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Title: Volunteer involvement in the support of self-managed computerised aphasia treatment:
the volunteer perspective

Abstract

Purpose: The speech-language pathology profession has explored a number of approaches to support efficient delivery of interventions for people with stroke-induced aphasia. This study aimed to explore the role of volunteers in supporting self-managed practice of computerised language exercises.

Method: A qualitative interview study of the volunteer support role was carried out alongside a pilot randomised controlled trial of computer aphasia therapy. Patients with aphasia practised computer exercises tailored for them by a speech-language pathologist at home regularly for five months. Eight of the volunteers who supported the intervention took part in semi-structured interviews. Interviews were audio recorded, transcribed verbatim and analysed thematically.

Result: Emergent themes included: training and support requirements; perception of the volunteer role; challenges facing the volunteer, in general and specifically related to supporting computer therapy exercises.

Conclusion: The authors concluded that volunteers helped to motivate patients to practise their computer therapy exercises and also provided support to the carers. Training and ongoing structured support of therapy activity and conduct is required from a trained speech-language pathologist to ensure the successful involvement of volunteers supporting impairment-based computer exercises in patients' own homes.

Introduction

As the population rises without increase in available resources to manage larger caseloads, consideration of workforce composition in speech-language pathology is increasingly important (Nancarrow et al 2008). Speech-language pathology assistants are now commonplace in the profession's workforce (RCSLT 2006). Volunteers also have a part to play. For example, Worrall et al (2000) involved volunteers in the delivery of a ten week functional communication therapy programme and there has also been a growth of volunteer involvement in 'conversation partner' schemes, which provide people with aphasia the opportunity to engage in conversation within their own homes (McVicker et al 2009).

For some individuals, treating the underlying language impairment to increase the amount of language available to them is the focus of therapy. High intensity of treatment is the key component of many effective impairment-focused aphasia therapies, including constraint-induced aphasia therapy (Pulvermuller et al 2001; Meinzer et al 2005; Pulvermuller & Berthier 2008; Raymer et al 2008). Unfortunately the resources required to achieve this through face to face speech-language pathology in the routine clinic are often prohibitive. Involvement of volunteers has been recognised as a potential way of supporting intensive therapy practice and extending use of communication skills learned in therapy into everyday use (Meinzer et al 2005; Enderby 2012).

Computers are also increasingly being used as a method of enabling more intensive and extended language practice without the need for a speech-language pathologist (SLP) to be present during all therapy sessions (Mortley et al 2004; Ramsberger & Marie 2007; van de Sandt-Koenderman

2011). Fink et al (2005) proposed trained volunteers could support computer practice. The StepbyStep© approach to computerised aphasia therapy involves volunteers to assist with practical support of the computer hardware and software, encouragement to practise, and support for transfer of new language skills into everyday use (Mortley & Palmer 2011).

Interviews with patients and carers using computer therapy highlight the fact that compliance with the computerised intervention was greater for many people if they had practical support and reminders of how to use the software, and also a relationship that motivates practice and provides positive reinforcement in addition to that provided by the computer (Palmer et al 2013).

Identifying volunteers' perceptions of undertaking their role with computerised impairment-based therapy is important to understand how best to train and support them. Berry & Planalp (2009) formally interviewed 38 hospice volunteers to understand the issues they faced. They found that volunteers were challenged by communication of information between staff and patients, feeling a conflict of interest at times, dealing with confidential issues, and knowing the boundaries of a role in which they are "not quite a professional" and "not quite a friend".

McVicker et al (2009) report some of the issues experienced by volunteers providing conversational support to people with aphasia including clarification of roles and boundaries; dealing with emotions; and managing expectations.

This paper presents the training needs, volunteer roles and challenges faced by eight volunteers who took part in the CACTUS (Cost effectiveness of Aphasia Computer Therapy versus Usual Stimulation) study, supporting people with aphasia to use computer software for language practice over a 5 month treatment period (Palmer et al 2012). This voluntary speech and language pathology role differs from those previously described in the literature as the key focus is on support for impairment-based therapy activities delivered by computer software. The

purpose of this paper is to gain further insight into volunteer experiences to inform SLPs of the issues to consider in the involvement and management of volunteers assisting with computerised therapy approaches.

