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The experiences and perspectives of overseas trained speech and language therapists working in the UK

Naomi Cocks and Madeline Cruice

Abstract

There is a growing body of research which has investigated the experience of the migrant health worker. However, only one of these studies has included speech and language therapists thus far, and then only with extremely small numbers. The aim of this study was to explore the experiences and perspectives of migrant speech and language therapists living in the UK. Twenty-three overseas qualified speech and language therapists living in the UK completed an online survey consisting of 36 questions (31 closed question, 5 open-ended questions). The majority of participants came from Australia or the USA and moved to the UK early in their careers. Participants reported a range of benefits from working in another country and more specifically working in the UK. The findings were consistent with other research on migrant health workers regarding known pull factors of travel, finance, and career. This study suggests additional advantages to working in the UK were realised once participants had started working in the UK, such as the UK job lifestyle. Finally, the migrant speech and language therapists were similar in profile to other migrant health workers in terms of age and country of origin previously reported in the literature.

Main Text:

With increased globalisation of labor markets the workforce is becoming increasingly mobile (Buchan, 2007). According to the International Organization for Migration, 2.5% of the world's population is now defined as a migrant [1] (International Organization for Migration, 2000). In the UK, migrants make up 8% of the population and almost 10% of the working age population (Kempton, 2002). The UK healthcare sector in particular attracts a high number of migrant workers (Buchan, 2005). The increasing mobility of the workforce has been used by many parts of the health sector to their advantage. International recruitment is now commonly being used to fill workforce shortages, for example to fill the UK's shortage of nurses (Department of Health, 2002). In the nursing profession, international recruitment has become so popular in the UK that in 2001/2002 there were more overseas qualified new entrants to the Nursing and Midwifery Council register than UK qualified (Buchan, Parkin, & Sochalski, 2003). In 2002, 7.5% of UK's nurses were migrant workers (Buchan, 2007). In 2008, the UK government brought in a points based immigration system for migrants from outside the EU. In this system, migrants who have skills that are in demand will be more likely to obtain a working visa, than migrants who do not have skills that are in demand. At the time that this manuscript was written, a number of health professions were listed on the national shortage occupation list, including Band 7 and Band 8 speech and language therapists (highly specialist) and some nursing occupations (UK Border Agency, 2008).

The advantages of international mobility include more than just a means of providing "man power". It has beeen suggested that international recruitment also results in an

[1] Migrant defined as "those who reside in a country other than their birth for more than a year" – (International Organization for Migration, 2000, p4)

improvement in the quality of the workforce (International Council of Nurses, 2002). Migrant workers bring with them new ideas and knowledge, which in turn results in a profession with a larger knowledge and skills base, known as an increase in "brain gain" (Moran, Nancarrow, & Butler, 2005). Further advantages include a more transcultural workforce and increased cultural sensitivity (International Council of Nurses, 2002).

However, the advantages are not just for the "recipient country" but also for the migrants' country of origin. Increased use of technology, such as email, and more affordable airfares, have allowed for increased communication between the migrant worker and their colleagues in their country of origin. Thus ideas and knowledge are circulated between the recipient country and the country of origin, known as "brain circulation" (Organisation for Economic Co-Operation and Development, 2002). However, brain circulation is not simply a result of increased communication. Many healthcare workers only temporarily migrate and then return to their country of origin, taking back the knowledge and skills they gained in the recipient country (Organisation for Economic Co-Operation and Development, 2002; Stalker, 2000). When 1000 migrant nurses from London were surveyed not long after they had arrived to work in the UK, only 60% indicated that they intended to stay in the UK for more than 5 years (Buchan, Jobanputra, Gough, & Hutt, 2006). Moran et al.'s (2005) survey of 33 migrant allied health professionals about their experiences and perspectives of working in the UK revealed that the majority of participants were "temporary movers" and simply in the UK for a "working holiday" (Moran et al., 2005, p6). However, such a claim needs to be considered within the context of the study's survey, that is Moran et al. (2005) did not specifically ask if participants

intended to return home but instead made this assumption based on their motivation to work in the UK which was mainly travel.

There has been substantial research on what are called “push” and “pull” factors that influence migrants’ decisions to leave a country or migrate to a country. It has been proposed that the main reasons health workers migrate to a country (the pull factors) are for better or mirror (i.e. equal) pay, career opportunities, better working conditions and a better work environment (Buchan & Perfilieva, 2006; Stalker, 2000). Similarly, those factors that then encourage health workers to leave a country (the push factors) include low pay, poor working conditions, lack of resources to work effectively, limited career opportunities, limited educational opportunities, impact of HIV/AIDS, unstable/dangerous work environment and economic instability (Buchan & Perfilieva, 2006; Stalker, 2000).

Despite the substantial body of research on migrant nurses, there has been limited published research which has extended to the experiences and perspectives of overseas qualified allied health professionals. In their survey of migrant allied health workers in the UK, Moran et al. (2005) found similar pull factors to those reported by other migrant healthcare workers in other countries, but in addition the opportunity to travel was most frequently selected as a reason to work in the UK followed by money, career, partner and other. An additional advantage of working in the UK identified by participants was increased opportunity for professional development.

Moran et al. (2005) also identified a number of push factors which could influence allied health workers decision to return home. These included large caseloads, poor recognition or respect for profession, the bureaucracy, the weather and racism.

