

**Researching the Role of Therapy Assistants to Support
the Delivery of Paediatric Therapy Services in British
Columbia**

Final Report

January 2007

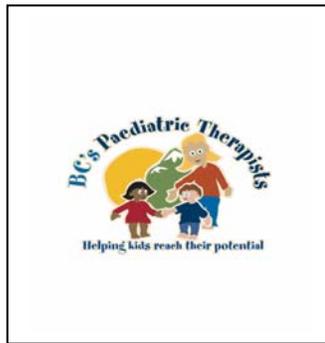
Researching the Role of Rehabilitation Assistants
In Pediatric Settings in British Columbia

Jason Gordon

January 2007

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Researching the role of therapy assistants to support the delivery of paediatric therapy services in British Columbia

Letter of Introduction to the full Project Report

The Provincial Paediatric Therapy Consultant is part of an interdisciplinary approach to address issues in access to therapy services for children in British Columbia, particularly recruitment and retention of Occupational Therapists, Physical Therapists, and Speech Language Pathologists. Several surveys have indicated that therapists are interested in exploring the role of therapy assistants in paediatric settings. In the 2006-2007 Work Plan for the Office of the Provincial Paediatric Therapy Consultant in British Columbia, the objective to research the role of therapy assistants was identified. A project was then commissioned to determine if there is a role for therapy assistants in paediatric settings.

With direction from the Provincial Paediatric Steering Committee, the project was developed to include a survey to investigate current use of therapy assistants in paediatric settings across the province; conduct literature and jurisdictional reviews; communicate with stakeholder groups to gather contextual information; collect information on the therapy assistant programs in BC; and present recommendations and considerations for using therapy assistants in paediatric settings. The findings from these activities are presented in the Final Report.

The following is a summary of the recommendations and future considerations provided at the conclusion of this report:

1. Require therapy assistants to join the support personnel membership category of a provincial professional association
2. Set supervision guidelines in pediatrics that stipulate a therapist may supervise a maximum of 2 therapy assistants at once, and must perform a re-evaluation of their clients being followed by TA's every 3 months
3. Establish tasks and activities specific to pediatrics in accordance with regulatory body guidelines
4. Develop a document and workshop or teleconference on strategies to effectively incorporate therapy assistants in pediatric rehabilitation
5. Develop strategies with Aboriginal communities to support the use of therapy assistants
6. Strengthen communication and collaboration between BC therapy assistant education programs and agencies delivering pediatric rehabilitation services

I wish to offer my sincere appreciation to the many individuals who contributed their expertise and energy to this project: Jason Gordon, Project Leader and Author; BC Ministry of Children and Family Development, Children and Youth with Special Needs Branch for the funding support to commission this project; the Provincial Steering Committee for direction and feedback throughout the project; and to the many participants who shared their experience during the provincial survey and stakeholder feedback processes. The combined effort of everyone has created a comprehensive report that can be used to guide the direction of practice for delivering therapy services to paediatric populations in BC.

The plan is to widely distribute the *Researching the role of therapy assistants to support the delivery of paediatric therapy services in British Columbia Report* to therapists, agencies, and stakeholders; welcome feedback; participate in discussions across the province; and identify the next phases to support the informed utilization of therapy assistants in paediatric settings in BC.

Please feel welcome to direct your comments, feedback, ideas, suggestions or requests to me. I look forward to our collaborative discussions.

Sincerely,

Christie Diamond
Provincial Paediatric Therapy Consultant

Executive Summary

This project investigated the use of rehabilitation assistants in pediatric settings in British Columbia. The intent of the project was to determine if there is a role for therapist assistants in pediatrics by exploring current practice standards, stakeholder identified barriers and concerns, and a review of the literature. Recommendations were developed based on the findings of this report.

Current practice standards were investigated through a survey sent to agencies providing pediatric rehabilitation services in British Columbia. Seventy-two agencies were sent the survey, and the response rate was 53%. Rural and urban practice settings were represented, and of the 72 agencies that responded to the survey 29% of these agencies currently employ rehabilitation assistants. Urban practice settings and Speech-Language Pathologists utilize support personnel to the greatest extent, and agencies heavily utilized professional association guidelines to guide the practice of support personnel. 67% of agencies who did utilize rehabilitation assistants in the delivery of pediatric rehabilitation felt that this greatly enhanced the quality of service.

A literature review concerning the use of rehabilitation assistants in pediatric settings demonstrated increased access to service and cost-effectiveness as two benefits of this practice. Rural therapists felt less isolated, and support personnel increased the ability for therapists to perform more specialized work. Disadvantages revealed by the literature include an increased time required to initially train assistants and set-up a supervision plan, an increased distance between the client and the therapist, and concerns regarding liability.

PT's and OT's in BC have Colleges regulating their practice. These Colleges provide guidelines for support personnel use, and any therapist not appropriately utilizing support personnel can have disciplinary action taken against them. Speech-Language Pathologists do not currently have a regulatory body in BC, but they do have the BC Association of Speech-Language Pathologists and Audiologists which does provide guidelines on the use of support personnel. The provincial and national associations for the rehabilitation professions (OT, PT, SLP) acknowledge appropriate use of support personnel can provide valuable contributions such as increased access to services.

Rehabilitation assistants are currently not regulated in BC. In general, tasks and activities that can be performed by therapy assistants in British Columbia are more conservative than in other provinces. There are no concrete guidelines regarding supervision ratios, and frequency of client re-assessment.

Discussions with various stakeholders in the delivery of pediatric rehabilitation services occurred via phone interview and a focus group. Increased access to service, cost-effectiveness of service delivery, and more appropriate use of therapists' skill level were all cited as potential benefits of utilizing rehabilitation assistants. Barriers included a lack of funding, a lack of knowledge regarding how to appropriately utilize support personnel, and in rural settings a lack of therapists to provide intervention planning and supervision. Concerns included inappropriate use, the increased time needed to train support personnel, a potential for decreased "hands-on" treatment time by therapists, and the lack of SLPA programs in BC.

There are currently 4 therapy assistant programs in BC, and all are offered at public post-secondary education institutions. All programs have recently updated to a 2 year diploma. All offer OTA/PTA training; however, only one program incorporates SLPA training. All programs have significant pediatric content, and 2 of the programs are currently developing a course specific to pediatrics.

There are significant benefits of utilizing rehabilitation assistants in pediatric settings identified by the literature and service delivery stakeholders; thus, strategies to increase their appropriate use should be explored. Recommendations include requiring therapy assistants to become members of a professional association to improve the monitoring and data collection abilities of the pediatric rehabilitation communities. Second, supervision guidelines for pediatric therapists using therapy assistants should limit the number of assistants supervised at one time to two, and require the therapist re-evaluate a child being followed by a therapy assistant a minimum of every 3 months. Third, much of the ambiguity surrounding what tasks pediatric therapists can assign support personnel could be resolved by establishing a list of pediatric specific tasks and activities that could be reviewed by the professional regulatory bodies. Fourth, dialogue and a document should be created that provides education to pediatric therapists and agencies on how to effectively utilize therapy assistants.

This type of education would serve to ease many of the fears reported by pediatric rehabilitation stakeholders. The fifth recommendation is a partnering with aboriginal communities to develop strategies to support the use of rehabilitation assistants. Finally, the sixth recommendation is to increase the collaboration and communication between therapy assistant education programs and agencies providing pediatric rehabilitation services. These recommendations would not only address the majority of concerns and barriers reported by stakeholders, but would help facilitate the use of the therapy assistant occupation in the delivery of pediatric rehabilitation services.

Introduction

Multiple factors are causing strain on our existing system of healthcare delivery. In response, providers are required to be increasingly innovative in order to meet the needs of clients while still providing a high level of care. Many sectors of our healthcare system are utilizing support personnel such as rehabilitation assistants to try and meet these demands.

In pediatric rehabilitation there are three main professionals involved in the delivery of service, the Physiotherapist (PT), Occupational Therapist (OT), and the Speech-Language Pathologist (SLP). Each of these professions has experience in the use of support personnel in the delivery of service in various healthcare sectors and environments; however, pediatric rehabilitation has to date not seen a great deal of support personnel use. The purpose of this project is to investigate the role of rehabilitation assistants in pediatric settings in British Columbia. This project consists of five main components:

1. Inventory of agencies delivering pediatric rehabilitation services in BC
 - This was accomplished via a survey sent to 72 different agencies involved in the delivery of pediatric rehabilitation. The purpose of the survey was to gather information regarding current utilization of rehabilitation assistants in pediatric settings in BC.

2. Literature Review
 - A literature review was performed to explore papers discussing the use of support personnel in pediatric rehabilitation. In addition, College and professional association guidelines regarding the use of assistants were examined for the OT, PT, and SLP professions. The use of assistants in other professions, and the use of assistants in the United States were investigated as well.

3. Stakeholder Communication

- This portion of the project involved discussions with several different stakeholder groups concerned with the delivery of pediatric rehabilitation services. Information was gathered via phone interviews and a focus group. Key topics discussed were barriers and concerns regarding the use of rehabilitation assistants in pediatric settings, and potential benefits.

4. Existing education programs for rehabilitation assistants in BC

- A table was compiled containing relevant information from all existing rehabilitation assistant education programs operating in BC.

5. Recommendations and considerations regarding the use of rehabilitation assistants in pediatric settings.

Component #1 – Survey of Agencies Providing Pediatric Rehabilitation Services in BC

An inventory of a representation of agencies currently providing pediatric services to children in British Columbia was performed via survey. The purpose of this survey is to gain insight regarding the utilization of therapy assistants in pediatric settings. Factors such as delegated activities, the supervision policy agencies employ with assistants, and the education levels of assistants were investigated. The survey was developed by Jason Gordon, with input from the Provincial Pediatric Therapy Consultant and the Consultant's Steering Committee. A survey website (Survey Monkey) was used in the development, dissemination, and collection of results. An html version of the survey is located in Appendix B.

The Survey

The survey was e-mailed to a total of 72 public agencies providing pediatric services to children in British Columbia. This included the tertiary centers Sunny Hill Health Center for Children and BC Children's Hospital, 22 Child Development Centers, 12 School Districts, 17 Health Units, and 19 other agencies such as community services societies. Selection criteria ensured both rural and urban agencies were represented. All agencies received a follow-up phone call 1-2 weeks after the survey had been initially sent to encourage completion, and any questions or difficulties agencies may have had in completing the survey were handled promptly via e-mail or phone. Response rate to the survey was 53%, or a total of 38 agencies. A study by Couper, Blair, & Triplett (1999) that compared ten different survey response rates via e-mail had a combined average reply rate of 36%, thus a 53% response rate can be considered creditable.

The first question of the survey requested the person responding to identify their position at the organization. In most cases the survey was completed by the Executive Director of the agency (32%), or the Head of the Therapy Department (26%). At some agencies the survey was done by Program Managers (16%) and staff therapists (16%). Lastly, there were several individuals (9%) completing the survey who had multiple roles at their agency. These individuals typically had some sort of supervisory role in addition to carrying a clinical caseload. The second question of the survey asked if the agency currently utilizes therapy assistants in their practice setting.

Respondents who answered 'yes' to this question were then taken to an additional 11 questions. The remaining respondents who had answered 'no' were directed to a question asking them to identify reasons for not utilizing therapy assistants.

Reasons for Not Utilizing Therapy Assistants

Of the agencies that do not employ rehabilitation assistants the most common reason given was funding limitations, selected by 72% of the respondents. The next most common reason for not employing therapy assistants was that the agencies would rather hire more therapists, specified by 48% of respondents. In the comments section of this question several agencies indicated their focus was on recruiting therapists for existing vacant positions, and others indicated that they felt their long waitlists would be better served by hiring more therapists. 32% of respondents identified they were uncertain of the role of therapy assistants in pediatric settings, 20% indicated they were unable to recruit qualified assistants, and 16% of agencies were unfamiliar with the supervision requirements. 4% of respondents didn't feel the use of therapy assistants was necessary, and 8% indicated their organization didn't have their contracts set-up to be able to hire therapy assistants.

The remaining results discussed in this paper address the 11 questions answered by those agencies that identified themselves as currently utilizing therapy assistants. This accounted for a total of 29% of the agencies who responded to the survey, and the majority (56%) of these agencies had utilized assistants for at least 5 years.

Education Backgrounds and Therapist to Assistant Ratio

The education background of therapy assistants working in a pediatric setting is quite varied. A slight majority (56%) had trained at a College or University accredited program for rehabilitation or speech language pathology assistants; however, several agencies reported assistants with no formal post secondary education at all (44%). Other training backgrounds reported included a Certified Personal Trainer, Early Childhood Education Diploma training, and a foreign trained Therapist working on licensure.

The Therapist to therapy assistant ratio was also quite varied amongst the agencies. Four facilities reported a ratio of less than 3 therapists to 1 therapy assistant; however, two facilities had ratios of more than 39 therapists to 1 therapy assistant.

Job Duties and Supervision

The activities most likely performed by therapy assistants are preparation and clean-up of treatment areas, directly assisting therapists with active therapy, running group classes or activities, and performing administrative duties such as charting and scheduling. Other duties indicated by the agencies included independently carrying out therapy treatment plans developed by supervising therapists, equipment fitting and maintenance, splint making and sewing, and pool therapy.

Agencies mainly utilize both direct and indirect supervision with their therapist assistants. Direct supervision is when the supervising therapist is able to directly observe the therapist assistant. Indirect supervision is when the supervising therapist is in the same location as the therapist assistant, but may not be able to directly observe the assistant's actions. There is one report of the use of independent supervision where the supervising therapist is not at the same location as the assistant; however, the assistant is able to contact the supervising therapist by phone should any questions or concerns arise.

Professional association guidelines and agency policy manuals are both heavily utilized to guide the practice of therapist assistants, and all agencies subjected their assistants to a performance review at least once a year. 67% of respondents felt that the contribution of therapist assistants at their facilities greatly enhances the service they provide, and 11% of respondents felt their service was moderately enhanced.

Trends

Agencies in more urban areas with large therapy departments tended to be the type of facility to utilize rehabilitation assistants. All therapy disciplines (OT, PT, SLP) worked with assistants, with SLP's utilizing them to the greatest extent. The type of duties therapist assistants performed were quite varied, and assistants tended to spend less than 50% of their work hours on any single particular activity.

Many rural agencies in this survey had only partial therapy positions (i.e. 0.8 FTE), and indicated their focus was more on the recruitment and retention of therapists rather than investigating the use of rehabilitation assistants. Some rural agencies with part-time therapy positions expressed concern over having an adequate amount of therapy staff to handle supervision duties.