Method

Design

Qualitative, semi-structured interviews were conducted with the volunteers to elicit their experiences and perceptions of conducting this role.

Volunteer participation in supporting computerised speech-language pathology

The voluntary role to support people with aphasia to use language therapy software in their own homes was advertised in two areas of the UK. In Sheffield it was advertised at the local university, at communication support groups, the local Stroke Association group, and Voluntary Action Sheffield (local volunteer bureau). In Newcastle, volunteers were sought from the North East Trust for Aphasia (NETA) and existing voluntary run aphasia groups. A role description, and person specification was also prepared. Those who fitted the person specification registered as volunteers for the Stroke Association in Sheffield and NETA in Newcastle, through which insurance and identity/criminal record checks were coordinated.

All volunteers were invited to a three hour training session delivered by speech-language pathologists. The first part of the training topics included the cause and symptoms of stroke; what aphasia is; how speech-language pathology can help; the volunteer role; patient confidentiality; lone working and patient safety. In the second part of the training, the SLPs

demonstrated how to use the computer software, StepbyStep© (Steps Consulting Ltd). Examples of how to encourage the use of new words in conversation and everyday use were given. The new volunteers were given the opportunity to explore the software in groups at a computer.

After setting up a patient with language exercises on the computer, and conducting a risk assessment, the speech-language pathologist took the volunteer to the patient's home to introduce them, discuss specific communication styles, and to show the volunteer how to use the patient's personalised therapy exercises.

The volunteers were asked to visit the patient for up to an hour weekly for the first month and once a month for the remaining four months of the treatment. Their role was to provide technical assistance; observe and encourage use of computer exercises; check results and discuss difficulties; and assist patients to move on to harder tasks in the therapy process pre-programmed by the SLP. Part of their role was also to encourage the use of new words in everyday situations and discuss with family about how to encourage use; and set up new vocabulary sets, as demonstrated during the training. The volunteers were able to contact the SLP by telephone or e-mail at any time to ask questions or raise concerns.

Participants

All eleven volunteers who provided support were contacted by telephone or e-mail by a member of the project team to ask if they would be prepared to be interviewed about their experiences of volunteering. Contact was attempted after all 34 patient participants had completed their treatment. This was therefore between two and ten months after the volunteering role had finished. Three of the volunteers were no longer contactable during the time period in which the

interviews were conducted. If those contacted showed an interest in participating in an interview, they were provided with an information sheet and asked to sign a consent form. Table I shows the profile of the eight volunteers who were interviewed.

Table I. Volunteer profiles

One male and seven female volunteers were interviewed from two areas of the UK. Four of the volunteers interviewed were speech-language pathology students from Sheffield University at different stages of the undergraduate and post graduate degree course. All of the other four volunteers had some experience of working with people who had stroke or communication difficulties as existing volunteers for stroke and communication charities. All female volunteers were aged between 18 and 25 years and the male volunteer was a retired gentleman over the age of 60. The three volunteers who were no longer contactable included an older gentleman from Newcastle, and two females SLP students from Sheffield (ages of these volunteers were not asked as this information was only sought if interviewed). The eight volunteers who were interviewed are therefore considered to be representative of the whole group of 11 volunteers in terms of gender and location.

All volunteers described their experience of computers as part of everyday life. No one claimed to have limited or advanced expertise. Each volunteer interviewed worked with one person with aphasia. Although initial recommendations were made, the volunteers were encouraged to discuss support requirements with their allocated patient. The amount of time volunteers spent supporting patients varied from an hour and five minutes to 25 hours over the five months with a median time of 4.5 hours. Low amounts of support resulted from one patient not really wanting

the volunteer support and one patient preferring the support remotely through e-mail. Greater amounts of support were provided to those who lived alone.