Because the study by Moran et al. (2005) included only four speech and language therapists, very limited information specifically about the migrant speech and language therapist's experience is available. Data acquired from the Health Professions Council[2] (HPC) suggests that the speech and language therapy (SLT) workforce in the UK does include migrant workers. While exact statistics for the profile of the current workforce are not available, the HPC does collect data on whether first time registrants obtained their qualification in the UK or overseas. From 2002-2008, an average of 180 overseas qualified speech and language therapists have registered with HPC, compared to an average 705 UK qualified therapists (HPC personal communication). For exact values for each year please see figure 1. The process and requirements for HPC registration for overseas qualified speech and language therapists are publically available (see http://www.hpc-uk.org/apply/international/). As the mutual recognition of credentials clearly states, it does not ensure migration or employment of overseas trained therapists. International registrants must submit a substantial application to the HPC which contains biographical information, information about current membership to professional bodies, character and health self-declarations, information about professional education and training, language proficiency, career history, clinical references, a health reference and a character reference (HPC, 2009). The application is reviewed by two registrant assessors who recommend/not recommend whether the applicant

[2] All speech and language therapists practising in the UK are required to registered with the Health Professions Council.

should be registered. Applicants who do not have English as their first language and are not from the European Economic Area, are required to submit proof of their English language proficiency. Only applicants with an Internatonal English Language Testing System score of 8 with no element below 7.5 are eligible to register with the HPC as a speech and language therapist.

In the UK, speech and language therapists are required to meet the Standards of Proficiency (SOPs) specified by the HPC in order to practice. This document is publically available at http://www.hpc-uk.org/publications/standards/index.asp?id=52. Initially, UK training courses entitle graduates to register with the HPC, but afterwards therapists are required to declare on a biennial basis (registration and renewal period) that they meet the SOPs within their chosen scope of practice. For overseas qualified therapists, these are judged by the afore-mentioned registrant assessors.

Insert Figure 1. about here

International mobility within the speech and language profession is expected to increase with the implementation of a mutual recognition agreement of professional association credentials of speech and language therapists registered with the Royal College of Speech and Language Therapists (RCSLT), Speech Pathology Australia (SPA), The American Speech and Hearing Association (ASHA) and the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) (Boswell, 2004). Two further associations, the Irish Association of Speech and Language Therapists (IASLT) and the New Zealand Speech-Language Therapists' Association

(NZSTA), joined the mutual recognition agreement in 2009. While it is unlikely that the speech and language therapy profession will become as internationally mobile as other health professions such as nursing because of the much heavier dependence on language competence, with this agreement the profession will become increasingly internationally mobile. As this development occurs, it is important to understand how this will impact on the profession, on the labor market and therefore influence policy.

Within the UK, the mission statement and scope of practice for speech and language therapy is:

> "to provide evidence-based services that anticipate and respond to the needs of individuals who experience speech, language, communication or swallowing difficulties. Speech and language therapists work in partnership with these individuals and their families and with other professions and agencies to reduce the impact of these often isolating difficulties on people's wellbeing and their ability to participate in daily life" (The Royal College of Speech and Language Therapists: RCSLT, 2006, p2).

The profession's focus is communication and swallowing disorders. Whilst health promotion and prevention work is explicitly included, this work is specified in relation to "identified groups and populations" (RCSLT, 2006, p3). Further guidance for different working contexts, service organisation and provision is found within *Communicating Quality 3* (RCSLT, 2006), and is useful in explaining the context of speech and language therapy in the UK.

We hypothesised that the migrant speech and language therapist would differ to the migrant nurse in profile. In the UK, the majority of migrant nurses come from the

Phillipines and African nations (Buchan, Jobanputra, Gough, & Hutt, 2006). While no data has been previously published that has explored the profile of the migrant speech and language therapist, we anticipated that because of the need for a high level of competency in English and the mutual recognition agreement between the countries listed above, that the migrant speech and language therapist would come from either Australia, Canada or USA. Furthermore given the differences in country of origin, we hypothesised that the migrant speech and language therapist will have very different push and pull factors to the migrant nurse. In the study by Buchan et al. (2006) 73% of Fillipino nurses sent money back to their families in the Phillipines, thus financial gain was a big pull factor. For the African nurses a big push factor from their country of origin was HIV and AIDs (Buchan, Parkin, & Sochalski, 2003). We hypothesised that the issues around AIDS and HIV are not as much a concern to the speech and language therapist due to the less invasive nature of their work. So what does motivate the speech and language therapist to come to the UK?

In a first step to understand how international mobility will impact on the speech and langauge therapy profession, this study aimed to collect preliminary data on the experiences and perspectives of overseas qualified speech and language therapists living in the UK using an online survey. From this research we aimed to begin to build a profile of the "migrant speech and language therapist". We explored the aspects that influence speech and language therapists' decisions to migrate and the probability of migrant speech and language therapists becoming permanent migrants. We hypothesised that the profile of migrant speech and language therapists would differ to the migrant nurses and other allied health professionals, and that differences

would also exist between the professions with regards to the push and pull factors that influence a migrant's decision to move or to leave the UK.

Method

Participants

23 participants took part in this study. For demographic details about participants please see results section.

Questionnaire

A 36 question online survey was used to investigate the experiences and the perspectives of the overseas trained speech and language therapist working in the UK. An online method was used to allow electronic distribution to participants who were geographically spread around the UK to allow respondents to remain anonymous. The online survey tool, Papaya Polls (Perceptus Solutions Inc., 2006), was selected as the online tool for this purpose.

An initial page on the website provided an explanation of the aims of the study and a rationale for targetting speech and language therapists specifically for research. Thirty-six questions then followed, including 31 multiple choice questions and 5 open-ended questions. The open ended questions included: 18, 32, 34, 35, and 36. Not all questions were available for all participants to answer. Question 18 was hidden unless the participant answered that their qualification did not prepare them for work in the UK in question 17. Question 20 was also hidden unless the participant selected that their was a difference in the number of professional events that they attended compared to their home country in question 19. Question 32 was also hidden unless

the participant selected there was a difference in the status of speech and language therapy in comparison to their home country in question 31. Only questionnaires that included responses up to and including question 32 were included in the analysis.