Respondent Comments

Opportunity was provided throughout the survey for a respondent to add a comment or answer to a question in addition to the selections already offered. Many valuable comments were provided, particularly for the question regarding reasons for agencies not utilizing therapy assistants. Here are some of those comments:

-“There could be use for therapy assistants, but also have lengthy waitlists for therapists, and assistants won’t have a significant impact in reducing waitlists for therapy services at this time.”

-“There is not a job description for a pediatric therapist assistant for our organization, so this is our current barrier.”

-“Long waitlists due to funding limitations require that we need to focus on more therapy positions in order to provide assessment and consultation.”

-“Because of recruitment issues around therapists, may have an aide and no therapist.”

-“I work as a sole-charge therapist in a remote community with limited opportunity for interaction or supervision with others.”

-“We are a small department and currently our contracts are set-up to hire therapists not assistants, but not sure we have the personnel capacity to supervise assistants.”

-“We have just created a position of therapy aide and are going through the process of having the job evaluated before posting it.”

-“I’m in education, no one besides myself knows what a therapy assistant does, nor do they feel they have the funding to support such opulence.”

-“As the director of this facility this decision would be left to the department head for the designated therapy and on recommendation would come forward to me.”

The following are two of the comments provided by respondents for the question regarding to what degree they felt the use of therapy assistants enhanced the quality of the rehabilitation being provided to the families utilizing their service:

-“Greatly enhances as enables sole-charge clinicians to run groups, to see more clients, to provide more resources to clients, saves therapists from burn-out.”

-“Would enhance the service because of heavy caseloads for SLP’s when we have SLP’s.”

Survey Results Discussion

The broad agency representation represented by this survey has offered a reasonable depiction of the current use of therapy assistants in pediatric settings in British Columbia. It appears that urban centers with a higher level of therapy staffing positions tend to utilize assistants to a greater extent than their rural counterparts. The education background of therapy assistants, and the therapist to assistant ratios are widely varied among the practice settings surveyed. Direct and indirect supervision methods are used, and organizations utilize profession regulatory body guidelines and agency policy manuals to guide the use of their therapy assistants. A wide variety of duties are being performed by therapy assistants in pediatric settings, and all agencies currently utilizing assistants feel that they are enhancing the quality of rehabilitation services they offer their clients.

When agencies were asked to identify some of the barriers preventing them from utilizing therapy assistants there were some interesting challenges. A lack of funding was the most common obstacle; however, some other factors such as lack of an appropriate job description, or contract limitations were identified. Some agencies expressed that their primary focus needed to be directed towards waitlists, so they felt that hiring more therapists would best serve the needs of their agency in this regard. Smaller departments and those located in more rural settings had concerns more around the issue of therapist recruitment, and weren’t sure if they would even have the staff to provide supervision to an assistant. This survey has identified that there are positive aspects to utilizing therapy assistants, yet also unique challenges and obstacles preventing their use.

Component #2 – Literature Review

The title ‘Rehabilitation Assistant’ is typically given to personnel assisting therapists in a variety of settings; however, there is no formal recognition of this title. Other common names to describe those assisting professionals in a rehabilitation setting include therapy assistant, support worker, support personnel, rehabilitation aide, aide worker, and the term ‘assistant’ following a professional designation (i.e.- occupational therapist assistant). Through the course of this project it became apparent the various professions involved in pediatric rehabilitation most commonly identified assistants by placing the term ‘assistant’, or ‘support worker’ following the title of the profession they are assisting. Thus, for organizational purposes this review is arranged accordingly.

There are several abbreviations used throughout the literature concerning rehabilitation assistants that will be used in this report:

RA	-	Rehabilitation Assistant
SLP	-	Speech-Language Pathologist
PT	-	Physical Therapist
OT	-	Occupational Therapist
SLPA	-	Speech Language Pathology Assistant
PTA	-	Physical Therapist Assistant
PTSW	-	Physical Therapist Support Worker
OTA	-	Occupational Therapist Assistant

Additional abbreviations will be identified in brackets following the term to be abbreviated, and a quick reference for abbreviations can be found in Appendix A.

There are also several terms that will be used throughout this review that I will define here:

Assignment - the process by which a Therapist designates another service provider, other than a Therapist, to deliver specific therapy service components. The recipient of the service component is a client of the Therapist. The Therapist has the ongoing responsibility for the provision of the service. (Canadian Association of Occupational Therapy, 2003)

Delegation - the process by which a therapist appoints competent support personnel to act on the therapists behalf giving support personnel the authority to exercise discretion in the performance of specific activities in a selected situation. The following conditions must be satisfied in order for specific activities to be delegated:

- these are within the therapists practice
- the client will not be at risk if these are performed by support personnel
- these are established and/or stable parts of the client's care
- these are not restricted activities, as per the Health Professional Act (Alberta College of Occupational Therapy, 2005)

Consultation - the process of providing expert advice, education, and/or training regarding a specific issue with another service provider, on a time limited basis. The consultant Therapist is not assigning therapy service components and does not have continuing responsibility for supervising the quality of the ongoing service of the provider. (Canadian Association of Occupational Therapy, 2003)

Supervision - a process in which two or more people participate in a joint effort to promote, establish, maintain or increase a level of performance and service. One person is identified as having ultimate responsibility for the quality of service. (Canadian Association of Occupational Therapy, 2003) There are two general types of supervision, direct and indirect.

Direct Supervision - the supervising therapist is present within the environment when the delegated task is being carried out. (Alberta College of Occupational Therapy, 2005)

Indirect Supervision - the supervising therapist is not present when the task is being carried out, but is available to the support personnel by communication technology (i.e.- phone, fax, e-mail) or has provided an alternate plan in case of doubt or perceived risk. (Alberta College of Occupational Therapy, 2005)

Literature Review

A literature review concerning the use of rehabilitation assistants in pediatric settings was performed. Key terms used in the search included: pediatric, therapy, community setting, rural setting, remote setting, rehabilitation assistant, therapy assistant, physiotherapy assistant, occupational therapy assistant, speech language pathology assistant. The CINAHL and Medline databases were primarily utilized in the search; however, the author also had access to the EBSCO research database collection via the University of Athabasca library. In addition to the key search terms, the Tree View function of the CINAHL database was used to isolate articles catalogued according to the following: physical therapist assistants, occupational therapist assistants, and speech language pathologist assistants. The MeSH heading function of the Medline database was used to further explore articles catalogued in the Allied Health Professionals subject heading. Articles published within the past ten years were considered for this review.

The review of literature revealed a dearth of information related to the use of rehabilitation assistants, and this amount decreased considerably when the focus of this material was narrowed to pediatrics. Thus, some general literature concerning the use of rehabilitation assistants was included for review.

The Use of Speech Language Pathology Assistants in Pediatrics

McCartney et al. (2005) compared direct therapy provided by Speech Language Pathologists (SLP's) to indirect therapy provided by Speech Language Pathologist Assistants (SLPA's) to a group of children ages 6-11. Therapy was delivered in a school setting, and at the conclusion of the study the Speech Language Pathologists were asked to discuss the benefits and disadvantages of the indirect therapy. The SLP's felt that there were benefits such as more children were able to receive therapy, the use of SLPA's for straight-forward language delays allowed SLP's to perform more specialized work, and SLP's working in remote or sole-charge environments felt less isolated working in a team with SLPA's. Some disadvantages of SLPA use indicated by the SLP's included high time demands in the initial set-up of working with an SLPA, the danger of problems if a SLPA stepped beyond an agreed practice, and difficulty in honing therapy aims and planning due to decreased direct contact with a child.

One recommendation from this study was to ensure that it is rewarding for therapists to work with assistants, but the investigation didn't elaborate on strategies to ensure this is the case.

New (1998) investigated a model for a speech language therapy service in mainstream schools that utilized the use of Speech Language Pathology Assistants. This investigation demonstrated an increase in the number of children receiving service, but a questionnaire completed by Speech Language Pathologists revealed concerns regarding the decrease in the interaction between SLP's and classroom teachers.

The Use of Occupational Therapy Assistants in Pediatric Settings

The American Occupational Therapy Association for Occupational Therapy Assistant Education Programs describe the curriculum requirements for support personnel in the statement: "Biological, behavioral, and health sciences that will be requisite to, or concurrent with, technical education and that encompasses normal and abnormal conditions across the life span (infants, children, adolescents, adults, and older adults)" (AOTA, 1999). This strongly suggests that it is a requirement of occupational therapist assistant education programs to include pediatric content in their curriculum.

In a paper by Russell (1998) a survey was sent out to over 510 selectively sampled Occupational Therapists, and 40% of these therapists currently worked with aides. 26% of these respondents worked in a pediatric setting. The most often endorsed benefit of working with an aid was that the practitioner's time was freed for higher level tasks (85%), and the biggest concern reported was liability issues (70%). Other benefits reported to a lesser extent included "increases efficiency" (54%), "decreases cost" (46%), "expands availability of services" (42%), "provides care in under-serviced areas" (26%), and "increases quality of service" (17%). Other concerns regarding working with an aid reported by the survey respondents included "overuse" (65%), "inappropriate billing" (52%), "increases distance between client and practitioner" (51%), "decreased quality of service" (50%), and an increased managerial role of the Occupational Therapist (35%). This paper also investigated ethical issues with the use of aides, and discovered that 19% of survey respondents had been in a situation where an ethical issue arose.

Themes of these ethical issues included lack of appropriate supervision, overuse, aid making errors or overstepping scope of responsibility, and billing issues.

General Occupational Therapy Assistant Literature

Lyons (2001) discusses the clinical reasoning of an occupational therapy assistant using a qualitative case study. Data in this paper suggests this occupational therapy assistant uses the same modes of reasoning seen in previous studies of the clinical reasoning of occupational therapists. However, the sample of this case study is limited to a single occupational therapy assistant with 16 years of experience.

A paper by Steele (2006) discusses the use of occupational therapy assistants in home health in the state of California. The author describes how an occupational therapy assistant can be effectively utilized in a home health setting while still adhering to the supervisory requirements of the American Occupational Therapy Association, California Board of Occupational Therapy, home health agencies, and third-party payers. Steele believes the occupational therapist-occupational therapy assistant partnership can make a vital contribution to the financial and continuity of care aspects of home health.

A unique paper contrasting the history of occupational therapy assistants in Canada and the United States was published by Salvatori (2001). She identified several key differences between Canada and the United States in the training, regulation, and certification of occupational therapy assistants. The United States has consistently supported profession-specific training whereas Canada has shown a preference for generic training and use of title (i.e. – occupational therapy assistant vs. rehabilitation assistant). Certificate and associate degree programs have been offered at community colleges in the United States since the 1960's; however, in Canada the first college programs didn't start to appear until the 1990's. The United States has also had national standards of education and a program accreditation process in place since 1958, while in Canada this is only now being more formally discussed. The regulation of practice of both occupational therapists and occupational therapy assistants is in place in 48 of 53 jurisdictions in the U.S.; however, in Canada only the practice of occupational therapists is regulated. Disciplinary action towards occupational therapy assistants in Canada rests solely with the employer, but in the U.S. disciplinary action can be taken by the American Occupational Therapy Association and state regulatory bodies. Finally, the

American Occupational Therapy Association offered assistants membership with limited privileges in 1963, and since the late 1970's assistants were able to have full membership status. In Canada, occupational therapy assistants have only recently been able to join the Canadian Occupational Therapy Association and many provincial associations.

Steib (1996) investigated the various employment settings that Occupational Therapist Assistants could be found working. It was discovered approximately 20% of certified Occupational Therapy Assistants in the United States work in pediatric settings.

General Physical Therapy Assistant Use

Loomis, Hagler, Forward, Wessel, Swinamer, and McMillan (1997) utilized a survey to determine the current utilization of physical therapy support personnel in Canada. This study revealed that 3% of support workers were working in exclusively pediatric settings such as schools. Schools also had the highest ratio of the various practice settings with 4 support personnel for every physiotherapist. Rural practice settings had higher ratios of support personnel than urban practice settings. The presence of support workers increased the number of clients treated by the facilities. The majority of facilities that did not employ support workers indicated inadequate funding as the main reason. Some potential benefits of support worker use cited by facilities were cost effective use of staffing, maximizing the number of clients seen by PT's, and targeting PT's time to high skill activities. Concerns to using support workers included inadequate training or supervision, and poorly defined roles and responsibilities.

Loomis et al. followed up the previously described study with another in 1998 titled "Future Utilization of Physical Therapy Support Personnel in Canada." This investigation utilized interviews and a survey to gather information from physical therapists, support workers, and therapy department heads concerning the future use of support workers. 24% of those surveyed represented rural areas of practice. Acute care, community care, and long term care agencies were represented. The results of this paper produced recommendations such as:

- the educational program for support personnel in PT to be a minimum of one year in length. 16 weeks of clinical practicum

- establish guidelines including mandatory supervision of support workers, ultimate responsibility for client care resides with the supervising PT, a 4:1 maximum ratio of support personnel to PT when in the same location, a 2:1 ratio when in separate locations, and the supervision of 20% of direct client care activities of the support workers.

A paper by Heck, Paulenko, Apostolatos, Li, and Peixoto (2001) compared the tasks physiotherapy assistants report performing and physiotherapists report assigning in the province of Ontario. Overall, there was high agreement between the two groups on administrative tasks and treatment tasks. However, there was a discrepancy between number and nature of tasks reported as assigned by PT's and performed by PTA's in the area of assessment tasks. In this area, PTA's reported performing more tasks than PT's reported assigning. Also, PTA's and PT's differed on the level of independence the PTA used in completing the task. This is likely concerning ongoing assessment tasks as PTA's in the survey made it clear they believed they were not trained to perform initial assessments, and felt this was the domain of the PT. However, it does reveal the need to further clarify the terminology and classification of therapy tasks so both PTA's and PT's are clearer regarding their roles.

Saunders (1997) produced an interesting paper regarding the delegation of tasks to assistants. It demonstrated the use of PTA's in outpatient settings resulted in an increase in PT productivity. Also, patient satisfaction with receiving physiotherapy services from a PTA was high.

General Use of Rehabilitation Assistants

Pullenayegum, Fielding, Du Plessis, and Peate (2005) discuss the use of rehabilitation assistants in an acute care setting. This paper investigated the provision of rehabilitation services in a stroke unit over the weekend utilizing the services of a rehabilitation assistant. All stroke patients found the weekend therapy sessions to be 'useful', and felt the rehabilitation assistant made a difference in areas such as personal care, sitting to standing, walking, and general wellbeing.

Literature Review Conclusion

The literature discusses many benefits of support personnel use such as an increase in the number of patients able to access service, more cost-effective service, less isolation for therapists practicing in rural or sole-charge positions, and the ability for professionals to spend the majority of their time performing more specialized work. There is also evidence in an outpatient setting that patient satisfaction is high despite receiving services from a physical therapist assistant.

