing "university clinics and groups" (260) and having SLT students "carry out assessments" (21) to manage waiting lists. Involving students in the workplace may enable larger numbers of children to be seen or facilitate greater therapy doses for children already on SLT caseloads.

3.2.4. Inaction

Some SLTs described inaction or passive strategies regarding waiting lists, although this was less common among the respondents. One SLT attributed their inaction to being "just a casual" and "I turn up, see the clients, and leave" (1). Some described facing challenges or barriers in their workplaces preventing them from taking action, including having "not enough staff" (227) and "little time or energy" (250), finding it "too difficult to set aside enough time" (21), or because actions were "not billable services" (42). Another challenge was incomplete or unclear referrals, and since "each child has individual needs and not all strategies are appropriate for every child" (236) it can be "difficult to provide 'blanket' strategies for parents" (236). SLTs also described a lack of control leading to their inaction. Some SLTs reported their waiting lists were "out of my hands" (62) and "entirely in the hands of managers" (181). Other challenges were blocks to collaboration with other organisations at a "systems level" (133) which were "quite depressing" (133) or restrictions on service delivery, including how telehealth was "not yet allowed at our facility" (221). A lack of control and autonomy in the workplace can lead to distress, whilst the ability to influence and contribute meaningfully to decisions in the workplace has been found to reduce work stress, improve performance, and enhance job satisfaction (Colligan & Higgins, 2006).

3.3. Summary

SLTs predominantly had negative feelings about waiting lists, and the associated personal toll was consistent with findings from prior studies (e.g., McGill et al., 2020) and an Australian Government Senate Inquiry (Commonwealth of Australia, 2014). However, some SLTs indicated neutral and positive views. SLTs' perspectives regarding waiting list management centred on the themes of service delivery, workplace processes and policies, workforce, and inaction. SLTs described service delivery models involving direct support (e.g., screening clinics, complex/multidisciplinary assessment and therapy, one-on-one and group therapy sessions) and indirect support (e.g., training and upskilling parents and professionals, providing advice, providing home programs for parents and other professionals, monitoring). Services were provided in clinics, schools, and homes, or via technology (e.g., telehealth). Process and policy actions related to referrals, caseload

management, and imposing restrictions on services, while the impact on SLTs' ability to implement evidence-based practice was outlined. SLT workforce shortages posed challenges for waiting list management. There is a need to enhance recruitment and retention of SLTs, increase managerial support, involve SLT students, and adopt flexible work practices. Some SLTs could not actively manage their waiting lists due to workplace constraints.

3.4. Limitations

Despite efforts to report on a range of SLTs' feelings, including positive, neutral, and negative feelings about waiting lists, the participant sample may have been biased toward negative feelings about waiting lists or those who actively manage their waiting lists, as those with strong views may have been more motivated to participate. Additionally, more participants were from Australia than from other countries. The perspectives reported in the present study therefore may not reflect the experiences and thoughts of all SLTs. Secondly, asking SLTs to answer based on a current or previous workplace may have affected the response accuracy if SLTs relied on memory to recall feelings about a previous workplace. Thirdly, not all SLTs in the sample had the opportunity to answer all questions since some questions were included in the online version of the questionnaire only; however, the majority of SLTs (82.9%) completed the online version. Fourthly, combining SLTs' responses to the waiting list management questions may have masked differences between current practice and aspirational solutions/strategies, but did reduce overlap and repetition of themes.

4. Future directions and conclusions

Service delivery and workplace processes were reimagined by SLTs, including aspirations for the use of technology to provide support, information, and services to children and families. Whilst many SLTs were actively managing their waiting lists, they acknowledged the lack of external evidence to support some of their waiting list management strategies. There is a need to determine which of the many waiting list management strategies SLTs described are effective or ineffective to ensure SLTs' and organisations' time, effort, and resources are invested in effective actions. Evaluation of waiting list management strategies through real-world research in clinical settings and localised, small-scale testing of solutions is valuable and can move the profession forward regarding waiting list management practices (cf. McGill & McLeod, 2020). However, some SLTs were passive and felt constrained by their organisation or the larger system. There is a risk of becoming increasingly service-focused, when the primary responsibility of organisations and SLTs should be the children and families who need services. The needs of children and families must remain at the forefront of decision-making regarding waiting list management. Greater transparency between SLTs and families regarding service delivery decisions and workplace processes and policies may be beneficial to inform families about the options and alternatives available to them, in line with evidence-based practice (Ruggero et al., 2012).