Procedure

Participants were recruited via emails to a variety of mailing lists, postings on a speech and language therapy listserv, through word of mouth and through the local clinical network from university clinical staff.

Data Analysis

The online survey tool produces both group and individual data. Most of the survey results are frequency counts, created by participants' responses to the different options available in the survey. This data is reported in a series of tables in the following section. A cross tab function within the survey tool enables data from two variables to be compared – for example, question 16 *When you first came to the UK, how long did you intend to stay?* with question 5 *How long have you been working as a speech and language therapist in the UK?* Cross tabs were only occasionally used to explore the data, and are explicitly stated as such in the following section. The final three survey questions were free text response options, and between 12 and 19 participants responded to the questions. Their comments were typically 1-2 sentences in length for survey questions 34 and 35, and slightly longer for question 36. Participants' comments were analysed according to each question. Both authors independently read the comments, and identified same or similar keywords amongst the responses. Same or similar keywords were then grouped into semantically related themes. Both authors

then met to compare and discuss the themes, and consensus was reached through discussion.

Results

Participant Sample

Thirty-one survey responses were started, however only 23 surveys were completed. With respect to these 23 participants, 11 participants heard about the study via email and listserv, 10 participants heard through word of mouth, and data is missing on two participants. Demographic information about these participants is reported in table 1. Participants were over the age of 26 years and primarily came from English speaking countries. The majority of participants commenced working in the UK early in their career, either within 4 years, or between 4 to 6 years, of graduating from their degree courses.

Insert Table 1 about here

Eighteen participants had worked in London at some point. Other places of previous work included Birmingham, Bristol, Cardiff, East Anglia, Essex, Hartlepool, Kent, Liverpool, Margate, Newcastle, Norwich, Nottingham, Portsmouth, Selby (North Yorkshire), Shrewsbury, Sussex, West Sussex, and Wiltshire. Participants' workplace experiences are reported in table 2. Rows that contain data from home country or compare UK with home country have been shaded for ease of identification. Ten participants had worked in two or more of the geographical locations listed above. Participants are evenly distributed across three main categories in terms of the length of time they've worked in the UK: under 2yrs, between 2 and 6yrs, and more than

6yrs (see table 2 for detail). The majority of participants currently worked in one facility (most in NHS facilities), worked full time, and held permanent positions. In terms of UK work experience, the majority had held sole paediatric positions, and no participant had worked in a mixed post. The results show that in the UK, participants worked in positions and with clientele and in settings that were similar to their home country.

Participants also reported their initial intentions to stay in the UK, and their current intentions to remain in the UK (see table 3). Individual survey responses can be isolated from amongst the group data, and participants' intentions to remain are reported here in the context of other data. The main findings are that: seven participants intended to remain in the UK for another 5 years or more (6 of these participants had been in the UK for more than 6 years, suggesting *permanent settling* in the UK); five participants were undecided (this includes 3 who where undecided when they first moved to the UK); and the remaining 11 intended to leave the UK at some point, with the majority thinking they would remain only another 1-2 years (suggesting migration out of UK or *temporary workers*). A cross tab function was used to explore whether participants had overstayed their original intentions. This revealed only one main finding: 9 of 10 participants who only ever intended to stay for up to 2 years, had overstayed their original intentions. The suggestion is that many individuals initially travel with the intention to stay for 2 years, but in fact, find reasons to continue working in the UK.

Insert Tables 2 & 3 about here

Experiences and perspectives of working in the UK

The following results are based on survey questions 17 to 36. They have been interpreted using the framework of possible *pull* and *push* factors for individuals working in the UK, which was referred to in the Introduction.

Motivations and a comparison of experiences and perceptions of working in the UK (potential pull factors)

Travel was the most frequently identified reason for choosing to work in the UK, followed by career opportunities (see table 4). Approximately half the sample had one reason for choosing to work in the UK (travel or life partner), and the remaining participants identified a combination of reasons. As identified from table 2, the majority of participants were working in permanent full time positions in the UK, which is a similar pattern to their previous employment in home countries. This suggests *comparable* job security between home countries and the UK.

Several questions in the survey required participants to compare situations and circumstances between the UK and their home countries (table 4). As eight of the 23 participants had worked in the UK for more than 6 years, the authors judged that comparison data for these participants may not be accurate or current as they would be required to compare the current situation in the UK with much older memories of their home country. Their responses to certain questions have therefore been removed from the analysis specific to professional development events, employment opportunities, and career development opportunities. Thus, the size of this sample is 15.

Insert Table 4 about here

Just over half of the participants reported attending fewer professional development events in the UK, with the main reason being a lack of funding and their clinical position (e.g. locums had less entitlement to PD events). A third reported attending more events, giving the reason of more specific events available for the clinical populations they worked with. It is important to note that this data is influenced by the participant's current trust and previous geographical location. The survey's quantitative findings conflict somewhat with participants' positive qualitative reports of professional development opportunities (question 35). This is understood as those participants who had positive experiences of professional development completed question 35's free text section of the survey. With respect to employment opportunities, there was no clear finding supporting either more or fewer vacant positions in the UK. With respect to career development opportunities (e.g. promotion), participants generally reported at least the same number in the UK as in home countries, and a small number reported more. Overall, this suggests that working in the UK offered fewer professional development opportunities, but somewhat comparable employment and career development opportunities to home countries. As an aside, it is interesting to note that of the eight participants who were removed from the above data (i.e. those who have been in the UK more than 6 years), a substantial number (n=5) perceived *more* career development opportunities in the UK. It is possible that because these participants were *more established* in their employment, and therefore more likely to be considering these opportunities.