Some of the disadvantages of utilizing support personnel identified by the literature include the increased time initially for a therapist to train and set-up a supervision plan, the increased distance between the client and practitioner, liability issues, and concerns surrounding roles and responsibilities of a rehabilitation assistant.

Speech-Language Pathologists and Occupational Therapists appear to utilize support personnel in pediatrics to the greatest extent, and do so primarily with school aged children. The school system and rural practice settings demonstrate higher ratios between therapist and support workers as compared to other practice settings. The main barrier to the utilization of support personnel is reported to be inadequate funding.

The United States has support personnel training more profession specific than Canada, and the U.S. has national educational standards and program accreditation for therapist assistant programs well entrenched in their system.

Professional Associations and Regulatory College Initiatives

This project also investigated the various professional associations and regulatory college initiatives surrounding the use of rehabilitation assistants in pediatrics. This included the professions of occupational therapy (OT), physiotherapy (PT), and speech-language pathology (SLP).

Occupational Therapy

The profession of Occupational Therapy has a national association, the Canadian Association of Occupational Therapists (CAOT), that defines occupational therapy support personnel/workers as “Any persons who are not qualified occupational therapists but are knowledgeable in the field of occupational therapy through education and training and are directly involved in the provision of occupational therapy services under the supervision of an occupational therapist” (CAOT, 2003). Membership to the association for OT’s is voluntary, and there is an associate membership category for support personnel. There is also a national group, the Association of Canadian Occupational Therapy Regulatory Organizations, representing the interests of the provincial OT regulatory bodies. Occupational Therapists must be registered with their provincial regulatory body in order to be licensed to practice. In BC this is the domain of the College of Occupational Therapists of BC (COTBC), a provincial regulatory body that operates within the framework provided by the Health Professions Act. This regulatory body has the power to investigate and discipline OT’s if necessary, but does not have any authority to discipline OT support personnel since they are not currently regulated in BC. The same is true for the other provinces in Canada.

Physiotherapy

The Canadian Physiotherapy Association (CPA) is the national association for physiotherapists. Membership is voluntary, and there is a membership category available for support workers titled the ‘National Support Worker Assembly.’ The provincial regulatory bodies for physiotherapy are organized nationally via the Canadian Alliance of Physiotherapy Regulators (the Alliance). Physiotherapists must be registered with their provincial regulatory body in order to practice.

In BC this regulatory body is the College of Physical Therapists of British Columbia, and its actions are governed by the framework provided by the Health Professions Act.

The Canadian Alliance of Physiotherapy Regulators recognizes two levels of physiotherapy support workers. Group 1 consists of support workers with an educational background including:

- Curriculum preparing students for physiotherapy practice models
- Broad curriculum to match the variety of client populations and physiotherapy environments
- Education program faculty members that include registered physical therapists
- A college diploma/certificate from a recognized post-secondary program that includes a minimum of three terms of full-time equivalent study. One term must be in physiotherapy specific coursework, one term in physical therapist supervised practical training, one term of generic coursework

The Alliance suggests that group 1 support workers use the job title of Physical Therapist Assistant (PTA).

The group 2 support workers includes assistants with educations that are not as extensive in nature, or less formal than as described for group 1. This makes it difficult to assume knowledge and skill levels in this group, thus the Alliance recommends work assigned to group 2 personnel should have “less direct hands-on patient care focus, likely not involved in the documentation process, and work assignments apply only for the context(s) trained.” The Alliance suggests group 2 workers use the job title Physiotherapy aide or Rehabilitation aide.

Speech-Language Pathology

The national association for Speech-Language Pathologists, the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA), defines support personnel as “any individual employed in a role supporting the delivery of speech-language pathology and/or audiology services AND receiving supervision in those duties by a qualified speech-language pathologist or audiologist.”

This association does have a membership category for support personnel, and has a Manager of Support Personnel working for the association to specifically address issues in this area. CASLPA also has a joint membership agreement with the British Columbia Association of Speech-Language Pathology and Audiology (BCSSLPA). Membership in BCASLPA is voluntary. There are currently only 6 of the 10 provinces and 2 territories that have a regulatory body SLP's are required to be registered with to practice. They are Alberta, Saskatchewan, Manitoba, Ontario, Quebec, and New Brunswick. British Columbia is currently in the process of having a provincial regulatory body established, and should have this accomplished in 2007. Support personnel are currently not regulated in any province of Canada.

National Association Guidelines on the Use of Support Personnel Occupational Therapy

The Association of Canadian Occupational Therapy Regulatory Organizations produced a document in 2003 titled 'The Essential Competencies of Practice for Occupational Therapists in Canada' that outlines requirements for ethical practice of OT's in Canada. The following is an excerpt from that document pertaining to the use of support personnel:

- Article 7.3 - Demonstrates responsibility for occupational therapy service components assigned to staff, assistants and others under the therapist's supervision.
- Article 7.3.1 - Understands and adheres to regulatory requirements and/or guidelines relating to the assignment of tasks and supervision of personnel and occupational therapy students.
- Article 7.3.2 - Utilizes strategies and engages in a process to ensure that assigned components are implemented safely, ethically and effectively.
- Article 7.3.3 - Maintains a documented process for assigning components of the program.

The Canadian Association of Occupational Therapy (CAOT) position statement regarding the use of support personnel states that the CAOT "supports the inclusion of support personnel in the delivery of occupational therapy services when their contribution will enhance the effectiveness of OT services."

The CAOT last revised their document regarding the supervision of assigned occupational therapy service components in 2003. This document makes it clear that Occupational Therapists are responsible for the provision of OT services, and for the supervision of assigned services. This responsibility for supervision remains regardless of the individual to whom the service component is assigned (i.e. – OT support personnel, family caregiver, teaching assistant). Three steps of the supervision process are identified: Task identification and analysis, development of supervision plan, and monitoring and evaluation of task completion.

Task identification and analysis refers to how the Occupational Therapist identifies tasks to be assigned. Conditions of this assignment include ensuring the client consents to the use of support personnel, the OT ensures the service provider is competent and has acknowledged accountability in completing the task, OT supervision is available, and the task will not compromise the OT service.

Development of a supervision plan refers to the frequency and type of service supervision. This plan should be reevaluated at regular intervals. Supervision is dependant on factors such as task difficulty, client needs, and service provider competency. The document describes how supervision “must be ongoing, involve regular contact with the supervising therapist, and involve a combination of methods such as observation of interventions and/or client-worker interactions, record reviews and informal or formal meetings.” The paper also makes it clear that face-to-face contact at regular intervals is a requirement of the supervision plan.

The final step in the supervision process described by the CAOT document, Guidelines for the Supervision of Assigned Occupational Therapy Service Components, is monitoring and evaluation of task completion. Appraisal concerns include “attainment of client and/or program outcomes, client and other stakeholder satisfaction with services, and cost efficiency of service provision” (Canadian Association of Occupational Therapy, 2003). The supervising OT is to document evaluation results, including any differences regarding assigned service completion vs. instructions provided.

CAOT recommends the following service components NOT be assigned to support personnel:

- interpretation of referrals

- initial interviews/assessments
- interpretation of assessment findings
- intervention planning
- interventions which require continuous clinical judgment
- modification of intervention beyond limits established by the supervising OT
- discharge decisions

The CAOT also produced a valuable report in 2003 titled “Profile of Performance Expectations for Canadian Support Personnel in Occupational Therapy.” The purpose of the Profile was to “describe the expectations that occupational therapists have of formally trained support personnel, so that they may receive safe and effective support in the provision of occupational therapy services” (CAOT, 2003). There were 154 performance expectations of support personnel developed, and the intention of this Profile was to try and have the CAOT members validate these expectations. If validated, this Profile could then be used by CAOT members to help guide the use of support personnel. This study revealed 34% of Occupational Therapists in practice were currently assigning service components to support personnel, and the main reason indicated for not utilizing such workers was lack of funding. The paper also consisted of Occupational Therapists’ responses to 154 performance expectations of support personnel. CAOT members strongly endorsed performance expectations concerning ethical issues, the relationship with the client, communication with the occupational therapist, and the safe storage and repair of materials and equipment. However, there were low levels of approval in areas such as the promotion of practice, monitoring and assessment of client status, and participation in the evaluation of occupational therapy services. Due to the general low level of validation by CAOT members of a significant number of performance expectations, it was determined that the Profile would not be suitable for use.

Physiotherapy

The Canadian Physiotherapy Association has rules of conduct section of its code of ethics that discusses a physiotherapist's responsibility to the client. This section states the following regarding support personnel: "Physiotherapists, with the client's or surrogate's consent, may delegate specific aspects of the care of that client to a person deemed by the physiotherapist to be competent to carry out the care safely and effectively. Physiotherapists are responsible for all duties they delegate to personnel under their supervision" (Canadian Physiotherapy Association, 1989).

The Canadian Alliance of Physiotherapy Regulators is a national organization that has been engaged for several years in developing guidelines for the use of physiotherapy support personnel. The 10 provincial regulatory colleges are members of the Alliance. Regular meetings with the Canadian Physiotherapy Association, the Canadian Universities Physical Therapy Academic Council, and the Accreditation Council for Physical Therapy Academic Programs help the Alliance to develop guidelines and solutions for issues affecting physiotherapy in Canada. The Alliance's mission statement is to "provide leadership and support to assist its members in fulfilling their public interest mandate" (www.alliancept.org).

The paper "Guidelines on the Role and Utilization of Physical Therapist Support Workers in Physical Therapy Practice" was produced by the Alliance, last revised in 2004. This paper discusses the components of supervision and communication in the relationship between the PT and the PTSW. Regarding supervision, the supervising physiotherapist assigning tasks to a support worker:

- must supervise the individual performing the task
- uses their best clinical judgment to provide the appropriate amount of direct and indirect supervision
- must be available by pager, telephone, or be in the same physical area as the PTSW when utilizing indirect supervision
- must not assign any task that the PTSW has not been observed by a physiotherapist to be able to competently perform
- determines the supervision required by taking into account provincial/territorial legislation

- determines the supervision by analyzing the practice setting, type and nature of the task, acuity of the patient's condition, complexity of the patient's needs, and the decision making required for modification of treatment based on patient response

Supervising physiotherapists are responsible to ensure PTSW's are clearly identified through the use of name tags and introductions. Ongoing communication must exist between the PT and PTSW, and the PT must ensure the PTSW comprehends any instructions and knows the limitations of their clinical practice. When assigning a task, the PT is responsible for completing an assessment and preparing a therapy treatment plan. The PT must also ensure a documentation process is established, and that the PTSW is competent for the task(s) assigned. Patient consent for portions of the physiotherapy care plan to be performed by a PTSW must be established.

The Alliance outlines the following as tasks that PTSW are able to perform:

- carry out portions of the physiotherapy care plan for the relatively medically stable patient
- participate in the collection of qualitative and quantitative client data related to the client's physical status and functional ability as assigned by the PT
- perform selected objective measures/tests/procedures as assigned
- implement therapeutic interventions as assigned which may include thermal, electrical and mechanical modalities or providing physical assistance
- reinforce the PT's explanation and provide verbal instructions regarding the intervention plan
- assist in evaluating the effectiveness of specific interventions
- document work and collect workload statistics in accordance with the policies of the practice setting
- perform any task that contributes to the creation of a safe and effective practice environment that supports a client-centered delivery of physiotherapy services

The Alliance outlines the following as tasks that are **NOT** to be assigned to support personnel:

- interpretation of referrals, diagnosis, or prognosis
- interpretation of assessment findings, treatment procedures, and goals of treatment
- planning, initiation, or modification of treatment program beyond established limits
- discussion of treatment rationale, clinical findings, and prognosis with the client/family
- documentation that should be completed by the PT
- discharge planning
- tasks or procedures requiring continuous clinical judgment
- manual therapy (i.e.- mobilizations)
- any act controlled by provincial/territorial regulation

Speech-Language Pathology

The Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) has a section regarding the delegation of tasks in its Code of Ethics. This states “members are responsible for all professional services they delegate to personnel under their supervision. Members shall not misrepresent the credentials of assistants, technicians, students or supportive personnel and shall inform the client of the name and professional credentials of persons providing services” (Canadian Association of Speech-Language Pathologists and Audiologists, 2005).

In addition, CASLPA released a document in 2004 discussing guidelines for the use of supportive personnel. According to this document, areas within the scope of practice of a speech language pathology assistant include:

- activities such as assisting a SLP during assessments
- preparing materials, performing clerical duties
- providing direct treatment to patients under the supervision of a SLP
- documentation

- participating in family conferences with the supervising SLP present
- assisting with family or community education approved by the supervising SLP
- performing hearing screening (without interpretation) under the supervision of a SLP
- using defined screening protocols selected by the supervising SLP (results not to be interpreted by the supportive personnel).

Areas outside the scope of practice of speech language pathology support personnel include:

- selecting patients for service
- screening for swallowing disorders
- demonstrating swallowing strategies or precautions
- conducting evaluations
- developing or altering treatment plans
- explaining assessment results
- counseling or consulting with the patient/family regarding the patient's status or service
- interpreting performance or progress
- discussing prognosis
- performing procedures that pose a significant risk to a patient or that require a high level of clinical acumen and technical skill without appropriate training and supervision

This document also states training will have been completed from an educational program for supportive personnel in speech-language pathology and/or audiology or equivalent. Supervisory guidelines suggest the supervising SLP has at least two years of clinical experience, and recommends additional preparation via course work, workshop attendance, or independent study in the area of supervision. Supervision amount and type is influenced by the skills and experience of the supportive personnel, the service setting, tasks assigned, and the needs of the client.

Supervisory SLP's should be available to consult with supportive personnel at all times, and supervisory SLP's should cite and approve all pertinent documentation provided by the supportive personnel.

Supportive personnel working with SLP's or Audiologists shall meet national membership requirements (the CASLPA has an associate member category), and must abide by the Code of Ethics for Supportive Personnel developed by the CASLPA. Each member is subject to disciplinary review as outlined by CASLPA policies.

Provincial Association Guidelines on the Use of Support Personnel

The focus of this initiative is on the practice of pediatric rehabilitation in British Columbia; therefore, the British Columbia regulatory body guidelines regarding the use of support personnel for the professions of Physiotherapy, Occupational Therapy, and Speech-Language Pathology were examined. The other provinces' guidelines were then compared to the BC documents.