Many potential solutions to systemic problems were described in individual workplaces; however, localised solutions can only address the issue of waiting lists to a limited extent. Recruitment of more SLTs and retention of experienced SLTs were key waiting list management strategies identified by SLTs and to realise these as possible solutions, governments and policymakers are urged to act to increase funding for speech and language therapy and support growth of the SLT workforce. System-level, top-down change in the supply and provision of services and funding, and collaboration across services and sectors, are needed to support effective bottom-up, localised strategies in speech and language therapy workplaces and implement lasting solutions to waiting lists.

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Conflict of interest

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Appendix

SLTs' Perspectives Regarding Speech and Language Therapy Waiting List Management

Theme	Sub-theme	Code	Points
1. SLT service delivery	1.1. Assessment	1.1.1. Triage/intake	
		1.1.2. Screening	
		1.1.3. Consultative services	
		1.1.4. Drop ins	
		1.1.5. Group assessment	
		1.1.6. "First stop" service	
		1.1.7. Monitoring	
		1.1.8. Single session model	
	1.2. Therapy	1.2.1. Therapy blocks	
		1.2.2. Group therapy	
		1.2.3. Intensive programs	
		1.2.4. One-on-one sessions	
		1.2.5. Weekend services	
	1.3. Collaboration	1.3.1. Partnerships with parents	1.3.1.1. Provision of advice/training
			1.3.1.2. Home programs/information
			1.3.1.3. Phone support
		1.3.2. Partnerships with professionals	1.3.2.1. Multidisciplinary involvement
			1.3.2.2. Provision of advice/training
			1.3.2.3. Involving non-SLTs in service delivery
			1.3.2.4. Preschool/school-based programs
	1.4. Prevention-focused services	1.4.1. Embed in universal services	1.4.1.1. Early detection
		1.4.2. Public health promotion	
	1.5. Technology	1.5.1. Support/education	1.5.1.1. Devices (apps, websites, online groups)
		1.5.2. Method of service delivery	1.5.2.1. Telehealth sessions
2. Workplace processes and policies	2.1. Funding	2.1.1. Alternate funding models	
		2.1.2. Public health funding	
	2.2. Administrative strategies	2.2.1. SLT caseload allocation	2.2.1.1. Autonomy over the waiting list
			2.2.1.2. Allocation based on client factors
		2.2.2. Waiting list policies	2.2.2.1. Audits/reviews
			2.2.2.2. Separate waiting lists (e.g., for weekend vs weekday appointments)
		2.2.3. Scheduling	2.2.3.1. Cancellation lists
			2.2.3.2. Flexible appointment times
		2.2.4. Administrative policies	2.2.4.1. Fail to attend/unable to contact policies
			2.2.4.2. Registration forms
			2.2.4.3. Limiting advertising
			2.2.4.4. Streamlining of documentation
	2.3. Referrals	2.3.1. Referrals to other services	
		2.3.2. Accessing other services while on waiting lists	
	2.4. Organisational strategies	2.4.1. Standards	2.4.1.1. Benchmarks for waiting times
			2.4.1.2. Key Performance Indicators
			2.4.1.3. Quality improvement
			2.4.1.4. SLTs being pressured into actions
		2.4.2. Restrictions on services	2.4.2.1. Prioritisation guidelines
			2.4.2.2. Closing the books
			2.4.2.3. Costs for services
			2.4.2.4. Discharge
			2.4.2.5. Eligibility criteria
			2.4.2.6. Limited service provision
			2.4.2.7. Assessment depends on availability of therapy
	2.5. Evidence-based practice	2.5.1. Conflict/dilemmas	

(*Continued*)

Appendix
(*Continued*)

Theme	Sub-theme	Code	Points
3. SLT workforce	3.1. Recruitment	3.1.1. More SLT positions	
	3.2. Level of experience	3.1.2. Training/upskilling SLTs	
	3.3. Flexibility of SLT	3.1.3. Work hours	
	3.4. Time constraints		
	3.5. SLT higher education		
	3.6. Students in the workplace		
	3.7. Support from management and organisation		
4. Inaction	4.1. Challenging/difficult to act		
	4.2. Lack of control/"out of my hands"		

Note. SLT = Speech and language therapist.