Procedure

Interviews were semi-structured with eleven predefined, open ended questions defined by three speech-language pathologists involved in the research project in Sheffield (the chief investigator; a research SLP involved in training and matching a volunteer with a patient; and a research SLP responsible for interviewing the patient participants of the study). The questions were designed to elicit information on perceptions, motivators and expectations of volunteering; suitability of the training provided; the volunteer role and tasks carried out; home visits; and benefits and disadvantages of the volunteering experience. The interview questions were reviewed by the chief investigator following the first two interviews to check that the questions were being understood by interviewees, and elicited information relevant to the purpose of the interviews. No difficulties with questions were identified and the questions were not amended for the subsequent interviews (See appendix). Three research SLPs conducted the interviews (one SLP per volunteer). The interviewers were the same research SLPs that defined the interview questions as described above. Interviewers only conducted interviews with volunteers who they had not previously had any direct involvement with. The interviews were conducted face to face at a location convenient for the volunteer (hospital or university premises, or in their own home), or on the telephone if meeting in person was difficult. Each interview lasted between 20 and 40 minutes, depending on the detail provided by the volunteers in response to the interview questions. At the end of each interview the interviewer summarised what had been discussed with each individual to check what they had wanted to say had been accurately reflected and to ask if there was anything else they would like to add.

All interviews were audio recorded and transcribed verbatim within one week by the researcher who conducted the interview. The data was managed using NVivo 9 qualitative analysis software (QSR International, 2011). A structured thematic analysis was conducted. Two speech-language pathologist members of the research team identified the main themes emerging from the data. Transcript data was coded into these main themes. Data within each theme were reviewed and first and second level subthemes were identified by two research speech-language pathologists independently of each other (the professional who conducted the interview and the investigator). All new ideas were identified as subthemes irrespective of the number of participants expressing this view to capture the breadth of experience of the participants. Where there were discrepancies in coding data in to themes/subthemes between the research SLPs, this was discussed to reach a consensus.

This study received ethics approval from Bradford NHS ethics committee as a nested qualitative study embedded within the CACTUS randomised control trial (reference number 09/H1302/20, 19th March 2009).

Result

Three main themes are reported in this paper: training and support requirements for the volunteers; perception of the volunteer role; and challenges facing the volunteer. Table II shows the development of the themes and subthemes which are described using illustrative quotes below.

Table II. Themes and subthemes emerging from the interview transcripts

Training and support requirements

Training

Managing volunteer expectations

The volunteers found the initial three hour training session gave a useful introduction to the role and what they might expect.

“We had quite a good introductory training session on what the overall aim was and what our part in *that would be, and obviously until you’re actually doing that, it’s hard to relate that to real issues but it was a good enough grounding*” (CR)

Structure and instructions

Being provided with a structured approach with which to conduct each visit was seen as beneficial, particularly by those new to working with people with aphasia on a one-to-one basis.

One participant described how having a structure to follow gave her confidence:

“In other places you might just get thrown in and told to help out with this but this was more structured. I think it was a good way to do it. I needed something to follow especially to know what I was doing [with the computer]. The structure was useful *especially at the beginning*” (PP)

Hands on experience

Hands on experience with the computer software was an important part of the training session and although the opportunity to practise with the computer following a demonstration was seen

as useful, participants suggested ways in which training to use the software could have been improved:

“There were laptops set up on four tables and we were all sitting around and we were invited to have a bit of a play with it, which was great but I think that [xxx] *that maybe it's useful to just do it with everyone once*”. (CR)

“I think the only thing that would have been useful either as part of the training or as an ongoing thing for volunteers would have been access to a copy of the program because quite often when I went out to see the lady I was supporting either something might have been slightly wrong or something would *happen that I wasn't quite expecting with the software and then I was on the spot*” (RR)

Timing of training

Although the majority of volunteers were trained together in one group, the patients were allocated to volunteers as they were randomised to computer treatment. Therefore some volunteers did not receive a patient to work with for several months resulting in a long gap between training and carrying out the role.