Occupational Therapy

The College of Occupational Therapists of British Columbia released a document in 2004 regarding the use of unregulated support personnel (College of Occupational Therapists of British Columbia, 2004) such as rehabilitation assistants. This paper acknowledged that support personnel have been working with Occupational Therapists for over 50 years, and that "in an ongoing effort to deliver quality, accessible and cost effective services in a timely manner, support personnel continue to assist occupational therapists to meet the needs of a greater number of clients." The College of Occupational Therapists of BC deems the use of support personnel helps access to occupational therapy services; thus, they endorse the use of such personnel. However, the occupational therapist must appropriately assign and monitor support personnel, and the course of action must be documented. The Occupational Therapist is responsible for ensuring the client "understands and consents to the provision of the service by the unregulated support personnel", and "receives care that is not compromised by the assignment."

Documentation must include evidence that consent has been obtained, and when support personnel notes are present these notes must be reviewed by the occupational therapist in revising the services. The Occupational Therapist must also ensure that the support personnel adhere to the following:

- understands their roles and responsibilities
- acknowledges accountability to the OT in completing the task
- receives appropriate training to carry out the procedures of the occupational therapy intervention
- is competent to provide the service safely and effectively
- receives appropriate and timely supervision
- understands how and when to contact the supervising therapist
- is monitored and evaluated by the OT on a regular basis and as required to ensure expected outcomes are obtained
- changes or modifies the task only within limits established by the occupational therapist
- records their interaction with the client as directed by the occupational therapist

The College of Occupational Therapists of BC recommends the following tasks should NOT be assigned to support personnel:

- interpretation of a referral
- initial assessment and reassessments
- administration of standardized diagnostic tests
- interpretation of assessment findings
- intervention planning
- determination of goals and objectives
- selection of treatment strategies
- modification of an intervention beyond established limits
- decisions regarding interventions where continuous clinical judgment is necessary
- determination of caseload

- personal counseling of clients or their significant others
- decisions about the initiation or termination of intervention
- referral of a client to other professionals or agencies
- discharge planning

Supervision requires ongoing monitoring of support personnel competence, and evaluation of the intervention outcomes. This can be accomplished via review of support personnel's "notes, case reviews, input from the client, family, caregiver, and other team members, and by informal or formal meetings face-to-face, by email, fax, or telephone calls." When evaluating the assigned service, the Occupational Therapist is to include consideration of the cost efficiency of service provision in addition to outcomes and service satisfaction. The COTBC also provide a critical thinking decision tool to help guide OT's in assignment of tasks. A copy of this tool is located in appendix C.

The Alberta College of Occupational Therapists document on the use of support personnel titled 'Responsibilities of OT's in Supervision of Support Personnel (Alberta College of Occupational Therapists, 2005)' has a few key differences from the COTBC document. The ACOT states that support personnel "must receive site and service specific training to have an understanding of the intent and procedures for the occupational therapy interventions. This training will vary depending on the complexity of the tasks assigned, the level of skill and knowledge of the support personnel, and the requirements of the department/occupational therapy service/institution." This document also states that in situations where indirect supervision is being used the therapist must always be available for consultation through some other mode of communication. Regarding instructions, the ACOT clearly states that all directions to support personnel from contracted agencies should be in written form. Role limitations of support personnel are essentially the same in both the COTBC and the ACOT documents. A helpful tool included in the ACOT document is the use of case studies to help OT's work through supervision strategies in various scenarios

The Saskatchewan Society of Occupational Therapists (SSOT) released guidelines concerning the use of support personnel in 2006 (Saskatchewan Society of Occupational Therapists, 2006). Supervision guidelines and tasks that should not be assigned support personnel are quite similar to the COTBC document.

One of the components OT's are to consider when deciding whether to assign part of the OT service is efficiency. The SSOT suggests OT's ask themselves the question 'Can the task be carried out more efficiently by support personnel than by the OT (due to caseload, location, etc.)?'

The College of Occupational Therapists of Manitoba released a document in 2006 titled "Assignment and Supervision in Occupational Therapy Practice" (College of Occupational Therapists of Manitoba, 2006). This document has very similar guidelines regarding supervision and scope of practice as those provided by the COTBC.

The College of Occupational Therapists of Ontario (COTO) released a practice guideline concerning the use of support personnel in 2004. Supervision of support personnel follows much the same guidelines as the COTBC provides; however, the COTO have a couple of key differences in their section on roles and responsibilities. The COTO allows for some aspects of assessment to be delegated to support personnel, provided the particular portion of assessment being delegated does not require ongoing clinical judgment. The COTBC document recommends initial assessment and reassessment, as well as the administration of standardized diagnostic tests should not be assigned to support personnel. Both COTO and CPTBC agree that interpretation of assessment findings is not to be delegated to support personnel. COTO also makes it clear regarding what type of information support personnel may appropriately share with the client or others involved. Their document describes how information concerning "OT recommendations, analysis, client's functional status or prognosis and expected outcome may not be communicated by the support personnel" (College of Occupational Therapists of Ontario, 2004). The COTBC document is vague in this area with its statement that "personal counseling of clients or their significant others" should not be assigned to support personnel.

The Ordre des Ergotherapeutes du Quebec (OEQ) is the regulatory body for Occupational Therapists working in Quebec. They have a practice statement titled 'Participation du personnel non-ergotherapeute a la prestation des services d'ergotherapie' that discusses the use of support personnel. This document does not have any key differences from the COTBC paper.

The New Brunswick Association of Occupational Therapists (NBAOT) last released a position statement concerning support personnel use in 2002. The NBAOT state that they endorse the use of support personnel "as a means of expanding public access to occupational therapy services by allowing occupational therapists to better utilize their professional skills" (New Brunswick Association of Occupational Therapists, 2002). Roles and responsibilities are similar to the COTBC document; however, the NBAOT document is more specific concerning supervision guidelines. It is recommended that a ratio concerning the maximum number of support personnel that can be safely supervised by one OT be established. Also, face to face contact between the supervising OT and the support worker should never be less than once per month. NBAOT clearly states that if an OT "is not available to provide the level of supervision stipulated in the guidelines for service, support personnel may not work." The College of Occupational Therapists of Nova Scotia released a practice guideline concerning the use of support personnel in 2005. This document differs from COTBC guidelines much the same way as the recommendations released by the COTO described previously.

PEI currently does not have a practice statement or guidelines concerning the use of support personnel.

Physiotherapy

The College of Physical Therapists of British Columbia released a practice standard effective September 1, 2006 regarding the assignment of task to a physical therapist support worker. This document indicates the physical therapist is responsible for the physical therapy care assigned to the support worker, for obtaining consent from the patient for the involvement of support personnel, and for explaining to the patient the relationship between the therapist and support worker for the purpose of clarifying the difference in roles and responsibilities.

The physical therapist must also ensure that the support worker is competent to carry out the assigned tasks, is instructed in standard infection control measures, and is aware of patient confidentiality standards. Assigned tasks must be recorded in the clinical record, the physical therapist must be available for consultation and reassess the patient at timely intervals, and the therapist must instruct the support worker to recognize any adverse treatment reactions, cease treatment and immediately report to the supervising physical therapist.

Supervision guidelines and considerations are similar to those previously described in the paper by the Alliance with a couple of additions. The following tasks are NOT to be assigned to support personnel:

- Tasks having an evaluative component that immediately influences the treatment program
- Interpretation of referrals
- Interpretation of diagnosis, or prognosis
- Performance of assessment and evaluative procedures
- Interpretation of assessment findings
- Discussion of physical therapy diagnosis or treatment rationale with anyone other than the physical therapist
- Planning or initiating physical therapy treatment goals or programs
- Tasks requiring a physical therapist's clinical judgment
- Modification of treatment beyond established limits
- Completion of documentation that is the physical therapist's responsibility
- Electrotherapy (except for neuromuscular stimulation and TENS)
- Teaching of the assigned task to another person
- Discharge planning

Physical Therapy Support Workers are currently not regulated in BC.

The College of Physical Therapists of Alberta (CPTA) last released a practice standard regarding supervision and delegation in 2005. This document has two key differences from the CPTBC paper.

First, much like the Alliance guidelines discussed earlier the CPTA paper states that performing selected objective measures/tests/ procedures may be delegated to support personnel; however, the paper does not elaborate on what some of those selected measures may be. The CPTBC paper does not contain such a statement and clearly indicates the performance of assessment/evaluative procedures must not be assigned to support workers. This can pose some confusion as some objective tests/measures may also be considered an evaluative procedure such as measuring joint mobility using a goniometer.

According to the CPTBC and CPTA practice statements some may interpret that goniometry is not to be performed by support workers in BC, but can be performed by support personnel in Alberta. The second key difference between these two practice guidelines is regarding the list of tasks that can NOT be assigned to support personnel. The CPTA paper clearly states that mobilization/manipulation is not to be assigned to a physiotherapist support worker, while the CPTBC paper does not clearly state these tasks in particular. However, mobilization/manipulation is likely included in the “tasks requiring a physical therapist’s clinical judgment” statement of the CPTBC paper regarding what can NOT be assigned. Physical Therapy Support Workers are currently not regulated in Alberta.

The Saskatchewan College of Physical Therapists guidelines are very similar to those already defined by the CPTBC. The one additional task stated that should NOT be delegated to support workers is the delivery of client education unless using approved preset packages/handouts of educational material. The Saskatchewan guidelines also provide recommended percentages regarding the use of supervision. It is suggested that 20% of direct client care activities are supervised by a therapist with at least 10% supervised utilizing direct observation or interaction. Saskatchewan does not currently regulate physical therapy support workers.

The College of Physiotherapists of Manitoba also utilizes the Alliance framework in determining the tasks that can be assigned to a support worker, and supervision requirements. An additional note in the “Physiotherapists Assigning Physiotherapy Care” (College of Physiotherapists of Manitoba, 2001) document discusses billing for services.

It states that physiotherapists who bill on a fee-for-service basis need to ensure the funder is aware that support personnel are providing services. This is due to some funders reimbursing services at a different rate if they are provided by support personnel. Manitoba does not currently regulate physical therapy support personnel.

The College of Physical Therapists of Ontario professional practice standard for physiotherapists working with physiotherapy support personnel was last updated in 2005. This document is quite similar to the CPTBC paper with only a couple of key differences. The CPTO document states that a registrant is not accountable for the support worker when the registrant is working in the role of a consultant and not providing treatment. In Ontario, the therapeutic acts of spinal manipulation and tracheal suctioning are controlled by provincial regulation and are NOT to be assigned to support personnel under any circumstances. Physical Therapist support workers are currently not regulated in Ontario.

Quebec utilizes two professionals in physical therapy, the university trained physiotherapist and the college trained Therapeutes en readaptation physique (TRP). The TRP were incorporated into the Ordre professionnel des physiotherapeutes du Quebec in 2003. Their title is reserved, and the activities that can be carried out and the conditions that can be treated by PRT's are defined by provincial legislation. TRP's are not required to be supervised by a physiotherapist for all activities, and are not classified as support workers.

The Nova Scotia College of Physiotherapists has endorsed the Canadian Alliance of Physiotherapy Regulators 'National Guidelines for Support Personnel in Physiotherapy Practice', and does not have any significant differences in their own guidelines. Physiotherapy support personnel are presently unregulated in Nova Scotia. Some information regarding PTSW's is collected via the PT's annual registration with their College.

The College of Physical Therapists of New Brunswick (CPTNB) guidelines on the use of support personnel are very similar to the document already discussed from the CPTO.

In addition, the Code of Ethics stated by the CPTNB includes the standards “each member shall ensure that no services that requires the skill, knowledge and judgment of a physiotherapist is delegated to a less qualified person,” and “each member shall ensure that those under her/his supervision or in his employ are knowledgeable and capable in the performance of their duties.” Physical Therapy support personnel are currently not regulated in New Brunswick.

The Newfoundland and Labrador College of Physiotherapists states “The use of support personnel in physiotherapy can enable the physiotherapist to provide service to a greater number of clients or to provide more regular treatment. When physiotherapy treatment is required, it is accepted that early intervention and adequate treatment is crucial for the client to achieve optimal outcomes. Cost effectiveness in physiotherapy is maximized.

As support personnel assume some routine responsibilities the physiotherapist can devote more time to the roles of clinician, consultant, educator and researcher and as a contributing member of the multidisciplinary team” (Newfoundland and Labrador College of Physiotherapists, 2002).

Supervision guidelines and delegated tasks are very similar to those provided by the Alliance; however, there are two key additions regarding supervision. The College requires a minimum of 7.5 hours of direct supervision a month when using an indirect supervision model. Also, the chronic stable patient (i.e.- long term care) must be re-evaluated by the supervising therapist a minimum of every three months. Newfoundland amended the Physiotherapy Act in 1999 to allow the College to make regulations regarding ‘physiotherapy auxiliaries.’ This allows for either registration or certification of P.T.S.W.’s. Currently, Newfoundland P.T.’s are providing information regarding the P.T.S.W.’s with whom they work allowing the College to create a database. This allows the College to follow-up with P.T.S.W.’s in small rural settings to investigate supervision levels.

Speech-Language Pathology

The British Columbia Association of Speech Language Pathologists and Audiologists (BCASLPA) released a set of guidelines for the use of supportive personnel in 2001. This document states that BCASLPA does not mandate the use of supportive personnel; however, the use of support personnel can “enhance the services provided to selected communicatively disordered individuals” (BCASLPA, 2001). The supervising SLP is responsible for all services provided, and decides which clients are appropriate to receive services from support personnel. Supervising SLP’s should work in the same physical setting as the assistant, and BCASLPA states a written rationale and arrangement should be available for any exceptions to this. It is suggested that supervising SLP’s have at least two years professional experience, and that they grow their supervision skills through continuing education. Supervising SLP’s are not allowed to receive payment from the SLA’s they supervise. The supervising SLP is responsible for developing a model of supervision.

Supervision must consist of regular contact for program discussion, and the supervising SLP must have enough contact with the client for adequate planning of an effective service delivery.

BCASLPA states the following tasks may be assigned to a SLPA:

- deliver direct support programs to clients selected by the supervising SLP
- follow documented treatment plans or protocols developed by the supervising SLP
- document progress, and report this information to the SLP
- assist the supervising SLP during screening and assessment process
- assist with informal documentation, prepare materials, and assist with other programs
- participate in in-service training and public relations programs with the supervising SLP

BCASLPA states the following tasks are NOT to be assigned to support personnel:

- perform standardized or non-standardized speech and language tests, formal or informal evaluations, interpret test results, or conduct speech/language screening procedures
- participate in parent or case conferences, or in any interdisciplinary meetings without the presence of the supervising SLP
- provide parent or client counseling
- communicate with the patient or family regarding any aspect of the patient's status or service without the specific consent of the supervising SLP
- write, develop, or modify a patient's individualized treatment plan in any way
- assist with patient without following the individualized treatment plan prepared by the supervising SLP or without access to supervision
- sign any formal documents unless countersigned by supervising SLP
- schedule or discharge patients for service
- disclose clinical information to anyone not specifically designated by the supervising member
- make referrals for additional services
- represent her/his self as an SLP or in any way advertise that they can provide specific speech and language therapy services

BCASLPA also suggests the supervising SLP be involved in the selection process of the assistant, the development of guidelines of job responsibilities, and regular performance reviews of the assistant's performance. Due to the variability in the preparation of SLPAs it is recommended a job description be developed by the supervising SLP and employer that details tasks and levels of difficulty. Consent must be provided by the patient prior to any service from a SLPA.