More than half the sample reported higher or similar salaries in the UK compared to home country. Whilst some participants reported feeling neutral or dissatisfied with their UK salary, roughly half reported being satisfied, suggesting that salary may be a pull factor for some.

Nearly all participants felt their qualification prepared them to work in the UK, suggesting a clear pull factor. Two USA qualified participants reported inadequate preparation for working in dysphagia and working with limited support in a residential environment. In the qualitative free comments section of the questionnaire, one respondent noted an advantage of their qualification (specifically, opportunities to use their training i.e. South African trained SLTs have additional audiology knowledge and skills which they can use to practise) and participants also noted that *ease of access to work* was a facilitatory factor, that is having the same qualifications and training, and people speaking English.

Summary of results

In summary, this study's findings are to be considered in the context of the responding participants who are characterised as predominantly female, aged 26 to 40 years, who had obtained their SLT degree from Commonwealth or English speaking countries, commenced working in the UK early in their SLT career, and felt prepared sufficiently to work in the UK. The sample is biased towards paediatric clinicians, and with the majority working in the NHS. There is a pattern of permanent settlers, as well as temporary workers, and a small subgroup that is undecided. The main motivation for working in the UK is travel, and interestingly a large number of

participants had also worked in several places throughout England. The experiences of some, but not all, participants suggest that career development opportunities and salary are attractive in the UK, however the main finding appears to be comparable experiences between UK and home. It seems that moving to the UK for work is *a low risk decision*, that is, the work pattern (i.e. full time), permanency of position, career development and salary seem to be the same as what participants left in their home countries. Upon reflection, the comparison questions in the survey addressed only work/career and to a small degree, salary, however, there were no comparisons around other potential benefits, i.e. comparing travel lifestyles in UK with home country, which might have been informative.

At the end of the survey, participants had the opportunity to write free comments regarding the main benefits of working specifically in the UK in speech and language therapy. Nineteen participants responded to this question. This data cannot be construed as pull factors, as participants were likely to have identified these benefits through their experience of working in the UK. However, there may be reasons that encourage participants to remain working in the UK. Their free text comments have been drawn into six themes, four of which relate to the job, and two of which relate to UK economy and accessibility:

- ***Benefits of the job in relation to job lifestyle*** (these are the non-clinical benefits, i.e. not specifically linked to the skills base of SLT), which included more reasonable work pace (assumed to be less stress), less hours, better benefits via the NHS, locum work, more holidays, equitable pay structure, better job opportunities, more opportunities (lots of jobs), clearer career structure

- ***Benefits of the job specific to SLT clinical areas*** which included more opportunities to work with different client groups, flexibility to pursue special interest areas (i.e. build specialist experience), opportunities to specialise, clinical challenges, wider access to ethnic minorities and minority language groups, different language and stammering programs, unique UK assessments
- ***Professional development*** which included opportunities for learning/ conferences/ lectures considered as good, easier access to facilities and resources, further education sources and special interest groups (SIGs), increased peer support, and more robust supervision structure and system
- ***Support (for the job)*** which included supportive co-workers (to understand systems), more support for UK therapists and graduates (participant gave rationale as the link between experience in pre-registration and support post-registration: different levels of support given between Canada/ UK because in Canada SLTs are expected to have more clinical experience before graduation);
- ***Geography*** which included closeness of the UK with the rest of Europe (2), good location for / opportunities for travel (3);
- ***Money,*** which included currency is strong for saving and travel, earning pounds, money for travel.

Participants were also invited to respond to the following question: *What do you see as the main benefits of working in a country different to the country that you obtained your qualification?* Again, 19 participants responded to this question. As before, they cannot be construed as pull factors, but may be reasons that encourage participants to

remain working in the UK. Their responses were classified into 6 categories, of which 5 were specifically linked to the job skills and environment:

- ***Exposure to difference***: different way of handling problems (caseload management, working with other professionals), work practices, aspects and approaches to practice (medical versus social model of disability), different models of service delivery and support systems, how different country deals with SLT service provision, different priority areas for intervention, different health care and systems
- ***Gaining experiences***: experiences, broadening, exposure to additional learning, fresh, new ideas and new cultures, experiences of bilingualism, new clinical populations (teenage fluency), more varied work/ variety of work settings, relevant events and developments in field
- ***Nature of the work environment***: variety (work setting, work experience, paediatric job, experiences, enjoying job), changing jobs, flexibility, versatility, and challenging professionally ("it stretches you in new ways so you're less likely to get bored professionally")
- ***Opportunities for skills development***: opportunities to specialise (head and neck), and opportunities to act up (cover senior positions) *[possibly there was more movement in the UK workforce, combined with life stage flexibility to move between positions without concern for permanent consistent income]*
- ***Increasing professional network***: links with wider range of practitioners, gaining resources from colleagues, exposure to professionals, increasing professional network *internationally*
- ***Other***: travel (2) and financial (1)

Negative experiences and perceptions of working in the UK

(potential push factors)

This section reports on waiting lists, caseloads, and respective satisfaction from respondents (table 5), as well as qualitative free text comments from respondents. It suggests that dissatisfaction with large waiting lists, as well as large caseloads, and problems finding work in the current climate are the main negative experiences of working in the UK as an SLT. The data suggests that status, respect, and satisfaction need further consideration in future research. Again, in the comparison questions only the responses of those who had worked in the UK for less than 6 years were considered, meaning the sample size is reduced to 15 participants for some items.

Insert Table 5 about here

The majority reported larger waiting lists in the UK than in home country. In terms of satisfaction, the data is spread roughly evenly across dissatisfaction, satisfaction and not applicable categories. One participant was removed from satisfaction analysis for inconsistent reporting. The majority of participants reporting dissatisfaction had larger waiting lists in the UK compared to home country. The majority of participants reported larger caseloads in the UK than home, and there is no clear trend in participants' reporting of satisfaction with caseload size. However, cross tabs analysis did reveal that all dissatisfied participants had larger caseloads in UK compared to home.

In the free comments section at the end of the survey, 12 participants responded to the final question: *Is there any other informaton you think we should know about your*

experience of working as a Speech and Language Therapist in the UK? Comments in the main reflected less favourably on the experience of working as an SLT in the UK. These comprised: (1) the ***difficult current work climate*** (difficult to get work, current financial climate means decrease in locums, locum hard to find, changes in current work, more competition for jobs, very demanding – not the holiday lifestyle); (2) ***problems in UK,*** namely bureaucratic systems in clinical settings; and (3) general ***differences*** such as less across-disciplines collaboration, and decreased exposure to professional education (techniques/ programs).

Miscellaneous

Participants were asked to consider the status (including respect) of the profession in the UK (see table 6). With one exception only, all participants reported it was respected, and the majority reported a similar level of respect as home country. One participant rated SLT as more respected in the UK than at home, and gave the following reason:

> "Awareness is more and facilities are more. SLTs provide intervention in numerous settings." (*participant from India*).

The one participant who reported UK SLT as less respected than home gave the following reason:

> "I'm partially biased working in a Sure Start[3] area and battling the stigma that families have of why a speech therapist needs to be involved with their child. In the US, I worked in a middle to upper class area where parents would

[3] Sure Start is a UK government programme which aims to improve the health and emotional development of young children, particularly in disadvantaged areas. Child Centres that were set up as part of this programme run a number of initiatives that aim to improve and assess children's language skills.

demand that a speech therapist sees their child individually 2x a week." (*participant from the USA*).

There is no clear trend for satisfaction with the status of the SLT profession in the UK, with the data spread across categories. Further cross tab analysis revealed that even though participants report the profession as respected, these participants varied widely from dissatisfied to neutral to satisfied. These findings suggest that status is not linked in a straightforward relationship with respect for the profession, or the question was not sufficiently clear to participants.

Discussion

In order to determine the differences between migrant speech and language therapists and other health professional migrants, we compared the findings of this study with the findings of similar research on the nursing and allied health professions. In particular we were interested in the differences in the migrants' profiles, their experiences and their perspectives of working the UK and from this we determined how the push and pull factors differed between the professions. This study has also highlighted reasons that therapists are likely to remain in the UK. These factors were not identified prior to working in the UK (so not exactly apriori *pull* factors) but gained through the experience of being there, and hence will be referred to as *stay factors*.

Differences in Profile

The findings of this study suggest that the migrant speech and language therapists differ in profile to migrant nurses. Based on previous research, the majority of

migrant nurses come from the Phillipines, Nigeria and South Africa (Buchan, 2007; Buchan, Jobanputra, Gough, & Hutt, 2006; Buchan, Parkin, & Sochalski, 2003), whereas the migrant speech and language therapist who responded to this survey mainly come from Australia, USA and South Africa. This is not a surprising difference due to the need for migrant speech and language therapists to either have English as a first language or obtain a score of 8 in the International English Language Testing System in order to obtain the required Health Professionals Council registration, compared with a score of 7 for nurses (NMC, 2009). The mutual recognition agreement between Speech Pathology Australia, American Speech and Hearing Association, and the Royal College of Speech and Language Therapists may also influence working migration patterns. It is also possible that government policy influences migration. In the Philippines, nurses are specifically trained for the international market and there is active encouragement for Filipino nurses to apply for overseas employment (Buchan, Parkin, & Sochalski, 2003). By doing so the Filipino government ensures remittance monies are returned to the Philippines. This is not a practice that has been actively adopted for the speech and language therapy profession.

Migrant nurses and speech and language therapists differ in terms of age and pull/push factors, which may be related to their country of origin. While in Buchan et al.'s (2006) study of migrant nurses living London, the majority of the migrant nurses from sub-Saharan Africa, South Africa, India, Pakistan and Mauritius were aged 40 or over, the majority of migrant nurses who came from Australia, New Zealand and USA were under the age of 34. Like the nurses who came from similar countries of origin, the majority of migrant speech and language therapists in this study were

under the age of 40 and had also travelled to the UK within 6 years of obtaining their degree. There are likely to be a number of reasons that the age of migrants from these particular source countries tends to be younger, however probably the main reason is the ease of obtaining a working visa. Commonwealth citizens (including Australians) under the age of 30 are able to apply for working holiday visas (soon to be renamed the youth mobility visa) to work in the UK for 2 years. It is more difficult to obtain a working visa in the UK once over the age of 30.

Pull, Stay and Push Factors

The pull factors are probably also influenced by the migrant speech and language therapists' age and country of origin. Travel was the main motivation for moving to the UK. Mobility is easier when you are younger, do not have a family to support, do not have a family to consider in decision making, do not have a mortgage and are not advanced and settled in one's career. Other studies of migrant nurses and other health professionals of a similar age and home country as our study have identified travel as the main motivation for moving to the UK (Buchan, Jobanputra, Gough, & Hutt, 2006; Moran, Nancarrow, & Butler, 2005).

The desire to travel also probably influences the migrant speech and language therapist's choice of location to work with 78% of our participants having worked in London at some point during their stay in the UK. London is an attractive location for the migrant worker, as it is the hub for European and other international travel with 5 international airports and an international rail service. This was confirmed with the qualitative data as some participants indicated that UK's closeness to Europe makes it easier to travel.

While the strength of the pound was highlighted by some participants, the majority of the participants indicated that the salary was not a main reason for coming to the UK. This was similar to the Australian nurses in Buchan et al. (2006) but differed to the predominately Australian health professionals in Moran et al. (2005), where financial motivation was the second most frequently listed motivation. It is likely that this is profession specific as the majority of Moran et al.'s participants were physiotherapists or social workers, or the two surveys (Moran versus current study) explored the concept differently: namely Moran et al. enquired about money, whereas the current study used the term salary. In the qualitative data, our participants indicated that it was the strength of the pound that was important. So it may not be salary that motivates health professionals to come to the UK, or remain in the UK, but instead the strength of the currency. This difference needs to be explored in future research.

The current study revealed that the majority of migrant speech and language therapists attended fewer professional development events, a few indicated they attended the same and a few indicated they attended more. This finding contrasts with that of Moran et al. (2005) who reported that there were more opportunities to attend professional development events in the UK and that this was a strong pull factor. Again, this could be profession specific or that survey questions account for this difference, with current participants being asked outright, whereas Moran et al. inferred the finding from qualitative responses. Interestingly in Moran et al.'s discussion of this pull factor they quote an Australian speech and language therapist however, they imply that the therapist may have come from a rural practice and thus the remoteness of the migrant's last position may be why there were more

opportunities in the UK. While we asked participants to indicate their home country, we did not explore whether the participants came from rural or urban settings. This should be explored in more detail in future research.

Comparing results across studies needs to be cautiously managed, when terminology has not been consistently interpreted in the same way. For example, reporting of professional development opportunities differ between Buchan et al. (2006), Moran et al. (2005) and the current study. Further research is needed that clearly defines (for participants and readers) what professional development constitutes (e.g. greater opportunities to act in more senior positions, to broaden skills base, or more supervision and opportunities to specialise in particular fields, as mentioned by participants in this study) and greater detailed exploration of home country factors. Further exploration of career, indicated by our participants as the second most common reason to move to the UK, is needed in future research. Nonetheless, career seems to be an important pull or stay factor for many migrant speech and language therapists.

This study also revealed new pull or stay factors, that have not been previously reported by other health workers. These included factors we referred to as “job lifestyle”, reduced hours of work and more holidays in the UK, and “job specific” factors comprising the advantages relating to flexibility and versatility of the workforce. Finally, a factor for speech and language therapists possibly supporting clinicians to remain in the UK seems to be greater support and supervision.

The main concerns and subsequent dissatisfactions of the migrant speech and language therapists were large caseloads and waiting lists. This could therefore be a push factor for migrant speech and language therapists returning back to their home country or to move to another country to work.

Risk Taking

Migrant speech and language therapists reported salary, career opportunities, job security, and job opportunities as largely similar in the UK to their home country. These findings or stay factors provide ample evidence for reasons to continue working in the UK. Some commented that it was easy to obtain working visas and their qualifications were recognised, and nearly all felt that their qualification prepared them to work in the UK. This collective positive experience suggests that the the move by a migrant speech and language therapist to the UK is fairly low risk for those who have done it. Reporting these findings may encourage other therapists to consider working in the UK, turning them into pull factors for future migrant therapists. Incidentally, whilst preparedness to work in the UK may reflect the high quality of speech and language therapy training, it may also be part of the profile of the speech and language therapist who chooses to migrate. That is, the more prepared the speech and language therapist feels, the more likely they are to make the decision to work in another country. Future research should investigate whether there are particular features that are unique to the speech and language therapist who decides to travel.

Permanency and Brain Circulation

One of the aims of this study was to determine whether migrant speech and language therapists were likely to be temporary or permanent migrants. Temporary migrants

who return to their country of origin, take back the knowledge and skills they gained in the recipient country and thus increase brain circulation (Organisation for Economic Co-Operation and Development, 2002; Stalker, 2000). While brain circulation can result from the migrant staying in close contact with the profession in their source country through email or frequent visits, the main benefits are from the migrant returning to their country of origin. This study found that the majority of the migrant speech and language therapists intended to move home at some point, which suggests that the speech and language therapy profession is likely to benefit from brain circulation. We propose that these benefits could be greater awareness of the difference in heath care structure and service delivery, new experiences, new skills and increased professional networks, as mentioned by the participants. Experience of different management styles and different government agendas has been reported previously (Moran et al., 2005). A further benefit of international mobility that has been highlighted by the nursing profession is the increase in more culturally competent health workers (International Council of Nurses, 2002), which is an aim for many health services including the UK's own National Health Service (Department of Health, 2000). Whilst we cannot attest to the increased cultural competence of the study participants, they did identify cultural issues such as wider access to ethnic minorities and minority language groups and exposure to new cultures as advantages of working outside their country of origin.

While we assume that the amount of migration and remigration influences the amount of brain circulation, we cannot be sure how much ongoing contact people who migrate to the UK have with professionals in their country of origin, or whether those who return to their countries of origin modify their practice as a result of working in

the UK. Similarly we are not sure what ideas and practices the migrant speech and language therapist brings to the UK, and how this influences UK practice. Future research should explore the degree of contact, the degree of exchange of ideas, what types of information is exchanged, how working in another country influences practice for both the returning migrant and the migrant who decides to stay in the UK, and how the migrant speech and language therapist influences local practice.

A new and interesting finding of this study was participants who initially only intended to stay for up to 2 years had overstayed their original intentions. This suggests that participants found other reasons to continue working in the UK. The findings also suggest that the longer that a speech and language therapist stays in the UK, the more likely they are to become a permanent migrant. Future research should explore the differences in motivation for staying in the UK year by year from 2 years to 6 years using qualitative research methods in order to determine what influences speech and language therapists' decisions to stay longer than they intended. Delineating motivations to *come* versus motivations to *stay* will be informative for future understanding of the migrant.

The current study revealed a somewhat surprising finding regarding the permanency of the workforce, with the majority of participants employed in permanent positions, and only 1/5 in temporary positions. This contradicts the general presumption that the migrant speech and language therapist tends to work temporary positions so that he or she can travel. It is likely that a freeze in many NHS trusts on recruiting temporary positions at the time of data collection has influenced the findings.

Limitations of the research and areas for Future Research

The results of this study make an important contribution to our understanding of the experiences and perspectives of the overseas qualified speech and language therapist living in the UK and suggest that this topic should be explored further in future research using similar methods. However, it had a number of limitations which will need to be addressed in future research on this topic, some of which have already been raised in the Discussion. Some further points are made here. The comparison questions that required participants to compare situations in the UK to their home country may be inaccurate. Participants who have been in the UK a long time may have found it difficult to make a comparison as they could not remember what it was like in their home country. This was explicitly identified by one participant who indicated that it was difficult to answer questions about work opportunities in her home country as she had lived in UK for 5 years. These questions may also have been difficult for participants who had newly arrived as we are not sure how much knowledge they have of these areas in the UK. This may have influenced our results as eight of the participants had worked in the UK for less than two years. Future survey research needs to carefully consider the inclusion of comparison questions, and collect further information from participants on how they make their judgements and comparisons. Furthermore, the majority of the survey questions addressed how factors relating to work influenced decisions to stay or leave a country or UK more specifically. We did not explore other factors such as travel lifestyle, weather and so on, and future research should explore these in more detail. Finally, only 23 migrant speech and language therapists responded to this survey and therefore may not be be representative of overseas qualified speech and language therapists working in the UK, future research should include a greater number of participants. It is also

possible due to our method of recruitment e.g. clinical networks and word of mouth that some of the participants would be clustered in one geographical area. As we did not ask the geographical location of where participants currently work we were unable to rule out this possibility.

Summary

This study explored the experiences and perspectives of overseas qualified speech and language therapists working in the UK. The findings of the research suggest that the majority of migrant speech and language therapists come from Australia or USA, and move to the UK not long after obtaining their qualifications. The main motivation for moving to the UK was travel but there was also evidence that career advancement was a motivation and a reason to continue to stay in the UK. The migrant speech and language therapists indicated that they benefitted greatly from working in another country and more specifically working in the UK. This research was a first step in understanding the experiences and perspectives of the migrant speech and language therapist and the findings suggest that this an area that requires further research and consideration.

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Table 1. Demographic information for participants (N = 23)

Characteristic	***Option***	***N***
Gender	Female	19
	Male	4
Age	26-30yrs	10
	31-40yrs	9
	41-50yrs	2
	51plus	2
Country of qualification as SLT	Australia	12
	USA	4
	South Africa	3
	New Zealand	1
	Canada	1
	Ireland	1
	India	1
Time between graduation and starting work in the UK	Less than a year	1
	1-2yrs	4
	2yrs 1month – 3yrs	5
	3yrs 1month – 4yrs	1
	4yrs 1 month – 6yrs	7
	6yrs 1 month – 8yrs	1
	8yrs 1 month – 10yrs	2
	10yrs 1 month – 12 yrs	1
	12yrs 1 month – 14 yrs	0
	14yrs 1 month – 20yrs	1

Table 2. Participants' workplace experiences (N = 23)

Characteristic	***Option***	***N***
Number of geographical areas in UK worked	One	13
	Two	8
	Three	0
	Four	1
	Five	1
Time spent working as a speech and language therapist in the UK *(Options with zero data for this question are not reported in table)*	2-3 months	1
	4-6 months	4
	19months – 2yrs	3
	2-6yrs	7
	More than 6 yrs: please specify	
	6yrs 5 months	1
	7yrs	2
	9yrs	1
	9yrs 5 months	1
	11yrs	2
	17yrs	1
Facility that best describes current employment in UK	*Sole facility*	21
	NHS	13
	University setting	3
	Charity	3
	Social Services Facility	1
	Nursery/ School	1
	Other: non-profit agency	1
	Other: City Council*	1
	Across two facilities	2
	NHS facility and private hospital/ practice	1
	NHS and nursery/ school	1
Current employment in UK	Permanent	17
	Locum/Bank	3
	Maternity cover	1
	Short term contract	1
	Other: changed career	1
Employment of last position in home country	Permanent	15
	Locum/Bank	0
	Maternity cover	5
	Other: casual	1
	Other: PhD student	1
	Other: unspecified	1
Overall current work status in UK	Full time	17
	Part time	5
	Other: 4 days per week	1

Work status prior to leaving home country	Full time Part time Other: graduate student	20 2 1
Position type that best describes UK work experience	Sole paediatric positions Sole adult positions Sole university position Both paediatric and adult positions	15 5 1 2
Clientele and setting that best describes UK work experience *(Can choose more than one option)*	*Paediatric positions* School Community clinics Nursery Language unit Sure Start ** Private practice Residential *Adult positions* Acute Rehabilitation Community clinic Domiciliary Residential Private practice	 12 6 5 5 4 2 1 4 5 3 1 1 1
Similarity of UK clientele and settings to home country	Completely similar Similar Some overlap Didn't practise as SLT in home country	1 11 10 1

* Participant described post as "multidisciplinary team working in paediatrics with educational, health and social services based at a city council"
** Sure Start is the UK government programme combining early education, childcare, health and family support (http://www.surestart.gov.uk/). Speech and language therapists work in the health promotion centres.

Table 3. Participants' working intentions (N = 23)

Characteristic	***Option***	***N***
Estimated length of time participant intends to remain in the UK	Up to a year	4
	Up to 2 yrs	3
	Up to 3yrs	1
	Up to 4yrs	1
	Up to 5 yrs	2
	More than 5yrs	7
	I am undecided	5
Time participant intended to stay in UK when s/he first arrived	Up to a year	3
	Up to 2 yrs	8
	Up to 3yrs	3
	Up to 4yrs	1
	Up to 5 yrs	2
	More than 5yrs	3
	I was undecided	3

Table 4. Participants' motivations, experiences and perceptions (potential pull factors) (N = 23 unless otherwise stated in the first column)

Characteristic	***Option***	*N*
Reasons for choosing to work in the UK *(Can choose more than one option)*	Travel opportunities	15
	Salary	5
	Career opportunities	10
	My partner lived in the UK	4
	Other: please specify	
	Experience another culture	1
	Further education/study	4
	Met partner in UK	1
Professional development events attended in the UK compared to home country *(N of 15)*	More	5
	Same	2
	Fewer	8
Reasons to account for difference in professional development events *(N of 15; Can choose more than one option)*	More funding	2
	Less funding	5
	More events nearby	3
	Fewer events nearby	0
	More events specific to relevant topics	5
	Fewer events specific to relevant topics	1
	Other: please specify	
	Locums not entitled to attend	2
	Inservice training provided onsite	1
Comparison of employment opportunities between UK and home country *(N of 15)*	More vacant positions in UK	4
	Same number	2
	Fewer vacant positions in UK	4
	I don't know	5
Comparison of career development opportunities (e.g. promotion) between UK and home country *(N of 15)*	More	3
	Same	7
	Fewer	1
	I don't know	4
Comparison of salary between UK and home country	Much higher in UK	5
	Slightly higher in UK	6
	Similar salary	4
	Slightly lower in UK	2
	Much lower in UK	1
	It is difficult to compare salaries between countries	5
Satisfaction with salary in	Very dissatisfied	0

UK	Dissatisfied Neutral Satisfied Very satisfied	5 6 11 1
Preparation of home country qualification to work in the UK	Yes Somewhat No	21 2 0

Table 5. Participants' experiences and perceptions (potential push factors) (N is listed for each row in the first column)

Characteristic	***Option***	*N*
Comparison of current UK waiting list with home country *(N of 15)*	Much larger in UK Slightly larger in UK Similar Slightly smaller in UK Smaller in UK Not applicable	7 2 3 0 1 2
Satisfaction with current UK waiting list (*N of 22, 1 participant removed as wrote non-applicable when asked about size of current waiting list)*	Very dissatisfied Dissatisfied Neutral Satisfied Very satisfied Not applicable	3 5 2 6 0 6
Comparison of current UK caseload size with home country *(N of 15)*	Much larger in UK Slightly larger in UK Similar Slightly smaller in UK Much smaller in UK I didn't work as SLT in country I trained in Not applicable	6 3 2 1 1 1 1
Satisfaction with current UK caseload size *(N of 23)*	Very dissatisfied Dissatisfied Neutral Satisfied Very satisfied Not applicable	3 4 4 7 0 5

Table 6. Participants' perceptions of SLT profession status in the UK (N = 23)

Characteristic	***Option***	*N*
Status of SLT profession in UK	Highly respected	1
	Respected	21
	Not respected	1
Comparison of status of profession in UK with home country	More respected in UK	1
	Same level of respect in UK	17
	Less respected in UK	3
	I don't know	2
Satisfaction with status of SLT profession in UK	Very dissatified	0
	Dissatisfied	6
	Neutral	8
	Satisfied	9
	Very satisfied	0

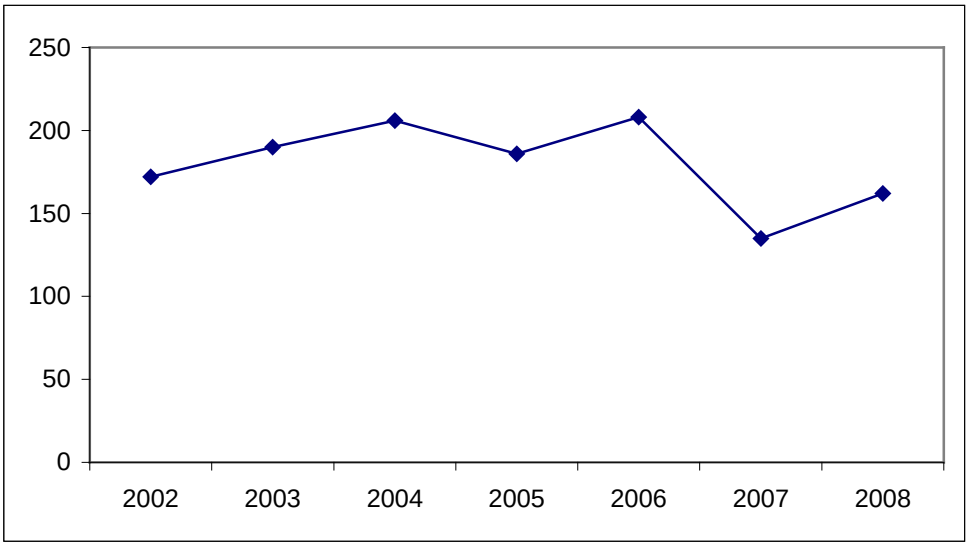

Figure 1.
The number of overseas qualified speech and language therapists who have registered with HPC between 2002-2008.