Ongoing support

Introduction to patients

The volunteers valued being introduced to the patient by the speech-language pathologist. Participants discussed the benefits of being able to observe how the SLP interacted with the patient and the use of the computer exercises set up specifically for that patient, giving them confidence in carrying out the support role:

“The first visit was with a therapist, which *was nice to see how she did it*” (EA)

“It was quite nice that the first time I went, I went with [SLP] so got introduced and then the next time I went, it wasn't so scary...she was able to explain to me a bit more about his needs and his actual level of understanding” (FS)

Supported autonomy and advice

Once a patient was allocated to a volunteer, ongoing support from a speech-language pathologist was provided both for technical issues with the software and general advice on how to manage the patient and move the therapy on:

“I did email [SLP], whenever I went to visit, I would email her what happened and then she would give me some suggestions. I think once the client asked for harder things and she suggested what we could do, *so there was always something*” (EA)

Two volunteers particularly appreciated the autonomy afforded to them by this voluntary role, with light touch support from the speech-language pathologist:

“[SLP] kept in reasonably regular contact but still giving us enough autonomy to not have someone breathing down your shoulders the whole time” (CR)

“I got to have a little bit of independence but there was always someone there if I had any questions and *they made that really clear*” (EM)

Perception of volunteer role requirements

Tasks specific to computer therapy support

Table III shows the specific tasks volunteers carried out in order to support the computer therapy directly. These tasks of explaining the purpose, ensuring patients moved onto harder tasks,

providing additional practice material and helping the patient to generalise using the new vocabulary are all key components of the therapy process.

Table III. Examples of tasks specific to computer therapy support

Support with computer use and Encouragement and motivation

In addition to specific support for the computer therapy tasks volunteers took on the role of supporting computer use and providing encouragement and motivation for practice:

“I felt I was there to facilitate her using the computer initially and to support and encourage her, make sure she was getting the most out of it and following the programme the way that it was intended to be used and just checking in on her, support and encourage her ” (RR)

“When I went round, he was so excited to show me what he’d been doing and show me his improvements so kind of motivated him to get better” (RW)

Home visits

Conducting this voluntary role in the patient’s own home was a topic of discussion in many of the interviews. This may be because visiting the home of an unfamiliar person was a new experience:

“It was a bit strange at first because I have never done that before *but it wasn’t really a problem*” (PP).

All participants discussed delivery of the computer therapy support from the perspective of what they felt was best for the patient. They recognised fatigue and reduced mobility as potential restrictions of accessing support outside of the home and the need for the patient to feel “comfortable” in a “quiet” setting for therapy practice:

“I felt she was in her own surroundings and it made her more comfortable rather than dragging her out somewhere when *she struggles to get out anyway*” (EM)

Flexibility

The volunteers recognised that the need for visits was patient driven, requiring them to be flexible in the amount and timing of their support:

“The first 3 weeks I went every week to get him cracking but then it was fortnightly” (JN)

“It was kind of as and when he wanted me to be there. *It wasn't very structured how we did it because that isn't how he wanted it*” (FS)

Support for carer

Two volunteers experienced provision of support to the patient's carer as their volunteer roles developed:

“*Sometimes [carer] needed someone more than [patient] and it wasn't part of the remit but in some ways it was just as helpful*” (CR)

“I think it gave her husband a few more ideas of how to *approach getting the message across*” (EM)

Challenges faced by volunteers

Managing relationship with patients

Managing patient expectations

CR described feeling unsure as to the expectations the patient had of her role to start with indicating an uncertainty of how to manage the patient's expectations at the outset of the therapeutic relationship:

"I don't know what you're expecting of me – whether you think I'm here to judge, to mark you or to be teaching you ...for the first couple of weeks it was like that but after that it was fine" (CR)

Managing boundaries

Another volunteer found it difficult to know how to interpret the behaviour of the carer and know how to set boundaries to avoid behaviour she felt was inappropriate:

"The husband got a little bit close for comfort on one occasion, and I came away thinking "Oh, I'm not really sure how to handle this, what the procedure is" so I had to go through all that which was something that I had never experienced before and more than likely will in the future if I go into community adult [SLP]. I think what he was doing was treating me more like a granddaughter so I was trying to learn where the boundaries were" (EM)

The SLP had carried out a risk assessment when introducing the volunteer to the patient and carer in their home. The volunteer contacted the SLP for advice on how to handle this situation and was given clear options of not going anymore if she felt uncomfortable or taking another volunteer with her.