The Alberta College of Speech Language Pathologists and Audiologists released a preferred practice guideline in 2006 concerning the use of support personnel.

This document differs from the BCASLPA paper by going into more detail regarding competencies of support personnel to consider prior to delegating activities. The document recommends support personnel demonstrate such skills as:

- an understanding of the appropriate role of support personnel, and the ethics applicable to their activities
- ability to interact with clients, families, and other team members in a respectful and positive manner
- effective time management
- understanding of normal processes and disorders in the development of communication and related skills relevant to the clinical population being served
- appropriate identification of need for additional input from the SLP, including the need to refer questions from patient/families to the SLP

Regarding activities which may NOT be assigned to support personnel, the main difference between the ACSLPA and the BCASLPA guidelines is that the ACSLPA includes a statement that support personnel must not be assigned the task of supervising other support personnel, other than approved supervision of support personnel in training. Another key difference between the two guidelines is that the ACSLPA recommends that a minimum of 10% of all client contacts should be directly supervised by the SLP.

The Saskatchewan Association of Speech Language Pathologists and Audiologists also provide guidelines regarding the use of support personnel. This document is very similar to the guidelines previously discussed in the BCASLPA document; however, the Saskatchewan guidelines go into greater detail regarding the amount of direct and indirect observations provided by the supervising SLP. It is recommended that support personnel are observed in a direct fashion a minimum of one in every ten clinical contacts per client, and that indirect observations should be provided one in every five clinical contacts.

The Manitoba Speech and Hearing Association (MSHA) produced the document titled “Guidelines for the use of Support Personnel in Speech-Language Pathology.”

This paper is similar to the ACSLPA document in that it recommends a minimum of 10% of client contacts are to be directly supervised by the SLP. The MSHA takes this a step further by recommending the first 3 sessions for each client also be under direct supervision. Regarding the role of support personnel, the MSHA document differs from the BCASLPA recommendations by suggesting that support personnel can assist the SLP with assessments such as with the administration and scoring of tests, and through conducting screenings. This is in contrast to the BCASLPA document that clearly stipulates support personnel should not perform standardized or non-standardized speech and language tests, or conduct speech/language screening procedures.

The College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO) released a practice guideline regarding supportive personnel in 2002. A key difference from BCASLPA guidelines is that CASLPO states speech-language or hearing screenings following specified screening protocols developed by the supervising member may be assigned support personnel.

However, the CASLPO document is similar regarding activities that can not be assigned support personnel including the performance of standardized or non-standardized speech and language tests, formal or informal evaluations, or interprets test results. The CASLPO paper also provides more detail regarding supervision by suggesting that some monitoring should occur at least weekly, and in the case of a new speech assistant supervision would be required for a minimum of 20% of the time the assistant spends in patient contact. It is recommended SLP's don't supervise any more than 2 or 3 assistants. Newfoundland and Labrador are currently in the process of finalizing a guideline on the use of support personnel that will be largely based on the CASLPA support personnel guidelines.

Support Personnel Use in the United States

Support personnel use is much more prevalent in the United States healthcare system. There are two general categories of support personnel found in rehabilitation, the assistant and the aide. Aides do not provide skilled services, and are not primary service providers in any healthcare setting. An aide is trained to perform a specifically delegated task, and a therapist is responsible for their overall use and actions.

The activities of an aide include non-client related tasks such as clerical duties, maintenance, and work area preparation. Activities can also include some client-related tasks; however, these are routine tasks with predictable outcomes in a stable environment. Such tasks must not require any judgment, interpretation, or adaptations to be made by the aide. In the U.S. aides can be supervised by therapy assistants, a topic not discussed in any of the Canadian literature. Therapy assistants in the United States operate in much the same manner as in Canada in that they must be supervised by a therapist.

Occupational Therapy

The American Occupational Therapy Association outlines recommendations regarding the use of support personnel in the document “Guidelines for Supervision, Roles, and Responsibilities during the Delivery of Occupational Therapy Services” (American Occupational Therapy Association, 2004). This paper clearly states that Occupational Therapists are responsible for all aspects of service delivery including evaluation, intervention planning, intervention review, and outcome evaluation.

The OT determines when to delegate to support personnel, and the support personnel are responsible for demonstrating service competency in the performance of delegated tasks. During the evaluation the OT directs the evaluation process and determines the need for service, defines the problems to be addressed, determines the goals and priorities, determines specific further assessment needs, and determines specific assessment tasks that can be delegated to support personnel. The OT interprets and integrates any information provided by the OT assistant. Intervention planning is the responsibility of the OT, and the support personnel are accountable for being knowledgeable about evaluation results and therapy goals.

OTA’s are required to be licensed in the majority of U.S. states. Some states utilize certification or registration instead of licensing. OTA’s graduate from accredited school programs, and must pass an entry-to-practice examination.

Physical Therapy

The American Physical Therapy Association states “physical therapists have a responsibility to deliver services in ways that protect the public safety and maximize the availability of their services” (American Physical Therapy Association, n.d.). It is suggested responsible utilization of physical therapy assistants who assist with selected components of intervention can help to achieve this goal. The APTA recommends support personnel are NOT to:

- interpret referrals
- conduct initial examination, evaluation, diagnosis, and prognosis
- develop or modify a plan of care based on the initial examination or reexamination
- determine appropriate support personnel utilization
- establish the discharge plan

The physical therapist must oversee all documentation, and is directly responsible for the actions of the assistant. General supervision when the supervising physical therapist is off-site is allowed; however, the physical therapist must be available by phone at all times, there must be regularly scheduled and documented meetings between the physical therapist and support personnel, and a supervisory visit will be made at least once a month and prior to any discharge planning. This supervisory visit by the physical therapist responsible for patient care will involve reexamination and appropriate revision of the care plan.

The most significant difference between PT support personnel in Canada and the U.S. is that Physical Therapist Assistants in the U.S. are regulated in the vast majority of states.

The following information regarding the regulation of PT and OT support personnel in the U.S. is provided by a background paper produced by the Canadian Alliance of Physiotherapy Regulators titled ‘Options for the Regulation of Physical Therapist Support Workers (Canadian Alliance of Physiotherapy Regulators, 2003).’ Regulation can be accomplished a variety of ways:

Registration - considered the least intrusive. Utilized for groups without an independent scope of practice and low risk of harming the public. Allows regulator to track the identity and number of workers in a particular occupation.

Certification - considered a level above registration. May be voluntary or required by statute. Includes title protection and a specified education level, and may involve an examination. Sanctioned members could be banished from membership and be no longer able to use the title.

Licensure - reserved for assistants who present the highest risk of harm to the public. At this level, the occupation possesses a unique body of knowledge. Licensure is mandatory and includes title protection, a defined and protected scope of practice, specifies education standards, and the passing of an examination. The regulator can investigate and discipline members.

The majority of PTA's in the U.S. are regulated via certification or licensure. The APTA supports licensure while a different national organization, the Federation of State Boards of Physical Therapy, supports certification. Regulated PTA's have graduated from an accredited school and have passed an entry-to-practice exam. The regulating bodies are able to investigate and discipline PTA's, and FSBPT data does indicate a higher incidence of disciplinary action for PTA's than for PT's.

Speech-Language Pathology

The guidelines developed by the American Speech-Language Hearing Association are contained in the document "Guidelines for the Training, Use, and Supervision of Speech-Language Pathology Assistants", last updated in 2004. The American document makes it more clear that although support personnel can assist the SLP with hearing screenings (without interpretation of results), support personnel may NOT perform standardized or non-standardized diagnostic tests. Supervisory guidelines are more explicit: "The speech-language pathology assistant must be supervised by a speech-language pathologist who holds a Certificate of Clinical Competence in Speech Language Pathology from ASHA, has state licensure (where applicable), has an active interest and wants to use support personnel, and has practiced speech language pathology for at least 2 years following ASHA certification."

It is also suggested supervisors complete continuing education in the area of supervision, and it is recommended that the supervising SLP participate in the selection of the assistant. This document also provides percentage guidelines as to how much supervision should be provided on a weekly basis. For example, “A total of at least 30% direct and indirect supervision should be provided weekly for the first 90 workdays.”

Thirty-five states currently regulate the use of support personnel either through licensure (12), registration (22), or certification (1).

Experience of Other Professions Utilizing Support Personnel

Pharmacy

Another healthcare profession undergoing an increase in the use of support personnel is the pharmacist. The use of the pharmacy technician to meet the growing demands on pharmacists was investigated in the paper “Environmental Scan of Pharmacy Technicians” developed by the Canadian Pharmacists Association. This document describes how the Canadian Council for the Accreditation of Pharmacy Programs that currently accredits the nine university programs in Canada has begun discussions with the Association of Canadian Community Colleges to accredit their programs. The purpose of these discussions is to ensure the quality of pharmacy technicians to meet the needs of current pharmacy practice. Pharmacy technicians also have a national organization, the Canadian Association of Pharmacy Technicians (CAPT). Membership is voluntary, and there are no regulatory bodies that require registration. The National Association of Pharmacy Regulatory Authorities and the Canadian Society of Hospital Pharmacists both provide guidelines for the delegation of tasks to pharmacy technicians.

Pharmacists are professionally responsible for pharmacy support personnel, and must ensure support staff is trained. Ontario and Alberta both have voluntary certification programs developed by their provincial regulatory organizations for pharmacists.

The College of Pharmacists of British Columbia released a document discussing pharmacy technicians in March of 2006 (White Paper on Pharmacy Technicians, 2006). This paper describes how due to an evolution of pharmacy practice pharmacist’s are becoming increasingly dependant on technicians. Pharmacists are taking more of a clinically active role utilizing their cognitive skills, thus their time is being taken away from more technical functions. The paper describes how the use of technicians “will allow pharmacists to practice to the full extent of their skill and knowledge and provide the public with greater access to this service” (White Paper, 2006). Due to these factors, this pharmacy task force recommends the creation of a new class of licensure for pharmacy technicians to be established by the College of Pharmacists of British Columbia.

The task force feels that through regulation pharmacy technicians can be disciplined in the event of misconduct, education and training can be standardized, and their roles and functions can be more clearly defined.

Dentistry

The College of Dental Surgeons of BC has regulated the certified dental assistant (CDA) occupation since 1971. The College is responsible for the registration and licensing of CDA's in BC, and investigating and disciplining registrants when necessary. The College has established educational standards for entry to the CDA occupation, and has standards in place to ensure continuing competency. In order to be eligible for registration and licensure in BC, the College of Dental Surgeons requires new dental assistant applicants to write a national exam, undergo a national clinical practice evaluation, and take a provincial clinical examination.

Professional Associations and Regulatory College Initiatives - Conclusion

The national professional associations for OT, PT, and SLP all have membership categories available for rehabilitation assistants. The appropriate use of support personnel to increase access to service and enhance patient care is supported by the three associations, and guidelines for working with rehabilitation assistants are provided. Supervision guidelines provided by the three national associations rely to a great extent on the professional judgment of the supervising OT, PT, or SLP. All three sets of guidelines recommend the supervising therapist must be available to consult with at all times, with the PT guidelines stating phone or pager contact a minimum when using indirect supervision. When discussing tasks and activities that are NOT to be assigned to support personnel all three sets of national guidelines indicated conducting evaluations, interpreting assessment findings, intervention planning and discharge planning are not to be performed by assistants. The PT and SLP guidelines also clearly state that discussion of treatment rationale or the counseling of patients and their families are not to be performed by support personnel.

The OT and PT documents state interventions requiring continuous clinical judgment should not be assigned to therapy assistants, and the SLP guidelines specify demonstrating swallowing strategies or screening for swallowing disorders are not to be performed by support personnel. In addition, the national PT guidelines state that therapists must not assign any task that the support worker has not been observed by a physiotherapist to be able to competently perform. National SLP guidelines state support personnel working with SLP's shall meet national membership requirements, and must abide by the Code of Ethics for support personnel developed by CASLPA.

Provincially, OT and PT practice is directed by their respective provincial regulatory bodies, the CPTBC and COTBC. Both organizations have guidelines for assigning tasks to support personnel that have a few key additions to their national guidelines. OT's are not to assign the administration of standardized diagnostic tests, or the personal counseling of patients and their families. PT's are not to assign the performance of assessment or evaluative procedures, or electrotherapy (except for TNS and NMES). An interesting addition to the provincial OT guidelines is the statement "the Occupational Therapist is to include consideration of the cost efficiency of service provision in addition to outcomes and service satisfaction" when assessing assigned tasks. The SLP profession is represented provincially by the BCASLPA, and is soon to have a provincial regulatory college licensing SLP's. The BCASLPA also has a few key additions to the national guidelines. SLP's in BC are not to assign to support personnel the performance of standardized or non-standardized tests, or conduct speech/language screening procedures.

The United States national bodies representing OT, PT, and SLP also have guidelines regarding the use of support personnel. Common themes with the Canadian national association OT and PT guidelines are that support personnel are not to interpret referrals, conduct evaluations, or perform intervention planning. The American SLP guidelines share with the BCASLPA guidelines that the performance of standardized or non-standardized diagnostic tests is not to be assigned to support personnel. However, some key differences exist in supervision guidelines.

The American Physical Therapy Association states that once a month a supervisory visit must be performed by the therapist, and the national SLP guidelines suggest at least 30% direct supervision should be provided weekly during the first 90 workdays of SLP support personnel. OTA's, PTA's, and SLPA's are all regulated in the majority of the United States through licensure, registration, or certification.

Other healthcare professions in Canada also utilize support personnel. The BC College of Pharmacists has just recently recommended creating a new class of licensure for pharmacy technicians in an effort to standardize training and education, clearly define roles and functions, and aid in discipline due to misconduct.

Component #3 – Stakeholder Discussion

Participants

This component of the project discussed the use of rehabilitation assistants in pediatric settings with the various stakeholders involved in the process. Potential benefits, concerns, and barriers to the use of assistants were investigated as well as any other topics the stakeholders wished to add to the dialogue. Representatives from the following stakeholders were interviewed for this component of the investigation:

- Provincial Government Ministries involved in pediatric rehabilitation delivery
- Regional Ministry of Child and Family Development offices
- Community Living Services BC
- Agencies employing pediatric therapists
- Pediatric therapists from OT, PT, SLP
- Rural and remote community therapy providers
- Acute care, community care, and School District services
- Child Development Center management and therapists
- IDP program
- Educational Institutions offering RA programs
- Professional Associations and Regulatory Bodies for OT, PT, SLP
- Professionals/Individuals involved in therapy service delivery to Aboriginal Communities
- Families accessing therapy services
- Rehabilitation Assistants

Method

The majority of information was gathered via 25 phone interviews with various stakeholders. In addition, a focus group was carried out to see if any additional trends or themes emerged when multiple stakeholders participated in a group discussion on the use of rehabilitation assistants. The focus group was comprised of 8 participants:

- Acute care physiotherapy department manager
- Instructor from rehabilitation assistant education program
- Physical Therapy department manager of a Child Development Center

- Program Manager of a Child Development Center
- Occupational Therapist from a Child Development Center
- Speech-Language Pathologist from a Child Development Center
- PT/OT combined trained therapist from School District Therapy Services
- Physiotherapist from Child Development Center

Of note is the fact the SLP participating in the focus group was initially trained and practiced as a Speech-Language Pathologist Assistant prior to continuing her education and becoming a SLP. Thus, she was able to provide input from an assistant's perspective as well.

Information for this component of the project was also gathered from a regional therapists meeting in the north of the province that included 12 pediatric therapists of various practice settings participating in a discussion of the use of support personnel.

Analysis

Data was analyzed using the ten steps to content analysis outlined by Handcock (1998). In content analysis, the researcher searches for codes, themes and patterned regularities in the transcript and makes inferences on the basis of these regularities (Myers, 1997).

Results – Potential Advantages/Benefits

Increased Access to Services

Increased access to services was by far the most stated benefit of utilizing rehabilitation assistants in pediatric settings. Therapists who had experience with the use of support personnel reported being able to manage a larger caseload. Other stakeholders were optimistic of the potential for rehabilitation assistants to help service providers more effectively cope with the lengthy waitlists for therapy services. There was discussion of the potential to provide increased access to services through group therapy via the utilization of assistants. It was described how the support personnel could do much of the preparation and logistics behind setting up group therapy programs since therapists simply don't have the time to perform such tasks.

Therapists could then assess potential group therapy candidates to ensure appropriateness, and also devise and develop the activities and tasks the program would entail. This could possibly be an effective method of providing a level of service to children with ‘milder’ developmental delays as it was described how excessive waitlists require therapists to prioritize services to children who have ‘higher needs’, and that kids with ‘milder’ developmental delays generally do not receive a great deal of service.

More Appropriate Use of Therapist’s Skill Level

Another potential benefit of rehabilitation assistants in pediatric settings is the more effective use of the higher level skills of therapists. Discussion in this area described how the use of assistants would free up time for therapists to focus on higher level tasks such as assessment and intervention planning, and to provide service to clients with ‘higher level’ developmental delays. It was felt that more routine tasks such as equipment set-up and preparation, appointment booking, and tracking funding sources could be accomplished by rehabilitation assistants, and that it was not a good use of financial resources to have therapists perform such tasks. This theme was expressed mainly by stakeholders in a management role, but was also mentioned by representatives from professional regulatory bodies, the Ministry of Child and Family Development, and educational institutions.

Cost-Effectiveness

Paying rehabilitation assistants for the performance of routine tasks instead of therapists would obviously be a more cost-effective use of resources as it would likely allow therapists to manage larger caseloads. Also, stakeholders from agencies providing therapy services to remote and rural communities expressed concern that a great deal of their budget for therapy services is spent on travel time, and that the appropriate use of rehabilitation assistants would likely allow more of their dollars to go towards intervention. This could be accomplished by having a therapist visit the community to assess and develop intervention plans, and then appropriately transfer functions to rehabilitation assistants living in that particular community.

Results – Concerns/Barriers to Use of Rehabilitation Assistants

Barriers – Lack of Knowledge Regarding how to Utilize

The utilization of rehabilitation assistants is still a relatively new concept to many stakeholders involved in the delivery of pediatric services, thus one of the barriers to their use is a lack of knowledge regarding what skills and tasks rehabilitation assistants can perform. Few of the stakeholders interviewed, particularly the therapists, had significant knowledge regarding the scope of practice for rehabilitation assistants. The regulatory body for Occupational Therapists indicated that inquiries concerning the use of assistants are the most frequent questions therapists ask the College. Rehabilitation assistants described how this lack of knowledge results in the inconsistent utilization of assistants amongst therapists, and often the rehabilitation assistants feel they are not always employed to their full abilities.

Barriers – Funding

More than one executive director of a child development center expressed concern regarding the wording of their contracts with their funding sources. They felt the wording did not allow for the use of rehabilitation assistants in the delivery of therapy services, thus seriously limiting a Center's ability to utilize therapy support personnel. Also, monies received by public agencies are 'earmarked' to be spent on specific professions. For example, funding will arrive at a Center specified to be for 'Occupational Therapy'. If the assistant is being utilized by multiple professions (i.e. – PT, OT, SLP), this would create a difficult situation for a manager to appropriately and fairly use the funding from the specific therapies to pay for the use of the assistant. Ministry representatives did acknowledge this lack of flexibility, and indicated that a process has been initiated looking into a different funding model allowing for greater community flexibility. Some Ministry of Child and Family Development contracts in the north have been modified to more easily incorporate the use of assistants.

Therapists also identified a lack of flexibility in funding made available through the School Aged Extended Therapies benefit, a component of the Ministry of Children and Family Development's At Home Program that provides funding to private practitioners to deliver OT, PT, SLP, chiropractic and massage services to school-aged children. To access this benefit, a therapist completes a request form on behalf of a child eligible for the At Home Program that indicates the intervention plan and functional outcomes intended as a result of the treatment. At this time, the School-Aged Extended Therapies benefit only applies to qualified professional therapists or practitioners and does not include 'assistants' working under the supervision of a therapist.

Additional Barriers

Remote and rural community stakeholders discussed how an additional barrier for them is the lack of access to the therapy professions. The recruitment and retention issues they face combined with the fragmented therapy position allotment (i.e. – 0.2 FTE positions) in rural areas would likely make it difficult to find therapists to meet support personnel supervision requirements.

Another barrier described by many therapists in child development centers is the shift to a consultative service delivery model due to large caseloads, long waitlists, and scarce resources. This consultative model results in primarily assessment and intervention planning, tasks that are not within the scope of practice of rehabilitation assistants and that must be carried out by the therapist. Intervention activities or tasks are instructed to the caregiver, and then a re-assessment is performed during a follow-up visit often several weeks later. The majority of therapists in such a situation had difficulty envisioning how a rehabilitation assistant could be effectively put to use in this type of practice setting.

Concerns – Education Levels

A concern expressed by many of the stakeholders was the level of education of rehabilitation assistants. Fortunately PT/OT assistant training programs in BC are well established, in fact, the Therapist Assistant program at Okanagan College graduated the first group of rehabilitation assistants in Canada in 1991.

The recent increase in curriculum to a two year Diploma program by all training programs in BC has further enhanced the scope of knowledge rehabilitation assistants acquire during their education. In addition, there is the Canadian Occupational Therapy Assistant and Physical Therapy Assistant Educators Council (COPEC, 2004) created to “develop, maintain and enhance the formal education for Therapist Assistants.” This council is comprised of physiotherapists and occupational therapists from various publicly funded Therapist Assistant education programs across Canada, and has several roles including assisting in developing standards in Therapist Assistant education. Consequently, educating therapists on the evolution of assistant programs and the implementation of COPEC should help to alleviate many of the concerns regarding the quality of education PTA’s and OTA’s are receiving.

SLPA programs in BC are unfortunately not as well established. There are currently no programs offering SLPA training exclusively, and the only program offering a SLPA component is the Therapist Assistant Diploma program at Capilano College. I was unable to locate any evidence of a Council or other body working on developing standards for SLPA education. I would recommend working with the BCASLPA and CASLPA to ensure support personnel education standards are established. Then existing programs such as the one at Capilano College, and any new programs developed in BC would have guidelines to help develop their curriculum to standards that would appease the concerns of stakeholders.

Concerns – Inappropriate Use

Several stakeholders expressed concern over the possible inappropriate use of support personnel. There were two potential scenarios of particular concern described. First, a situation where a therapist responsible for supervising an assistant has to leave their position due to a move, illness, maternity leave, etc. Some stakeholders were worried an employer might be tempted to allow the assistant to continue to practice, particularly if they are in a rural setting where recruitment and retention is an issue. The second situation is where an agency is not able to hire a therapist but does have access to a rehabilitation assistant.

Stakeholders were concerned in this situation the agency may be tempted to allow the assistant to provide services without appropriate assessment and intervention planning by a therapist, and without supervision.

A number of stakeholders also mentioned they felt supervision ratios were important to ensure adequate supervision could be provided by one therapist if they were responsible for multiple assistants.

Concerns – Therapists

The therapist stakeholder group was well represented by all professions (OT, PT, SLP), and a variety of practice settings (rural, urban, acute care, community care, child development center, school district). Several concerns emerged specifically from this stakeholder group. Fears over the initial increase in time required for the training and supervision planning of rehabilitation assistants were articulated by several therapists. Many felt their time was already stretched to the limit, and couldn't imagine finding extra time in their day to devote to such tasks. However, several therapists who had experience working with assistants did indicate this initial extra time paid dividends in the long term as many stated they couldn't imagine now working without an assistant.

There was concern over the increased distance the assistant would place between the therapist and client. It would be the rehabilitation assistant who would have the majority of "face-to-face" time with the client and their family, thus having more of an opportunity to communicate and establish a good relationship. Therapists expressed apprehension at allowing rehabilitation assistants to do the majority of patient/family education, and responding to family queries regarding prognosis and treatment goals. Fortunately, the professional associations and licensing bodies for PT, OT, and SLP provide clear guidelines for therapists to follow regarding this issue. The British Columbia Association of Speech-Language Pathologists and Audiologists states in its guidelines for the use of support personnel that an assistant may NOT "provide patient/client counseling", or "communicate with the patient/client/student, family or others regarding any aspect of the patient's/client's/student's status or service without the specific consent of the supervising SLP.

The College of Physical Therapists of British Columbia practice standard on the assignment of task to a physical therapist support worker states “discussion of physical therapy diagnosis or prognosis or treatment rationale with anyone other than the physical therapist” must NOT be assigned. Finally, the College of Occupational Therapists of British Columbia practice guidelines on the assigning of service components to unregulated support personnel states “personal counseling of clients, parents, primary caregivers, spouses, and significant others” is NOT to be assigned.

There was also concern that some conditions or complex issues a child may demonstrate are often difficult to notice unless substantial time is being spent with the child by the therapist. The use of an assistant in such cases may result in some complex issues being overlooked.

Many therapists also remarked how they feared the utilization of assistants would result in a decrease in the “hands-on” treatment time delivered by the therapists. Therapists expressed concern that the years of continuing education and experience that have honed their practical skills would be put to waste if they were to transfer function to assistants. However, higher-needs children requiring intervention of a high skill level would still require that any “hands-on” treatment be delivered by a therapist due to their ability to utilize continuous clinical judgment. In fact, it is possible that the use of an assistant to perform many of the routine tasks currently occupying a therapist’s time could actually provide more time for a therapist to perform direct intervention on higher needs children.

Another concern stated by several therapists was the lack of a code of ethics or licensing of rehabilitation assistants, and concern over a shared scope of practice. There certainly is discussion by the PT and OT Colleges regarding the licensing of support personnel in British Columbia, but as of this time there are no plans to do so. The British Columbia Association of Speech-Language Pathologists and Audiologists is set to establish a College to regulate SLP’s in 2007, and does not have any plans to license assistants at this time.

Finally, some therapists were familiar with College guidelines regarding the use of rehabilitation assistants and how the PT and OT Colleges stated tasks or activities requiring “continuous clinical judgment” should not be transferred to support personnel. Therapists indicated that they felt this statement was so subjective in nature that it was difficult to define in practice. Many felt that they utilize their clinical judgment skills throughout direct therapy with a child, and thus according to the College guidelines would not be able to transfer any direct therapy to rehabilitation assistants.

Concerns – Aboriginal Communities

Representatives of aboriginal communities are optimistic for the potential of rehabilitation assistants to improve the availability of services to their communities; however, they reported a few key barriers/concerns currently affecting their utilization. One of the largest gaps in service is in the area of speech, and a recent survey of aboriginal schools revealed service frequency was decreasing in this area, and that children who did get assessed often “aged-out” so that they no longer qualified for services before receiving any ongoing therapy. Stakeholders from these communities stated barriers to improve service in this area are the lack of training programs for Speech-Language Pathology Assistants, and the expense of contracting Speech-Language Pathologists to travel to remote areas to provide assessment. It was also felt that current assistant education programs were not developed for rural and remote practice, and were more urban/agency specific.

Aboriginal community stakeholders were also concerned that the certification or licensing of rehabilitation assistants would decrease the ability of their communities to train their own workers as assistants. This would make it even more difficult to provide therapy services to their communities.

Stakeholder Discussion Conclusion

Despite the variation in roles and practice settings of the stakeholders participating in this project there were definite themes that emerged from the discussion. There is little question all stakeholders felt that increased access to services is a potential benefit of the utilization of rehabilitation assistants. The majority of representatives from a managerial role expressed the use of assistants would allow the provision of services in a cost-effective manner. Another common theme emerging from the dialogue was that the use of rehabilitation assistants would allow therapists to more effectively utilize their higher skill level, and remove them from performing some of the more routine tasks associated with the delivery of rehabilitation services. It could be argued that this latter benefit may increase in importance due to the evolution of PT/OT training to a Master's level. The Master's trained therapists will likely be most satisfied in settings where they are able to maximize the use of their critical thinking skills, and would be uninspired performing mundane tasks. The use of rehabilitation assistants may help to provide a stimulating environment for Master's trained professionals, a vital consideration in the ongoing effort to improve retention and recruitment of therapists in pediatric settings. Interestingly, much of the current use of rehabilitation assistants in pediatrics is in the area of Speech-Language Pathology where all professionals are already at a Master's trained level.

There are several barriers and concerns that arose from the discussions with stakeholders in the delivery of pediatric rehabilitation services. A discussion of potential solutions for many of these obstacles occurs in the recommendations portion of this report and in Table A on the following page. Many of these difficulties involve multiple stakeholders, and can only be overcome through increased communication and cooperation amongst the people and levels of government involved in pediatric rehabilitation. All stakeholders expressed the desire to improve access to services, thus there is optimism sufficient collaboration can be achieved to initiate several strategies to address many of these barriers and concerns.