Ending the visits

Knowing how to draw the voluntary support role to a close with a patient was discussed in the interviews.

"They did know it was happening but the practical issue of ending it...was weird. Not that fact it ended but the practicalities of what do I do and what do I say" (CR).

Interviewer: And did you feel prepared for that or do you feel it would have been something useful to have talked about with [SLP] beforehand?

“You can’t really be given the right script. And I think that obviously for each volunteer and each client it depends on the relationship that they have and the kind of person they are” (CR)

Time management

The volunteers had to fit supporting the patients in with their other responsibilities which could be difficult at times and cause feelings of guilt if they were unable to support the patient as much as they would have liked:

“When it got a bit stressful with uni work, it was a bit hard to juggle, and then I was quite ill...I didn’t want to feel like I was letting [patient] down” (FS)

Knowing how far to ‘push’ a patient with therapy practice

Volunteers recognised that it was their role to encourage the patients to practise but identified a fine line between encouraging practice and asking them to do more than they were comfortable with at any given time.

“That wasn’t that clear was how much to push the client to use the computer. I mean because I took a very non-pushy approach because I you know, I hope that was alright!” (EA)

Discussion

The results of interviews conducted with eight volunteers provide insights into key components of supporting people with aphasia to carry out computer-based word finding therapy, associated training needs and challenges faced.

The components of training that the volunteers perceived as necessary for the support of aphasia computer therapy included being provided with a structured approach to follow during each visit and

hands on practice with the computer software. Volunteers appreciated the opportunity to observe the SLP using the specific set of exercises for the individual patient. The volunteers also found access to support for technical issues and advice on how to present or change computer therapy exercises beneficial. In this study, the volunteers were invited to e-mail the SLP about any issues they wished to discuss. In other studies, routine, structured feedback was requested from volunteers to support them and monitor activity (McVicker 2009). Such an approach to feedback and support resonates with the structured approach to patient visits which volunteers appreciated and could therefore be considered as a way to support and monitor the activity of volunteers supporting computer therapy in the future.

The volunteers suggested that a demonstration of the software during training and getting the volunteers to try specific tasks altogether whilst being guided by the trainer would be beneficial. The timeliness of the training was the main disadvantage of this voluntary placement discussed. Once taught how to use computer software, delays on being allocated a patient made it more difficult for volunteers to consolidate their newly learned knowledge/skills in using the software. Possible solutions to this may be to train only after identity clearance is attained and perhaps to offer more frequent training sessions.

The interview elicited the volunteers' perceptions of their role in supporting the patient with aphasia with their computer therapy. Computer support, and encouragement and motivation to practise were key aspects of the role perceived by the volunteers. This confirms that they understood the role from the training and carried it out as intended. These components of the role were also highlighted as benefits of the intervention in interviews with the patients and carers that they supported (Palmer et al 2013). The main challenge in supporting impairment-based therapy practice related to knowing how far to push a patient to practise without putting them in a position they are not comfortable with, physically or emotionally. Other than this, there is no suggestion that supporting computer therapy exercises is any more challenging than voluntary roles that aim to provide care or assist with achieving participatory therapy goals such as enjoying/taking part in a conversation.

Support for computer-based aphasia therapy cannot be considered outside of the context in which it is delivered. The volunteers in this computerised aphasia study recognised that their role was patient led, which meant visiting them in their own homes and being flexible about when appointments were made. As carrying out home visits emerged as a common apprehension in undertaking this voluntary role, it may be necessary to consider further attention and time for questions about volunteering in the patient's home in the training, and greater discussion and reassurance regarding lone working policies.

Additional contextual challenges to providing support that were faced by the volunteers include: managing patient expectations; estimating where professional boundaries should be; time management; and ending the relationship. It is striking that these are generally acknowledged as skills health professionals need to possess and are accounted for in the professional framework laid out in the first chapter of *Communicating Quality 3* (RCSLT 2006). Our training focused on the support of the patient's computerised therapy and assistance with transferring newly learned language skills into daily life. Although issues of confidentiality and safety were addressed, we did not explicitly focus on other fundamental elements of professional conduct and competence that are required whether a health professional or a volunteer working independently with patients in their own homes. Berry and Planalp (2009) observed that the role of a volunteer is that of "not quite health professional" and "not quite friend". This may make boundaries and expectations even more difficult to negotiate than for health professionals. Ending a support session or relationship that is similar to that of a friend could also be more of an uncomfortable experience. When providing regular support in the patient's home environment, it is not surprising that additional roles emerged for some of the volunteers. Support was provided for the patients' relatives at times as well as for the patient. Support for the whole family has also been identified as part of other voluntary roles that are conducted in hospice or home environments (Duggal et al 2008; Carter and Mandrell 2013).

Although the speech-language pathologist who delegates the work to the volunteers retains ultimate accountability, the interviews with these volunteers highlight a need for more focused advice/support on

issues of conduct and competence for the setting in which computer support is provided. In McVickers et al (2009) study of volunteers as communication partners, ongoing support and discussion was provided through feedback forms and regular group volunteer support sessions led by a speech-language pathologist. In addition, the SLP made telephone calls to the patients after the first couple of weeks to check they were comfortable with the volunteer.

Involvement of volunteers in supporting speech-language pathology services often raises a concern that support from volunteers may undermine the speech-language pathology profession or reduce the number of SLP posts. Communicating Quality 3 (professional guidelines) clearly states that professional speech-language pathologists retain responsibility for the work carried out by assistants and support workers. (RCSLT, 2006). To this end, SLPs are still required as experts to assess and plan the work to be carried out. The role of the SLP continues to evolve to ensure the appropriate recruitment, training and supervision of support staff and volunteers. In order to ensure appropriate conduct and competency of volunteers there is a need to consider the person specification carefully for the particular role, and provide training and ongoing support and monitoring (Duggal et al 2008). Table IV summarises suggestions for training and ongoing support of volunteers taking a role in home-based computer therapy based on the findings presented in this paper.

Table IV. Suggestions for training and ongoing support of volunteers working with home based computer therapy

Limitations of the study

Interviews were only conducted with eight volunteers, therefore the experiences and opinions about this voluntary role presented are unlikely to be exhaustive. Although interviews were conducted by a member of staff not involved in training the volunteer, individuals will have been aware that the interviewer was from the project team who delivered the computer therapy intervention, potentially influencing some

responses. Quality control was applied as far as possible by research team members coding the data independently of one another, and discussing any discrepancies in order to reach consensus. However, it was not possible to perform independent verification of the data coding by a professional outside of the study team, as for meaningful analysis the independent coder would need to be familiar with the interventions, and as a new intervention familiarity was limited to those involved in the research. If sufficient numbers of participants were contactable following analysis it would have been useful to send themes/conclusions drawn to check they felt their views were represented. As the majority of the participants were student SLPs contact could not be re-established.

Conclusion

Volunteers perceived their role as providing computer support and encouragement/motivation to practise therapy exercises. They also felt they provided support to the relatives of people with aphasia. A three hour training session was generally thought to be sufficient, although more guidance with use of the computer software would have been appreciated and there is a need to pair volunteers to patients as soon after training as possible. In addition to generic challenges experienced through volunteering to support patients in their own homes, supporting impairment based therapy posed the additional challenge of knowing how far to push a patient to practise.

The implications of this study are that volunteers can support impairment-based computer therapy exercises that have been tailored to the patient's needs by a speech-language pathologist provided that they are trained by a SLP and continue to receive support from the SLP to identify and work through challenges faced in order to maintain appropriate conduct and competence.

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Appendix

Topic Guide for Interviews with Volunteers

1. What are your perceptions of volunteering? What is volunteering all about for you?
2. What was your motivation for getting involved with this project?
3. Were our expectations of the volunteers too high, too low or ok?
4. What did you think about the training you were given?
 - Would you have liked more training/support?
5. What were your perceptions of your role in this research project?
6. How did you find supporting xx with the computer? What kind of help did you have to give?
7. Were you able to do any of the work helping them to say their words in everyday life?
8. How did you find going to see them at home?
 - Do you think it would have been different if they had come to see you somewhere mutual?
9. Have there been any benefits to you of being a volunteer?
10. Were there any disadvantages for you?
11. Is there anything else you would like to add?

Table I. Volunteer profiles

Volunteer number	Gender	Age	Volunteer status	Location
1 CR	Female	18-25	SLP student/Stroke Association registered volunteer	Sheffield
2 EA	Female	18-25	Stroke association volunteer	Sheffield
3 EM	Female	18-25	SLP student/Stroke Association registered volunteer	Sheffield
4 FS	Female	18-25	SLP student/Stroke Association registered volunteer	Sheffield
5 JN	Male	60-65	Volunteer for WRVS communication groups	Newcastle
6 PP	Female	18-25	Volunteer for North East Trust for aphasia	Newcastle
7 RR	Female	18-25	Volunteer for North East Trust for aphasia	Newcastle
8 RW	Female	18-25	SLP student/Stroke Association registered volunteer	Sheffield

SLP = Speech-language pathologist

Table II. Themes and subthemes emerging from the interview transcripts

Theme	Subtheme 1	Subtheme 2
Training and support requirements	Training (5)	Management of volunteer expectations (3) Structure and instructions (2) Hands on experience with computer software (3) Timing of training close to patient allocation (1)
	Ongoing support (4)	Introduction to patient (2) Supported autonomy and advice/technical support (3)
Perception of the volunteer role	Tasks specific to computer therapy support (3)	Reminders of purpose of exercises (1) Initiating moving onto harder tasks (1)
	Physical support with computer use (1) Encouragement and motivation (4) Home visits (5) Flexibility (7) Support for carer (2)	Adding new vocabulary to exercises (1) Helping generalisation of new words (1)
Challenges faced by the volunteers	Managing relationship with patients (3)	Managing patient expectations (1) Managing boundaries (1) Ending the visits (1)
	Time management (1) Knowing how far to 'push' a patient with therapy practice on the computer (2)	

Number in brackets denotes number of participants discussing each theme/subtheme listed

Table III. Examples of tasks specific to computer therapy support

Computer therapy task (subtheme 2)	Illustrative quote (example of task)
Providing reminders of purpose of exercises	I think that in some ways he got into the habit of doing it exercise, exercise, exercise and had forgotten what <i>the point of the exercise was so to refocus and say 'this is to try and get you to...to rewire and get you saying the words and see if you can do it and make it into a sentence (CR)</i>
Initiating moving on to harder exercises	<i>If he found it really easy, I'd click on the levels because he didn't want to do that himself. (RW)</i>
Adding new vocabulary to exercises	I recorded my voice for some words that were quite familiar for her so that she could practice those (EM)
Helping generalisation of new words	About the last four sessions, we went through each one of the four <i>levels on the computer and we'd spend half an hour or so playing a game[using the words practised on the computer] (RW)</i>

Table IV. Suggestions for training and ongoing support of volunteers working with home based computer therapy

Training	Ongoing support
Define person specification for volunteer role	Risk assess environment in which volunteer support will take place
Provided training in a timely way (e.g. after identity checks and receipt of indemnity	Provision of a structured plan to follow at each visit

insurance)

Overview of purpose of voluntary role

- Introduction to stroke
- Introduction to aphasia and communication strategies
- Therapy delivered by computer
- Volunteer role

Observation of SLP using therapy exercises with individual client to be supported

Introduction of structure for volunteer visits:

- provide technical assistance
- observe and encourage use of computer exercises
- check results and discuss difficulties
- assist patients to move on to harder tasks in the therapy process pre-programmed by the SLP
- encourage the use of new words in everyday situations and discussions with family about how to encourage use
- add new therapy material as required

Access to support for technical issues
Support for changing therapy exercises

Demonstration of how software works by SLP
Volunteer to practice using software (guided by the SLP)

Structured feedback form for volunteers to complete after each visit to be sent to therapists. Therapists to use form to monitor client progress and volunteer support, and to provide ongoing advice to volunteer

Advice/discussion on policy issues:

- conducting home visits,
- lone working policies
- safety

Consider peer support sessions for volunteers

Skills for interacting with clients

- time management
 - managing expectations
 - professional boundaries
 - ending relationships
-