Table A – Possible Solutions to Barriers/Concerns

Barrier/Concern	Potential Solution
Funding	<ul style="list-style-type: none"> - Continue to work with the MCFD in developing funding strategies that allow agencies flexibility as to how they utilize resources. - Negotiate contracts to allow the use of support personnel in the delivery of therapy services. - Lobby other possible funding sources (i.e. – CLBC, Ministry of Health) to allow the appropriate use of support personnel in the delivery of pediatric therapy services
Remote Communities and Fragmented FTE Positions (i.e. – 0.2 FTE)	<ul style="list-style-type: none"> - Rehabilitation Assistants are trained in multiple areas of practice (i.e. – PT and OT), therefore it is possible for different professions to utilize the same assistant. Thus two professionals with partial FTE’s could utilize one assistant to offer greater service delivery and access. - Different agencies with limited resources in remote communities could also cooperate and utilize the same assistant. - This would allow therapists and agencies with limited time (i.e.- 0.2 FTE’s) to ‘combine forces’ and employ a rehabilitation assistant to a greater FTE. This would increase the likelihood of recruiting rehabilitation assistants to remote positions. - Lobby funding sources for more ‘needs-based’ funding as opposed to ‘population-based’ funding. The hope here is to decrease the amount of fragmented therapist FTE positions in centers with small populations, but a high need for pediatric services. ‘Needs-based’ funding in such situations should provide for larger FTE positions.
Inappropriate Utilization	<ul style="list-style-type: none"> - Ensure agencies employing rehabilitation assistants have disciplinary measures in place for inappropriate scope of practice and inadequate supervision planning. - Recommend funding sources take action such as canceling contracts with agencies that demonstrate inappropriate use of rehabilitation assistants.

Component #4 – Table of Existing Rehabilitation Assistant Programs in BC

	Vancouver Community College	Capilano College	Okanagan College
Number of students per year	20	20	36
Type of Program	2 year diploma OTA,PTA	2 year diploma OTA,SLPA,PTA	2 year diploma OTA,PTA, Rec. Therapy
Admission Requirements	<ul style="list-style-type: none"> ▪ gr. 12, GED or equivalent ▪ Bi 12, Ma 11, Eng 12 ▪ 30 hrs paid or volunteer experience working with people with disabilities 	<ul style="list-style-type: none"> ▪ gr. 12 or GED ▪ Eng 12, one Science 12 ▪ 50 hours paid or volunteer experience 	<ul style="list-style-type: none"> ▪ gr. 12 or GED ▪ Eng 12, Chem 11, Bi 11 ▪ at least one of Bi 12, Chem 12 or Phys 12
Number of Courses	23	24	22
Examples of Courses	<ul style="list-style-type: none"> ▪ Clinical Kinesiology ▪ Growth & Development ▪ Rehabilitation Skills 	<ul style="list-style-type: none"> ▪ Disease, injury & intervention ▪ Audiology Theory & Skills ▪ Neurology Theory & Skills 	<ul style="list-style-type: none"> ▪ Disease & Disability ▪ Functional Neurology through the Life Span ▪ PTA Principles & Practice
Number of Credits	70	63	78
Weeks of Practicum	17	15	16
Approx. hours of pediatric contact	24	30	60
Instructors with clinical Pediatric Experience?	Yes	Yes	Yes

The four therapy assistant education programs in BC are all 2 year Diploma programs, and students successfully completing a program receive the designation of 'Therapy' or 'Rehabilitation Assistant.' Entry requirements are in general comparable, as are types of courses offered. All programs appear to teach from a lifespan perspective, thus address pediatric issues throughout their curriculum. Okanagan College, VCC, and Capilano all have instructors with clinical pediatric experience. The Okanagan College program is well established, and this is reflected in the number of students and applicants as compared to the newer programs at VCC and Capilano. Okanagan College receives around 100 applicants a year, Capilano about 30, and VCC is currently undersubscribed. The Malaspina program is due to begin in September 2007.

Okanagan College reports the highest number of hours of pediatric curriculum, and VCC and Capilano are each in development of their own pediatric specific course. Practicum requirements vary from approximately 12 weeks at Malaspina to 17 weeks at VCC.

The only program to offer a Speech-Language Pathologist Assistant component is the Capilano program. A part-time SLPA program offered through the University College of the Fraser Valley has not operated for several years.

Component #5 – Recommendations and Considerations

This project has employed diverse methods to gain knowledge of the current utilization of rehabilitation assistants in pediatric settings in BC. In addition the literature review has provided evidence of the potential for increased access for families requiring therapy services, and the cost-effectiveness for funding sources providing such services. Rehabilitation Assistant programs in BC have recently increased their program curriculums to a two year Diploma, thus allowing for more thorough training and knowledge development. Such factors position rehabilitation assistants to be a valuable asset to the provision of pediatric therapy services in BC provided stakeholder concerns are addressed.

Perhaps the most important stakeholder to reassure concerns regarding the use of rehabilitation assistants in pediatrics are being addressed is the pediatric therapist. These professionals have dedicated their professional careers to improving the quality of life for children with disabilities, and the extensive knowledge and skill levels of therapists are exceptional. Further, rehabilitation assistants simply have no role without a therapist present to provide one. A strong and confident working relationship between therapist and rehabilitation assistant is vital for the effective delivery of therapy services using support personnel. Fortunately the guidelines provided by professional Colleges and Associations, the literature on the use of support personnel in pediatrics, the enhanced rehabilitation assistant education programs, and the following recommendations and considerations provided in this project should alleviate the majority of concerns expressed by the therapist stakeholder group.

Recommendation #1: Require therapy assistants to join the support personnel membership category of a provincial professional association

CASLPA's guidelines on the delegation of tasks to support personnel discusses how supportive personnel working with SLP's or Audiologists shall meet national membership requirements (the CASLPA has an associate member category), and must abide by the Code of Ethics for Supportive Personnel developed by the CASLPA.

Each member is subject to disciplinary review as outlined by CASLPA policies. The requirement to join a respective professional association should be extended to rehabilitation assistants working in OT or PT as well, as this could address the concern regarding a lack of a code of ethics for therapy assistants that was expressed during the stakeholder discussion. It will also provide a method for the pediatric community to monitor the utilization of assistants in pediatrics and gather data such as the types of work environments they are being employed in, the professions most commonly utilizing assistants, and supervision ratios in use.

The three professions of PT, OT, and SLP work together more in pediatrics than perhaps any other healthcare sector; thus, a rehabilitation assistant in such a situation would likely be used by more than one profession. This raises the issue of what professional body should the rehabilitation assistant be registered under if the assistant will be working under the supervision of multiple professions. A potential solution would be for an assistant to join the association of the profession they are most commonly utilized by. Associate members would be required to adhere to the code of ethics developed by the corresponding professional association. Rehabilitation assistants who violate a code of ethics could be punished by being removed from the association, and employers and agencies could be encouraged to hire only rehabilitation assistants with an associate category membership. This process would serve to gather vital information regarding the use of rehabilitation assistants, and provide a method of penalizing assistants that do not follow ethical practice guidelines.

Recommendation #2: Set supervision guidelines in pediatrics that stipulate a therapist may supervise a maximum of 2 therapy assistants at once, and must perform a re-evaluation of their clients being followed by TA's every 3 months

The COTBC, CPTBC, and BCASLPA respect the autonomy of professionals by allowing the use of professional judgment to set appropriate supervision levels; however, inappropriate use of support personnel is an area several stakeholders, particularly therapists, expressed concern.

Developing more concrete guidelines in this area would serve to ease many of the apprehensions stakeholders have in the use of support personnel, and this could be done in a way that doesn't significantly restrict rehabilitation assistant use. As discussed in Component #2, several provinces have guidelines that provide figures regarding minimum supervision of support personnel:

- The ACSLPA states a minimum of 10% of client contacts be directly supervised
- The CASLPO suggests SLP's are not to supervise more than 2 or 3 assistants
- The NBAOT recommends face-to-face contact between supervising OT and support personnel occur never less than once per month
- The NLCPT advises a minimum of 7.5 hours of direct supervision a month, and the chronic, stable patient be re-evaluated by the supervising therapist a minimum of every 3 months

The COTBC, CPTBC, and BCASLPA could use such examples to set more concrete guidelines that satisfy the concerns of stakeholders, yet do not inhibit the use of support personnel. For example, a pediatric therapist should not supervise more than 2 assistants at one time. This figure is only a guideline and in acute situations should be even lower; however, in many rural and remote situations dealing with stable patients this figure should allow for effective therapy service delivery without overburdening a therapist. Another suggestion for more concrete guidelines would be that clients should be re-evaluated a minimum of every 3 months. Since children are continuously growing and developing it is imperative to have a set guideline in this area to ensure intervention goals are being updated in an appropriate timeframe. The three month figure still allows for ample time to access children in rural and remote settings.

Other strategies to help decrease the potential for inappropriate utilization have been previously described in Table A on page 57.

**Recommendation #3: Establish tasks and activities specific to
pediatrics in accordance with regulatory body
guidelines**

The College of Occupational Therapists of BC (COTBC), the College of Physical Therapists of BC (CPTBC), and the BC Association of Speech-Language Pathologists and Audiologists (BCASLPA) each have their own set of guidelines regarding the use of support personnel. Due to the potential in pediatrics for rehabilitation assistants to work with all three professions, it would facilitate their use amongst the professions if each set of provincial College/Association guidelines were comparable regarding activities and tasks that can and can not be assigned to support personnel.

The CPTBC and COTBC documents discuss the steps in assigning tasks to support personnel more thoroughly than the BCASLPA. Discussions with the BCASLPA should occur to have them include in their document therapist responsibilities such as:

- establishing informed consent
- explaining the roles of therapist and assistant to the client
- ensuring assistant competence in the task to be assigned
- determining appropriate supervision levels by considering:
 - practice setting, patient acuity, complexity of task and environment, degree of clinical judgment and decision making required, level of risk, patient preference

Tasks or activities that can and can not be assigned to support personnel are in general quite similar among the three professions; however, several guidelines are subject to interpretation. For example, CPTBC guidelines denote assessment or evaluative procedures are not to be assigned to support personnel. Developing an inventory of pediatric specific tasks and activities that could potentially be assigned to support personnel should be developed, and this inventory could then be reviewed by the professional regulatory bodies. This would help to decrease the ambiguity some pediatric therapists experience when deciding whether a task is assignable.

Recommendation #4: Develop a document and workshop/teleconference on strategies to effectively incorporate rehabilitation assistants in pediatric rehabilitation

It would be valuable to provide therapists with concrete examples of how some agencies are successfully using assistants. One of the benefits of the focus group and the discussion that took place at the northern therapist's regional meeting was the positive effect of therapists who had no experience working with assistants listening to the experiences of therapists who currently utilize assistants. This helped to alleviate many of the fears and concerns of therapists with no experience using support personnel.

Performing a series of workshops or teleconferences on the topic of rehabilitation assistant use in pediatrics would provide an opportunity for therapists across the province to gain knowledge regarding how to effectively and safely utilize support personnel, addressing the lack of knowledge identified by stakeholders as a barrier to therapy assistant use. Workshops could also provide strategies decreasing the initial set-up time required by agencies in implementing support personnel, another stakeholder identified barrier. In addition, current models in use that have demonstrated success could be shared with other agencies.

Recommendation #5: Develop strategies with Aboriginal Communities to support the use of rehabilitation assistants

The use of rehabilitation assistants has the potential to significantly enhance therapy services to marginalized populations such as aboriginals. The remoteness of many aboriginal communities presents a significant obstacle to therapy services, and assessment and intervention planning by therapists occurs on a very limited basis. The use of rehabilitation assistants in remote areas would provide a cost-effective method to ensure therapist recommendations are being followed, and provide increased access to services. In addition, developing strategies with aboriginal communities should include the recruitment of community members to pursue a career as a rehabilitation assistant. Rehabilitation Assistant programs in the province often have seats reserved for aboriginal students that meet the entry requirements of the program. Assistant programs are more accessible than therapist programs for marginalized populations, and provide an opportunity for aboriginals to acquire the training they need to enhance services in their own communities.

Recommendation #6: Strengthen communication and collaboration between BC therapy assistant education programs and agencies delivering pediatric rehabilitation services

These two groups would certainly benefit from increased collaboration. Therapy assistant education programs in BC struggle to find agencies to provide pediatric clinical placements for their students. In addition, several stakeholders expressed concern over their own lack of knowledge regarding the pediatric content in therapy assistant curriculum, and whether assistants were being taught strategies for rural, remote, and marginalized populations. The other common complaint from stakeholders was the lack of Speech-Language Pathologist Assistant programs. A liaison to facilitate ongoing communication between pediatric agencies and therapy assistant education programs could serve to solve many of the concerns expressed by stakeholders.

References

- Alberta College of Occupational Therapists (2005) *Guidelines for the Assignment/Delegation of Occupational Therapy Services to Support Personnel*. Retrieved October 25, 2006 from http://www.acot.ca/pages/college_documents
- Alberta College of Speech-Language Pathologists and Audiologists (2006) *Speech-Language Pathologists' Use of Support Personnel to Augment Speech-Language Pathology Service Delivery*. ACSLPA
- American Occupational Therapy Association (1999) *Guidelines for Supervision, Roles, and Responsibilities during the Delivery of Occupational Therapy Services*. AOTA
- American Occupational Therapy Association (1999) Standards for an Accredited Educational Program for the Occupational Therapy Assistant. *The American Journal of Occupational Therapy* Nov-Dec; Vol. 53 (6), pp. 583-9
- American Physical Therapy Association (n.d.) Retrieved September 22, 2006 from http://www.apta.org/AM/Template.cfm?Section=Ethics_and_Legal_Issues1&CONTENTID=23731&TEMPLATE=/CM/ContentDisplay.cfm
- Association of Canadian Occupational Therapy Regulatory Organizations (2003). *The Essential Competencies of Practice for Occupational Therapists in Canada*. Retrieved November 3, 2006 from <http://www.cotns.ca/files/EssentialCo.pdf>
- American Speech-Language Hearing Association (2004) *Guidelines for the Training, Use, and Supervision of Speech-Language Pathology Assistants*. Retrieved October 10, 2006 from <http://www.asha.org/members/deskref-journals/deskref/default>
- BCASLPA (2001) *Guidelines for the Use of Supportive Personnel* British Columbia Association of Speech-Language Pathologists and Audiologists
- Canadian Alliance of Physiotherapy Regulators (2004) *Guidelines on the Role and Utilization of Physical Therapist Support Workers in Physical Therapy Practice in Canada*. Retrieved September 22, 2006 from http://www.alliancept.org/alliance_resources.shtml
- Canadian Alliance of Physiotherapy Regulators (2003) *Options for the Regulation of Support Personnel*. Retrieved September 12, 2006 from http://www.alliancept.org/alliance_resources.shtml

- Canadian Association of Occupational Therapists (2003) *Guidelines for the Supervision of Assigned Occupational Therapy Service Components*. Retrieved October 11, 2006 from <http://www.caot.ca/default.asp?pageid=579>
- Canadian Association of Speech-Language Pathologists and Audiologists (2004) *Supportive Personnel Guidelines: Working with Speech Language Pathologists*
CASLPA
- Canadian Association of Speech-Language Pathologists and Audiologists (2005) *Code of Ethics: Delegation*. Retrieved November 1, 2006 from <http://www.caslpa.ca/english/resources/ethics.asp>
- Canadian Physiotherapy Association (1989) *Code of Ethics: Rules of Conduct –Responsibility to the Client*. Retrieved November 2, 2006 from <http://www.physiotherapy.ca/public.asp?WCE=C=47|K=222829>
- CAOT (2003) *Project Summary Report: Profile of Performance Expectations for Canadian Support Personnel in Occupational Therapy*. Retrieved October 10, 2006 from <http://www.caot.ca/pdfs/Project%20Summary%20Report.pdf>
- College of Audiologists and Speech-Language Pathologists of Ontario (n.d.). *Supportive Personnel*. Retrieved November 2, 2006 from http://www.caslpo.com/english_site/m_mempositsupp.asp
- College of Occupational Therapists of British Columbia (2004) *Assigning of Service Components to Unregulated Support Personnel*. Retrieved September 10, 2006 from <http://www.cotbc.org/resources.php>
- College of Occupational Therapists of Manitoba (2006) *Practice Guideline: Assignment and Supervision in Occupational Therapy Practice*. COTM
- College of Occupational Therapists of Nova Scotia (2005) *Practice Guideline: Occupational Therapy Support Personnel*. COTNS
- College of Occupational Therapists of Ontario (2004) *Practice Guideline: Support Personnel* Retrieved October 20, 2006 from http://www.coto.org/pages/resource/res_room_college_docs.html
- College of Pharmacists of British Columbia (2006) *White Paper on Pharmacy Technicians*. Retrieved October 12, 2006 from <http://www.bcpharmacists.org/resources/projects/>

- College of Physical Therapists of British Columbia (2006) *Practice Standard: Assignment of Task to a Physical Therapist Support Worker* CPTBC
- College of Physiotherapists of Manitoba (2001) *Physiotherapists Assigning Physiotherapy Care (Support Personnel)*.
- College of Physical Therapists of New Brunswick (1985) *CPTNB Regulations*. Retrieved October 31, 2006 from <http://www.cptnb.ca/regulationsE.html>
- COPEC (2004) *Objectives*. Retrieved December 18, 2006 from <http://72.14.253.104/search?q=cache:2TKZIZJdtHkJ:www.caot.ca/pdfs/TERMS-COPEC.pdf+copec+site:.ca&hl=en&gl=ca&ct=clnk&cd=2>
- Heck, C., Paulenko, T., Apostolatos et al. (2001) A Comparison of Tasks Physiotherapist Assistants Report Performing and Physiotherapists Report Assigning: A Survey of Current Practice in Ontario. *Physiotherapy Canada* Vol. 53(2), pp. 121-35
- Loomis, J., Hagler, P., Forward et al. (1997) Current Utilization of Physical Therapist Support Personnel. *Physiotherapy Canada*. Vol. 49(4), pp. 284-91
- Loomis, J., Hagler, P., Forward et al. (1998) Future Utilization of Physical Therapist Support Personnel. *Physiotherapy Canada* Vol. 50(1), pp. 17-24
- Lyons, K. (2001) The Clinical Reasoning of an Occupational Therapy Assistant. *The American Journal of Occupational Therapy* Vol. 55(5), pp. 577-81
- Manitoba Speech and Hearing Association (n.d.) *Guidelines for the Use of Support Personnel in Speech-Language Pathology*. Retrieved October 30, 2006 from http://www.msha.ca/public_about.html#professional
- McCartney, Boyle, Bannatyne, et al (2005) 'Thinking for two': a case study of speech and language therapists working through assistants. *International Journal of Language & Communication Disorders*. Apr-Jun; Vol. 40 (2), pp. 221-35
- New Brunswick Association of Occupational Therapists (2002) *Position Statement: Occupational Therapist Support Personnel*. Retrieved October 18, 2006 from <http://www.nbaot.org/SupportPersonnel.doc>
- New, E (1998) An effective model for a speech and language therapy service in mainstream schools. *International Journal of Language & Communication Disorders*. Vol. 33 Suppl, pp. 602-7
- Nova Scotia College of Physiotherapists (2005) *Support Personnel*.

- Pullenayegum, S., Fielding, B., DuPlessis et al. (2005) The Value of the Role of the Rehabilitation Assistant. *British Journal of Nursing*. Vol. 14, No. 14, pp. 778-84
- Russel, K. (1998) Use of Aides in Occupational Therapy Practice. *The American Journal of Occupational Therapy* Vol. 52(2), pp. 118-24
- Salvatori, P. (2001) The History of Occupational Therapy Assistants in Canada: A Comparison with the United States. *The Canadian Journal of Occupational Therapy*. Vol. 68, 4. pp. 217-27
- Saskatchewan Association of Speech-Language Pathologists and Audiologists (n.d.) *Guidelines for Supportive Personnel: SLP Assistant*. Retrieved October 25, 2006 from http://www.saslpa.ca/guidelines_sp.html
- Saskatchewan College of Physical Therapists (n.d.) *Position Statement: Direct Care Physiotherapist Support Workers in Saskatchewan*
- Saskatchewan Society of Occupational Therapists (2006) *Practice Guidelines: Assignment of Service Components to Unregulated Support Personnel*.
- Saunders, L. (1997). Issues Involved in Delegation to Assistants. *Physiotherapy*. Vol. 83(3), pp. 141-7
- Steele, M. (2006) A Good Fit: Occupational Therapy Assistants in Home Health. *Home and Community Health Special Interest Section quarterly* Vol. 13, pp. 2-4
- Steib, P. (1996) Top Employment Settings for Certified Occupational Therapy Assistants. *OT Week* Vol. 10(17):18
- BCASLPA (2001) *Guidelines for the Use of Supportive Personnel*. Position Paper, British Columbia Association of Speech-Language Pathologists and Audiologists
- College of Occupational Therapists of British Columbia (2004) *Assigning of Service Components to Unregulated Support Personnel*. Retrieved September 10, 2006 from <http://www.cotbc.org/resources.php>
- College of Physical Therapists of British Columbia (2006) *Practice Standard: Assignment of Task to a Physical Therapist Support Worker* Practice Standard Number 3, CPTBC
- Handcok, B. (1998). Introduction to Qualitative Research. Trent Focus Group Series. Retrieved on November 1, 2005 from <http://www.trentdsu.org.uk/cms/uploads/Qualitative%20Research.pdf>

Myers, M. D. (June 1997). Qualitative Research in Information Systems [Electronic Version]. *MIS Quarterly* 21;2, 241-242. Retrieved November 7, 2005 from www.qual.auckland.ac.nz

Appendix A
Abbreviations

ACSLPA	-	Alberta College of Speech-Language Pathologists and Audiologists
AOTA	-	American Occupational Therapy Association
APTA	-	American Physical Therapy Association
ASHA	-	American Speech and Hearing Association
BCASLPA	-	BC Association of Speech-Language Pathologists and Audiologists
CAOT	-	Canadian Association of Occupational Therapy
CASLPA	-	Canadian Association of Speech-Language Pathologists and Audiologists
COTBC	-	College of Occupational Therapists of British Columbia
CPTBC	-	College of Physical Therapists of British Columbia
CPA	-	Canadian Physiotherapy Association
CLBC	-	Community Living British Columbia
MCFD	-	Ministry of Child and Family Development
NBAOT	-	New Brunswick Association of Occupational Therapists
NLCPT	-	Newfoundland and Labrador College of Physical Therapists
OT	-	Occupational Therapist
OTA	-	Occupational Therapist Assistant
PT	-	Physical Therapist
PTA	-	Physical Therapist Assistant
PTSW	-	Physical Therapist Support Worker
RA	-	Rehabilitation Assistant
SLP	-	Speech-Language Pathologist
SLPA	-	Speech-Language Pathologist Assistant
TA	-	Therapist Assistant

Appendix B

HTML version of Component #1 survey

1. What is your employment position at your facility?			
		Response Percent	Response Total
Executive Director		31.6%	12
Head of Therapy Department		26.3%	10
Staff Therapist (PT, OT, or SLP)		13.2%	5
Other (please specify)		28.9%	11
Total Respondents			38
(skipped this question)			0

2. Do you employ therapist assistants (i.e.-rehabilitation assistants, speech language pathologist assistants) at your facility?			
		Response Percent	Response Total
yes		28.9%	11
no		71.1%	27
Total Respondents			38
(skipped this question)			0

3. If you do not employ therapy assistants at your facility, please indicate why (check all that are appropriate).			
		Response Percent	Response Total
uncertain of role of therapy assistants in pediatrics		32%	8
funding limitations		72%	18
don't feel the use of therapy assistants is necessary		4%	1
unable to recruit qualified assistants		20%	5
unfamiliar with supervision requirements		16%	4
would rather hire more therapists		48%	12
Other (please specify)		40%	10
Total Respondents			25
(skipped this question)			13

4. How long has your facility employed therapy assistants?			
		Response Percent	Response Total
5 years or more		55.6%	5
4 years		22.2%	2
3 years		11.1%	1
2 years or less		11.1%	1
Total Respondents			9
(skipped this question)			29
5. What type of education background have assistants employed at your facility possessed? (check all that are appropriate)			
		Response Percent	Response Total
Trained at a College or University accredited program (i.e.- Rehabilitation Assistant, Speech Language Pathologist Assistant)		55.6%	5
Kinesiologist		0%	0
Certified Personal Trainer		11.1%	1
No formal post secondary education		44.4%	4
Other (please specify)		44.4%	4
Total Respondents			9
(skipped this question)			29

6. What percentage of the total number of assistants employed at your facility have been trained in a College or University accredited Therapist Assistant program?			
		Response Percent	Response Total
less than 25%		55.6%	5
26-50%		22.2%	2
51-75%		0%	0
76-99%		0%	0
100%		22.2%	2
Total Respondents			9
(skipped this question)			29

7. What is the current ratio of therapists to therapist assistants at your facility?			
		Response Percent	Response Total
less than 3 therapists to 1 therapist assistant		44.4%	4
3-5 therapists to 1 therapist assistant		11.1%	1
6-8 therapists to 1 therapist assistant		0%	0
9-12 therapists to 1 therapist assistant		11.1%	1
Other (please specify)		33.3%	3
Total Respondents			9
(skipped this question)			29

8. What type of activities do the therapist assistants at your facility perform? (check all that are appropriate)			
		Response Percent	Response Total
preparation and clean-up of treatment areas		66.7%	6
directly assist therapists with active therapy (participate in one-to-one treatment sessions with the supervising therapist)		66.7%	6
independantly carry out therapy treatment plans developed by supervising therapists (may occur without the supervising therapist in the same room/location)		44.4%	4
run group classes/activities		55.6%	5
equipment fitting/making splints and other items		22.2%	2
charting/scheduling/administrative duties		66.7%	6
Other (please specify)		55.6%	5
Total Respondents			9
(skipped this question)			29

9. Please indicate approximately what percentage of your therapist assistant's work hours are spent performing the following tasks							
	less than 5%	6-25%	26%-50%	51%-75%	75% or greater	N/A	Response Average
treatment area preparation and equipment set-up	12% (1)	62% (5)	0% (0)	0% (0)	0% (0)	25% (2)	1.83
direct assistance with active therapy of clients	0% (0)	62% (5)	25% (2)	0% (0)	0% (0)	12% (1)	2.29
independently carry out treatment plans	20% (1)	0% (0)	40% (2)	0% (0)	20% (1)	20% (1)	3.00
run group classes/activities	29% (2)	29% (2)	29% (2)	0% (0)	0% (0)	14% (1)	2.00
equipment fitting/making splints and other items	0% (0)	0% (0)	0% (0)	25% (1)	25% (1)	50% (2)	4.50
charting/scheduling/administrative duties	14% (1)	29% (2)	43% (3)	0% (0)	0% (0)	14% (1)	2.33
other	25% (1)	25% (1)	0% (0)	0% (0)	25% (1)	25% (1)	2.67
Total Respondents							9
(skipped this question)							29

10. What level of supervision is provided to your therapist assistants? (check all that are appropriate)			
		Response Percent	Response Total
direct supervision (supervising therapist able to observe TA directly)		66.7%	6
Indirect supervision (supervising therapist in same building/facility as TA, but not able to directly observe TA's actions)		66.7%	6
Independent (supervising therapist is able to be reached via phone should any questions or concerns arise, but supervising therapist is not in the same building as the therapy assistant)		11.1%	1
Other (please specify)		11.1%	1
Total Respondents			9
(skipped this question)			29

11. What policies and guidelines do you currently utilize to guide the practice of therapist assistants in your facility? (check all that are appropriate)			
		Response Percent	Response Total
Respective professional association guidelines (i.e.-College of Physiotherapist's of British Columbia guidelines on the supervision of therapist assistants, CASLPA/BCASLPA guidelines)		77.8%	7
The policy manual of your organization		88.9%	8
At the discretion of the supervising therapist		22.2%	2
Other (please specify)		11.1%	1
Total Respondents			9
(skipped this question)			29
12. What discipline utilizes the therapy assistants at your facility the greatest?			
		Response Percent	Response Total
Speech Language Pathologists		33.3%	3
Occupational Therapists		22.2%	2
Physiotherapists		22.2%	2
Other (please specify)		22.2%	2
Total Respondents			9
(skipped this question)			29

13. How frequently are your therapy assistants subject to a performance review/appraisal?			
		Response Percent	Response Total
Once per year		77.8%	7
Twice per year		11.1%	1
More than twice per year		0%	0
No formal review process in place		0%	0
Other (please specify)		11.1%	1
Total Respondents			9
(skipped this question)			29

14. To what degree do you feel the contribution of therapist assistants at your facility enhances the quality of the rehabilitation that is provided to the families utilizing your services?			
		Response Percent	Response Total
mildly enhances the service		0%	0
moderately enhances the service		11.1%	1
greatly enhances the service		66.7%	6
Other (please specify)		22.2%	2
Total Respondents			9
(skipped this question)			29

Appendix C

Assigning of Service Components to Unregulated Support Personnel

Critical Thinking Decision Tool

The following decision loop (tool) provides a guideline:

