THERAPY ASSISTANT RURAL WORKFORCE DEVELOPMENT

Research report

December 2021

autism spectrum AUSTRALIA

THE UNIVERSITY OF SYDNEY

Acknowledgement to country

We acknowledge the Traditional Owners and Custodians of Country throughout Australia and recognises their continuing connection to the land, sea, waterways and community. We pay our respects to them and their cultures; and to their Elders past, present and emerging.

Funding

Autism Spectrum Australia received funding for this project under the Department of Social Services Jobs and Market Fund. Titled Allied Health Assistant workforce development to deliver professional, culturally competent therapy services to participants in their local community in thin market areas. (Grant ID 4-D2IFZA7)

Note on terminology

Based on the NDIS price guides and the shift in perspective of this model within the disability sector, we have chosen to use the term **therapy assistant** (as opposed to Allied Health Assistant) throughout this report.

Design by: BlueFox Group | Crealo

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BACKGROUND

Access to therapeutic supports for people with a disability in regional and remote areas continues to be problematic despite the introduction of the National Disability Insurance Scheme (NDIS) in many of parts of Australia.

While disability workforce shortages were the main contributor to the access barriers in rural areas prior to NDIS, these shortages are now being reflected across the entirety of the scheme as workforce demand far outweighs supply.

Historically workforce shortages in remote areas have been associated with a lack of available positions, inflexible employment conditions and inadequate career development opportunities.

However, with the shift to individualised NDIS funding, the sustainability of delivering services in the bush under the NDIS price guides, impacts on travel and casualised work are exerting a strong impact on the disability workforce.

Access to therapeutic supports has been problematic for people with a disability in regional and remote areas, resulting in long distance travel to reach existing services or infrequent and inconsistent outreach services. Additional travel has economic and social impacts, including accommodation costs, disruption to attending work, sibling impacts and transportation costs, as well as the emotional consequences of removing the person with a disability from their home and disrupting daily routines.

The therapy assistant model has been included in policy and funding frameworks in the NDIS with a slowly emerging uptake by disability service providers[1].

The remote, community-based therapy assistant model, whereby therapy assistants are employed and work in their local community, has the potential to address barriers experienced in regional and remote communities. Therapy assistants are part of the local community and can provide direct in-person therapeutic intervention.

1: Mucic, 2019

A therapy assistant, as described by the Australian National Disability Insurance Scheme (NDIS), provides community support for people with disabilities by working "under the delegation and supervision of a therapist... and can work independently without direct supervision at all times"[1].

This approach means therapy assistants can provide holistic person-centred care by collaborating with therapists to address common goals, as part of a transdisciplinary team with the NDIS participant. In rural and remote areas and 'thin markets', therapy assistants can also provide the integral link between NDIS participants and their local support team and the therapists located at a distance.

The therapy assistant, therefore, can facilitate engagement in day-to-day activities that increase the NDIS participants community participation, such as going to school/work, accessing public spaces/facilities (parks, libraries, shops), engaging in leisure/recreational activities outside the home (concerts, sport, cinema), by implementing therapeutic strategies designed to increase participation.

To date, there has been scant attention paid to the adaptation of service delivery models and governance frameworks to support this emerging model of practice within the disability sector.

There are lessons from existing health and medical model therapy assistant frameworks that address risk, quality, supervision, competency assessment, training, and scope of practice that may be applied in a disability context. However, the social model of disability and a focus on participation and inclusion requires a more nuanced and contextualised understanding of the therapy assistant model in a NDIS-governed disability sector that is fundamentally different.

The *NDIS National Workforce Plan: 2021-2025* outlines the therapy assistant model as one of sixteen priority initiatives to build a responsive and capable workforce within the NDIS. Therefore, it is essential to design and evaluate therapy assistant services in the context of the social model of disability. This will influence the factors considered as part of service design, the model of service delivery and the governance frameworks applied to therapy assistants in the disability sector.

In addition, the scope of practice, approaches to supervision, assessment of competency and training, and the collaboration between therapy assistants and therapists require rethinking in long-term, disability settings with supports provided in a diverse range of contexts.

The inclusion of remote practice options such as Telepractice, with intermittent contact between therapists and therapy assistants, requires additional consideration to ensure high quality service delivery and mitigate risks. Technology has the potential to provide a timely, low-cost platform to extend the reach of remotely located therapists and therapy assistants to people in rural and remote locations. Telepractice, a means of delivering intervention using diverse technology (also known as e-health or telehealth), is currently emerging in research and practice in the Australian disability sector, including inter-disciplinary models. Favourable outcomes and good social validity have been reported to provide foundational support for extending this service design to include therapy assistants.

1: NDIS, 2018, "Pricing review of therapy services"

PROJECT
SCOPE

In 2019, Aspect was awarded funding by the Australian Government under the Jobs and Market Fund to develop a therapy assistant workforce delivering professional, culturally competent therapy services to participants in their rural community.

Aspect therapy assistants were trained to implement therapy supports under the supervision of an Aspect therapist using a fly-in, fly-out/drive-in, drive-out and telepractice model of support.

In addition, research was conducted to evaluate the model's success in facilitating positive therapeutic outcomes for NDIS participants in their local areas and identify factors associated with a sustainable model moving forward.

Activity 1

Creation of the Aspect therapy assistant position and employment

of four therapy assistants to work under the guidance of therapists to deliver therapy services to participants in remote locations.

Output

Successful recruitment of four therapy assistants into employment with Aspect.

Benefit

Growth of the therapy assistant workforce and ability to offer more frequent therapeutic services to participants in targeted rural regions and extend the reach of their collaborative, person-centred model of support.

Activity 2

Training and supervision

of therapy assistants, including:

- enrolment and participation in TAFE accredited therapy assistant training,
- regular Aspect internal face to face and online training,
- and regular supervision outside of regular service delivery.

Output

Completion of accredited TAFE training and professional development offered by Aspect.

Benefit

Therapy assistants have increased skills and confidence in their role and will support a broad range of participants under the guidance of a therapist.

Activity 3

Delivering services

using a therapist/therapy assistant model of support to a minimum of 100 participants.

Output

Successful implementation of the therapist/therapy assistant model shown through participant goal progress and service growth.

Benefit

Participants in regional, rural, and remote areas benefit from access to therapy supports that were otherwise limited or inaccessible in their local area.

Activity 4

Delivering an evaluation report

of the therapist/therapy assistant model of support

Output

A formal report has been completed, which outlines the findings of the research evaluation of the model and future directions.

Benefit

The evaluation report informs other organisations interested in implementing a therapy assistant model and policymakers on the successful sustainability of the model under the NDIS.

This study contributes to an evidence-based therapy assistant framework that is relevant and applicable to the NDIS context, to support the delivery of quality supports to people with a disability. There is significant support for therapy assistant models of service delivery from participants, service providers and government. However, the uptake of this model has been slow.

The findings of this study provide further support for the potential benefits to NDIS participants and NDIS providers to include therapy assistants. This approach will increase access to the scarce allied health resource and enable NDIS participants to receive specialised therapeutic supports that allow them to reach their goals.

PROJECT OUTPUTS

Outputs 1 & 3: Recruitment

We compiled and trialled questions to support the interview process for suitable candidates.

We currently have six therapy assistants – five working three days per week and one working two days a week and one vacant position.

Despite the challenges around both Covid-19 and staff movement, we have been able to successfully recruit and are currently operating across seven sites providing support for 73 participants with a disability.

Output 2: Induction and training

We reviewed the induction program (on boarding process) for therapy assistants and developed modules to support this process. A tailored 12-week induction program and roadmap have been developed and implemented with all new therapy assistants.

We developed and delivered a tailored therapy assistant PBS 101 training package and are looking to develop a tailored PBS 201 training package. The feedback received from the therapy assistant team has been very positive.

A training module has been developed to support therapists working with therapy assistants (See appendix A).

Two staff will complete their Certificate IV in Allied Health Assistance in December 2021.

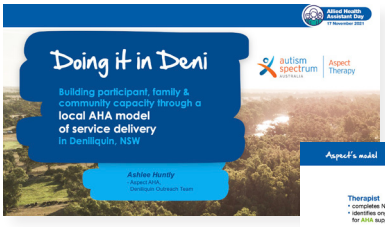
Four staff have enrolled to complete Certificate IV in Allied Health Assistance and commenced at the end of October 2021 with a view to completing in December 2022.

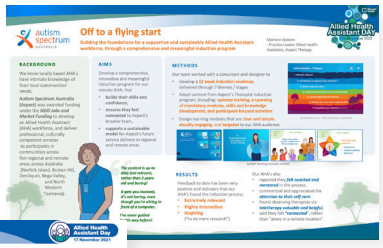
Regular therapy assistant team meetings have supported learning and development around reflective practice, positive behaviour support, communication development, self-help, emotional regulation, and play and social skills.

Therapy assistants attended quarterly regional team meetings and participated in discussions around practical examples re mandatory reports in different jurisdictions and to understand their role in the process. They also attended Aspect's internal annual 2-day national meeting (held virtually).

Conference & workshop presentations

- **Aspect Therapy National Conference 2020** entitled "***An introduction to working with Allied Health Assistants***" presented jointly by Practice Leader Allied Health Assistants and TAFE Teacher Allied Health Assistance; 46 staff attended this presentation.
- Poster submitted for presentation at **Monash Health Allied Health Assistance Day 2020** on 11/11/2020 – "***Off to a flying start***" – showcasing 12-week intensive induction program, received **best poster award**.
- **Aspect Therapy National Conference 2021** entitled "***Doing it in Deni - Successfully building participant, family and community capacity utilising a local AHA model of service delivery in Deniliquin, NSW***" presented jointly by therapist assistant, speech pathologist and occupational therapist supporting the Deniliquin community.
- **National Allied Health Conference pre-conference workshop August 2021** entitled "***Therapy assistants: an integral part of the rural disability sector workforce***" jointly presented by Kim Bulkeley, Genevieve Johnsson, Marlene Eksteen and Caryn Ferguson.
- **Monash Health Allied Health Assistance Day 2021** on 17/11/2021 –"***Doing it in Deni - Successfully building participant, family and community capacity utilising a local AHA model of service delivery in Deniliquin, NSW***" presented by therapy assistant received **"best innovation" award**.





Project output 3 and 4: Evaluation

Aspect evaluated the model in collaboration with the University of Sydney Centre for Disability Research and Policy using a Realist Evaluation research framework[1].

Pre- and post-evaluation includes surveys and interviews with participants (where possible), their families, their local support team and the Aspect allied health therapists and therapy assistants.

Rather than simply investigating whether a program works, a realist evaluation also aims to explore "how" this program works, "for whom", and "in which contexts".

This allows program developers, key stakeholders, and policymakers to adapt and tailor programs and policies to suit the needs of the program's recipients within their local context.

1. Pawson & Tilley, 1997

We aimed to find out the following:

- **What are the known characteristics of successful governance** for therapy assistants working with people with a disability in rural and remote settings?
- **What are the impacts** of a therapy assistant model of service delivery from the perspective of NDIS participants, therapy assistants, therapists, and managers?
- **What is the work** of a remote, community-based therapy assistant?
- **What is the experience of participants with disability** of the therapy assistant model?
- **What are the costs** of the therapy assistant model of service delivery for rural and remote communities?
- **How do we create a sustainable therapy assistant model** in rural and remote communities under the NDIS context?

SUCCESSFUL MODELS OF GOVERNANCE

OF DISABILITY THERAPY SUPPORT WORKERS IN RURAL AND REMOTE SETTINGS A SCOPING REVIEW

A collaboration between Services for Australian Rural and Remote Allied Health (SARRAH), Centre for Disability Research and Policy (CDRP), and Autism Spectrum Australia (Aspect)

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Secondary authors: **Dr Kim Bulkeley** (CDRP) and **Dr Genevieve Johnsson** (Aspect)

Search Strategy support: **Elaine Tam**, Health Sciences librarian, University of Sydney

Aim

The objective of this scoping review was

- **to identify existing governance models for disability therapy assistants in rural and remote settings;**
- **to better understand the contexts and mechanisms that underpin these models;**
- **and how these elements come together and interact to influence their "success".**

This scoping review is part of an ongoing programme of research that aims to produce a robust, evidence based and consumer-informed disability therapy assistant governance framework.

Method

We conducted the scoping review following the Joanna Briggs Institute methodology for scoping reviews[1]. Below is a summary of the methods and results.

Search strategy

Information sources include electronic databases, contact with study authors and other electronic search engines. The databases searched include CINAHL, EMBASE, Web of Science, InfoRMIT: Health Collection, and MEDLINE.

Inclusion criteria was applied to screen for literature that was an empirical study or published report, evaluation, framework or guideline describing governance models pertaining to allied health assistants, therapy assistants and disability therapy support workers who deliver care and interventions under the guidance of therapists and specifically in disability contexts (Tier 2) and in regional, remote and/or rural areas (Tier 3).

The review included peer-reviewed evidence, experimental and quasi-experimental study designs, observational studies, qualitative studies, systematic reviews, published reports and evaluations. We included studies published in English since 2000.

1. Peters et al., 2017

The review considered four key concepts: •

- Concept **1: Assistants who deliver therapeutic supports**
  (Therapy support workers who deliver allied health supports)
- Concept **2: Governance of these workers**
  (Governance interventions and models relating to therapy support workers who provide support under the guidance of therapists)
- Concept **3: Disability setting**
- Concept **4: Rural and remote setting**

Combining these four concepts, the review considered studies that explored evidence relating to governance and governance models of disability therapy support workers who deliver support under the guidance of therapists in rural and remote settings.

A rigorous process including all three authors was undertaken to screen papers and determine inclusion of the final data set in a consensus manner.

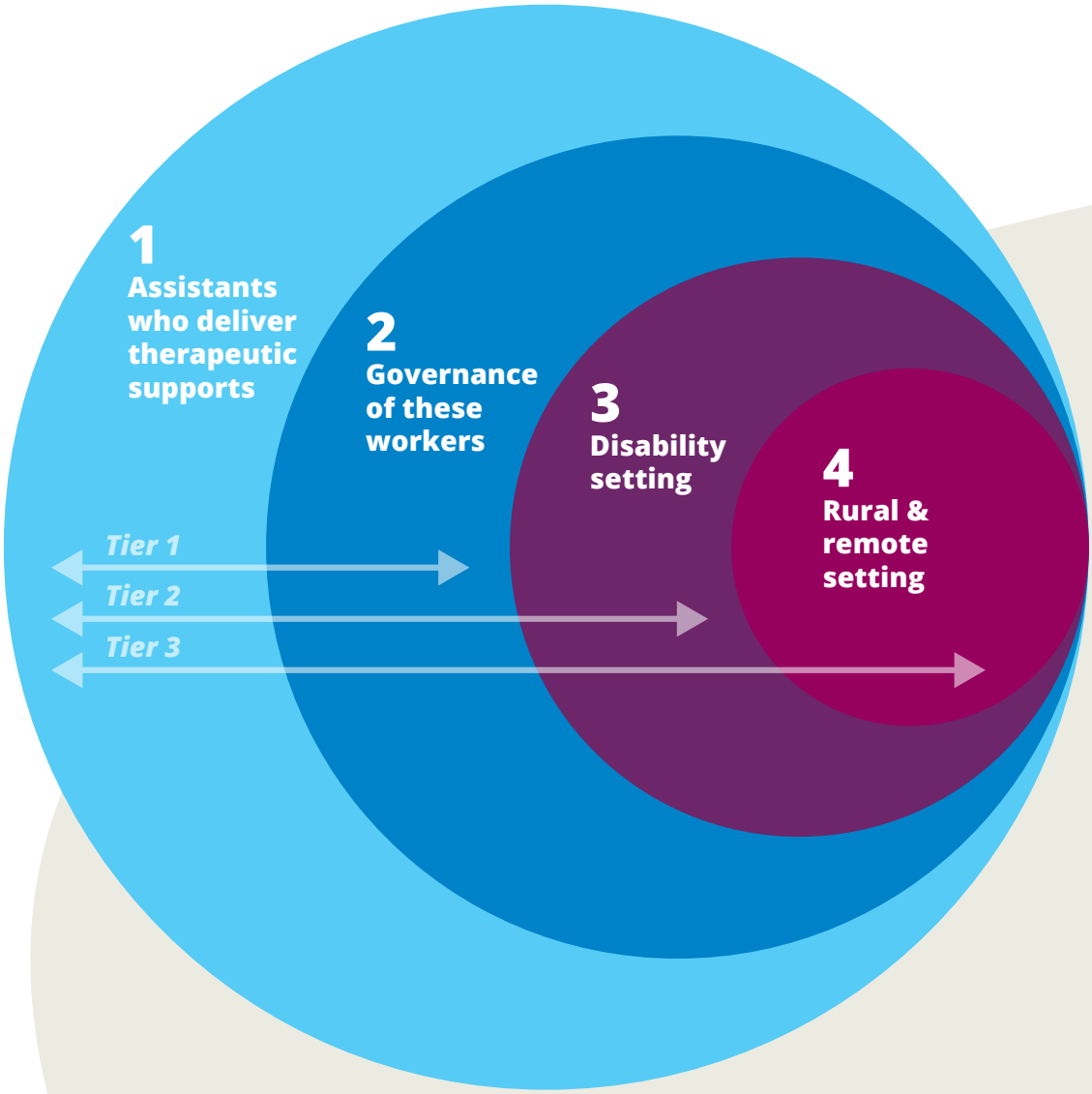


Figure 2: Concepts and evidence sampling tiers
• Concept 1 & 2 make up **Tier 1**;
• Concept 1,2 & 3 make up **Tier 2**;
• and all four concepts make up **Tier 3**.

Results

After removing 3926 duplicates from the original 7096 records, screening 3170 abstracts led to the inclusion of 26 full-text papers.

The majority of papers (n=18) related to all four review concepts, with the remaining eight papers addressing all but the rural concept. Australian papers dominated the evidence base (n = 12), as did qualitative methodologies (n=12).

In terms of governance interventions, qualitative studies describing support worker capabilities dominated the retrieved evidence followed by studies describing training, assessment, credentialling and/or competency requirements around technical, clinical and administrative skills and knowledge.

The literature specifically about disability therapy assistants was limited, however we included 26 full text papers in the review that were related to community and disability supports. No papers fully described a governance framework for the disability context. The level of evidence would best be described as emerging.

The most consistent finding was the importance of **soft skills** as a key factor in a successful therapy assistant model. The capacity to relate to a range of stakeholders, problem solve, function independently & operate as a collaborative team member were foundational. Specialist skill sets were seen as a capability that could be developed when necessary in specific contexts.

Another strong finding was the development of **tailored support & oversight** of the therapy assistant in a collegial manner with a focus on team-work, sharing of knowledge & role release. The value of developing clear programs & support plans was emphasised. This process ensures all members of the team had a shared understanding of goals, aspirations and therapeutic strategies.

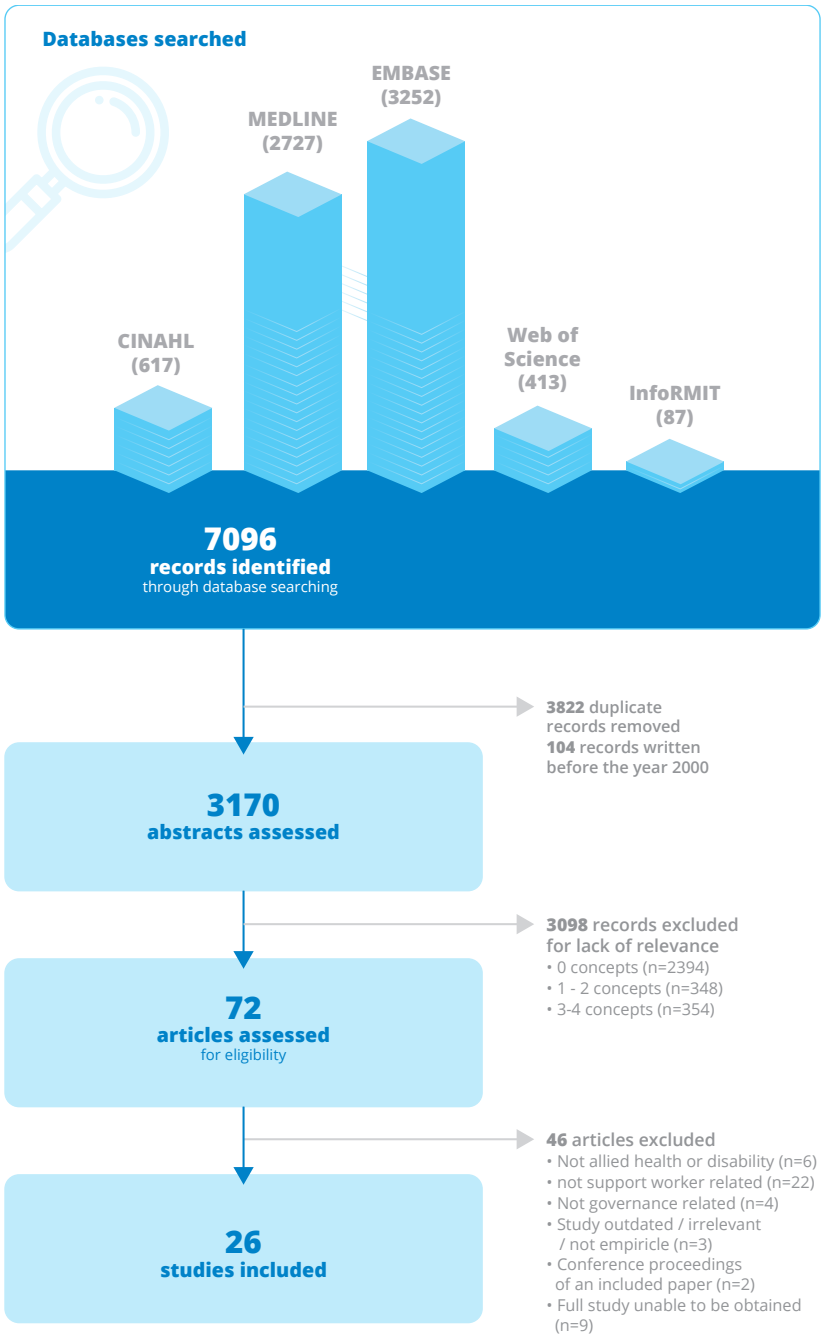


Figure 3: Preferred Reporting Items for Systematic reviews and Meta-Analyses (Page, 2021) for the therapy assistant scoping review.

The literature also identified the need for **contextualised responses** that recognise the diversity of individuals and service systems. A strong therapy assistant model will require adaptation to suit local needs, both geographical & human resources.

The literature demonstrates that **therapy assistant models are used in a wide range of contexts to support people with a disability but are not clearly described in a way that supports implementation and scale up.**

The full data extraction table is available on request from the authors.

EXTERNAL STAKEHOLDER PERSPECTIVES

OF THE THERAPY ASSISTANT MODEL IN THE DISABILITY SECTOR

Aim

The aim of this research is to identify the particular aspects of therapy assistant models of service delivery that are important in implementing this model in the disability sector and differentiate the model from a medical model of service delivery.

Research questions:

- **What are the roles/potential roles undertaken by a therapy assistant in the disability sector?**
- **What is different about therapy assistant roles in the disability sector, driven by a participation and inclusion framework?**
- **What are the components required in a governance framework to support therapy assistants working in the disability sector?**
- **What resources will support the implementation of a therapy assistant governance framework?**

Method

Stakeholders in this study were drawn from service providers and community organisations that have been involved with delivering or developing services using therapy assistants in the disability sector.They were identified through publicly available NDIS service provider listings and other disability sector networks.

This study adopted a purposive sampling strategy including snow-ball recruitment, to access stakeholders with relevant experience and knowledge in this specialised context and ensure a spread of stakeholder experience in this emerging area of practice.

Individual, semi-structured interviews were conducted using telephone and online platforms for half an hour to explore the current operation of therapy assistant models. Interviews were recorded using a digital device and transcribed to ensure accuracy of the information from stakeholders. A qualitative approach is appropriate for this study as there is limited information available about the topic and allowed for an exploration of the topic using probing, open ended questions to elicit deep and reflective responses[1].

Individual interview data was analysed thematically using inductive methods, with line by line coding. Constant comparison was undertaken to ensure rigour and interpretation that is in keeping with the data[2].

1. Creswell, 2000
2. Clarke & Braun, 2017

Results

Conversations were held with sixteen stakeholders from six states and territories across Australia (no stakeholders from ACT or WA).

There was a mix of professionals with:

- 9 occupational therapists,
- 3 therapy assistants,
- 1 human resource manager,
- 1 speech pathologist,
- 1 medical doctor and
- 1 physiotherapist.

Five overarching themes were identified from the interview data:

Business considerations

A strong theme was recognising the billable hours context, service design, insurance coverage, waiting times and the value of the therapy assistant role to the business profile.

The stakeholders were all mindful of the context of NDIS plans and the business modelling that was essential for the development and design of a therapy assistant service.

...It's a lot better from a business point of view, and I guess a lot more feasible for businesses to be able to employ AHAs than at the start, when they were all the lower level.
- Stakeholder 11

Providers described a process of grappling with local conditions, the price guide and allocations in NDIS participants plans to establish a viable, high quality therapy assistant service.

...We went to a provider forum day and did market research. Down on the [rural location], there was not one bit of interest whatsoever. So we we were not going to put our resources here... But closing our books every few months and managing six months waiting lists, we said we'd be happy to do this in our more populated region... And we did: we recruited last year and that's been successful in the more regional area.
- Stakeholder 5

Scope of practice

Assistants had a broad scope, that developed in responsive and diverse ways. There was significant potential identified to expand the scope of practice with support, training development and negotiation to recognise prior learning and experience. This service describes a very broad range of activities undertaken by the therapy assistant.

We get quite complex cases and that just comes from our backgrounds... So it may be actually the allied health assistant does the skill development with them, sets up visuals, or works with the family on how to implement their behaviour support plan, or shows how to use their iPad...
There's lots of training: we do a lot of sexual health here, so they might deliver the SoSAFE! program, so they've been trained in that. We also do a lot of zones of regulation, social, emotional learning programs... So going to the homes and set up all of the visuals and, there's a showering visual schedule, they'll make that up, they'll put it in, they'll go and show the staff how to use it and follow it. And the individual as well.
- Stakeholder 5

Administrative tasks, documentation and supporting service delivery in indirect ways was also identified broadly by stakeholders, with some having a very strong commitment to the full range of service activities. This was recognised as a way to make the best use of therapy assistants time when they did not have a full caseload due to fluctuations in demand for instance.

When I employed the allied health assistants I was very clear with them that their role would be quite diversified and they may be asked to do even practice management-type tasks: they might go and do registering referrals, wash the work car, or fill it up in preparation for the OT visit. They might even do some invoicing.
I made it quite clear that, yes, you're being employed as an allied health assistant, but we're all a team in this organisation and we all chip in and do whatever's necessary at that time.
- Stakeholder 6

Support and oversight

Support and oversight is an essential component that is linked with risk management as well as staff collegiality and teamwork. The connection between therapy assistants and therapists is collaborative mutually beneficial, recognising the value of shared learning.

One thing we're working more on, which I think is key to getting the best outcomes for participants, is the therapist relationship. It can be difficult because we have to establish exactly what everyone's roles are: what kind of things can be delegated and what can't be. There needs to be oversight with each participant and Allied Health Assistant pairing. The big thing is everyone knowing where they stand, and having regular communication / everyone knowing what their role is and being able to provide feedback as to what's taken place in each session.
- Stakeholder 4

Telepractice

The inclusion of telepractice is a potential unrealised in the main. Providers did not consider direct service delivery by therapy assistants as a primary focus of telepractice in their organisations.

Technology had been used in response to COVID, but was valued more as a support and connection opportunity between staff rather than participant facing.

It has potential to work if it's the right client. We liked the part that the allied health assistant was in the community. I'm finding Zoom and telepractice limiting in generalisation, because you lose that social interaction. So you need that... I still need that generalisation into the community.
- Stakeholder 1

We found that a lot of the Allied Health Assistant work we do didn't translate to telehealth well, because it is quite hands on with the person, quality checking what they're doing... and you don't get that experience remotely. So we put a hold to about two thirds worth of the service we were doing during COVID. Some of that was our recommendation to participants, but also a number of them didn't want to do their therapy assistant work via telehealth. I think this is something people in regional areas sometimes struggle with.
- Stakeholder 2

I don't know that I'd ever want to go down that road in any major way. I think it's fantastic for our meetings, for collaboration, discussions with parents, that kind of thing.... But no one prefers telehealth. No one. We can make it work in these times if we need to, but it looks quite different.
- Stakeholder 16

Workforce capabilty

Soft skills and collaboration were key.

Formal training was less valued, with a preference for responsive in-house staff development.

It's more the person that's important than anything else. As I say to both the allied health assistants and OTs, I can teach anything in terms of clinical skills or technical knowledge, I can't teach you a value set, an attitude, or communication skills. If they've got all those things, the right attitude, the communication skills, value set where they put the client at the center and they're genuinely interested in helping people - as opposed to, "this is a career and a paycheck for me and I'm interested in the bigger dollars" - I can teach them anything.
- Stakeholder 3

ASPECT STAKEHOLDER PERSPECTIVES

IMPACT OF A 2-YEAR RURAL THERAPY ASSISTANT PILOT IN THE DISABILITY SECTOR

Aim

This qualitative research aimed to explore the experience and impact of the Aspect therapy assistant service across a broad stakeholder group.

Interviews were conducted with relevant Aspect staff and service users to examine a range of elements of the rural therapy assistant model, including strengths and challenges.

Method

We conducted semi-structured interviews via phone or online for up to 30 minutes with Aspect staff and service users connected with the four therapy assistant sites, including the participants and/or their caregivers, therapy assistants, therapists and managers.

Interview data was analysed thematically[1] to elicit new concepts and ideas in this emerging service delivery model.

Qualitative interview data was transcribed to ensure accuracy and entered into nVivo for qualitative analysis. The researchers read through the entire data set to understand the full breadth of the data. Preliminary analysis identified a broad set of categories. Using a constant comparative approach, we identified sections of the text under each category. Relationships within and between categories were explored and then grouped to form several central themes.

Finally, we synthesised themes and categories to develop a story to connect the entire data set[1]. We ensured rigour in the data analysis by constant comparison with the original data set and confirmation of the coding and thematic structure by a second researcher who coded and analysed 20% of the transcripts.

1. Clarke & Braun 2017

Results

We conducted a total of 15 interviews.

Two interviews were repeated with the one stakeholder who was involved for a longer period to explore any new learnings.

Stakeholders' details are outlined in Table 1.

Stakeholder	Time working for Aspect	Location (MMM)
Therapist 1	4 years	1
Therapist 2	2 years, 9 months	1
Therapist 3	6 years	1
Therapist 4	5 years, 6 months	1
Therapist 5	4 years, 2 months	2
Therapist 6	5 years, 8 months	1
Therapist 7	4 years	1
Therapy Supervisor 1	6 years, 1 month	2
Therapy Supervisor 2	11 years	1
Therapy Manager 1,3	7 years, 7 month	2
Therapy Manager 4	13 years	1
Therapy Manager 2	14 years	3
Caregiver 1		4
Caregiver 2		3
Caregiver 3		3

Table 1. Interviewed stakeholders' details

Interviews with key stakeholders identified seven themes related to the therapy assistant model:

Reflections on various therapy assistant models

The therapy assistant model has been working well in the health sector for a significant period, with one stakeholder discussing their involvement dating back over 20 years ago in Western Australia. However therapists commented that the model looks different in the disability space.

It is a lot more complex and multifaceted than it is within a hospital setting, where it's ... that process for every client that comes in.
- Therapist 1

In discussing potential models of therapy assistant service design, some stakeholders identified a co-located therapy assistant model as an option to consider in the future. Some managers were planning to include locally-based therapy assistants in their therapy teams.

They're part of us within this region. So they will have the opportunity to go and do joint visits in those initial stages, and then go on with therapy and have either face to face or remote collaboration depending on where everyone's situated.
- Manager 4

It is proposed that these locally-based therapy assistants would primarily be allied health students.

Once these AHAs graduate, we hope they transfer across into the therapy role, which would grow our therapy team... but it also means those AHAs who are now therapists have an understanding of working with an AHA.
- Manager 1

At an organisational level, however, it was noted that it is important to make a clear distinction between a locally-based student and remote therapy assistant.

A mix of both models was suggested as a way to ensure the development of a stable workforce.

If this is the way our organisation is going to go, we're going to have to be clearer: these are all our AHAs, but these are outreach AHAs, and these are discipline specific AHAs.
- Manager 4

If we were looking at a model that is not just outreach, we would look at a different supervision structuring.
- Supervisor 1

Stakeholders identified the need to reframe the therapy assistant model, cognisant of the differences with remotely-located therapy assistants compared to therapy assistants colocated with therapy teams and potentially profession specific assistants.

If we're moving into a third or fourth year student relationship ... We'll need to reduce the amount of induction and onboarding. We won't be able to sustain a 12 week model for a more casualised workforce.
- Manager 2

Establishing the therapy assistant model

One stakeholder outlined the process of establishing the therapy assistant model as follows:

- **determine which regions** to move into,
- **recruitment process** to onboard the therapy assistants, working with them through their induction ,
- **support them to build a caseload** in the regions where the service is being established,
- **work with them around their day to day practice** (scheduling, learning needs, how to be an outreach worker, understanding how to work with a therapist, how to build relationships with staff in schools...).

However, several "teething problems" were noted in the establishment of the service at Aspect including:

- **working through the processes and expectations** for therapy assistants such as reporting requirements,
- **getting to know each person in the outreach team and their expectations**
- **understanding a therapy assistant's scope of practice,**
- **working with the participants' NDIS funding** and what this allows the therapy assistant to address,
- **understanding participants' suitability** for a remote therapy assistant service, and
- **building the therapist and supervisor's confidence** in the outreach model.

It was challenging to sit in meetings and try and respond to those questions because in reality, we were still working out what it was going to look like.
- Manager 1

Despite initial hesitancy, it was reported that once processes were established and therapists began working with the therapy assistants, the model was well-received.

There's not one therapist who provides outreach who hasn't asked me at some point "are we going to have an Allied Health Assistant on our team?". They all value having the AHA, they all want an AHA on their teams.
- Manager 1

It was a matter of making sure we were all communicating, and having really good relationships, because once we opened those lines of communication, things really changed.
- Manager 4

Establishing new remote sites encountered difficulties recruiting for the role, retaining in the role, and attraction of the role's pay scale.

We have actually employed and inducted through our 12 week program, two Allied Health assistants who haven't continued in that role... The reality of what the role entails probably hasn't been what they thought... even though we try to be really clear about that. Now, we have someone interested, but it's clear they could get paid better than what we can offer.
- Manager 2

So the AHAs come in, they're trained up, they work with our clients, work with our therapists... And then something will happen, and they'll move onto something else...
- Supervisor 2

Establishing the therapy assistant model

Stakeholders discussed the recruitment of therapy assistants and the characteristics that make a successful therapy assistant.

Soft skills were reported by stakeholders more so than training and experience. These included:

- **being flexible and adaptable** because things change so frequently, particularly with a disability, communication and rapport building skills,
- **the ability to develop a relationship with people**, to make any type of person just feel comfortable and relaxed, the willingness to identify when they need help, and
- **good connections within their community.**

We can teach all the skills and the therapists are there to teach... But at the end of the day, you're going to need all those interpersonal skills. Otherwise it won't work.
- Manager 4

We found the recruitment of therapists to work with therapy assistants was initially problematic, maybe due to the travel requirements. A lot of people have young families and don't actually have the capacity to take on that outreach work.
- Manager 1

Employing new graduate therapists or less experienced staff however, impacts the therapy assistant supports delivered under a remote model as the collaboration between the team members is key to a successful outcome for participants.

Sometimes the goals that are raised or the type of support that's requested in outreach is beyond the skill level of the therapist. But sometimes, there's a really big expectation from families for therapists to do everything, because they're the ones who are coming.
- Supervisor 1

Benefits of the therapy assistant model

Increase local access

One of the most significant benefits of the therapy assistant model is the increased access to locally-based support.

Many remote communities experience high staff turnover or intermittent outreach services which are unsatisfactory in achieving good outcomes for participants. A local, consistent provider is highly valued.

Having someone who is a local and already lives there really creates a consistency for those children and families they don't get otherwise.
- Therapist 3

Suddenly I've got ten families on my caseload... which I wouldn't have been able to help with the old model.
- Therapist 6

This has the added benefit of increased frequency of supports as well as supporting the efficiency of therapy supports.

This family was having very erratic service because of the enormous amount of travel. Now they're able to have weekly, sometimes twice weekly therapy supports.
- Manager 1

It has really increased the success of our clients. I've had more success with my [Therapy assistant location] clients than I have had with local clients.
- Therapist 5

This decreases travel for families who often navigate long distances to access therapy supports for themselves or their child, impacting their family functioning and well-being.

Two and a half hours to [local town] and then two and a half hours back... it's a very long day. It was just Tantrum City by the end of the day, because we would go all the way over there and then she would have a session, which wouldn't necessarily be that long, but she's trying so hard to concentrate and do what she's been asked to do ... by the time we get home, there was meltdowns and blowouts, and all kinds of things were going wrong there.
Carer 1

This may go some way to address workforce shortages not just in regional and remote areas but also across all areas of Australia. However, more needs to be done to create awareness and attraction into the role.

I don't think is the issue the NDIS funding... I think it's the potential for positions like this to be created. Students who are training in these areas to understand that working as an AHA in a rural area is a vital need, a vital service and that there is a workforce that is available for them to slide into those roles.
- Carer 1

Benefits of the therapy assistant model

Building community capacity with quality local supports

Therapy assistants living in rural and remote areas with smaller populations may be more visible within their community. This provides opportunities to build the capacity of people in that community to understand disability and what best practice disability support looks like.

They're bringing in awareness into the community that perhaps therapy doesn't always have to look the same, therapy doesn't mean that you have to sit across a table repeating things over and over from a speech perspective, that therapy can be community-based and there are opportunities to see outcomes even when therapy's not offered in the same way.
- Manager 1

Therapy assistants working in rural and remote communities often become more of a rural generalist and are seen working autonomously as the implementer in the absence of direct therapy supports.

I haven't really noticed much of a difference between an AHA implementing a little bit of the interventions we do compared to how a therapist would do it. So yeah, I see it as highly valuable.
- Therapist 2

I think a lot of our clients respond better to that face-to-face support than via tele-therapy.
- Therapist 5

We've seen that the services can be as high quality, depending on what the goals are.
- Therapist 6

Local relationships built on an understanding of the local cultural context

A locally based therapy assistant who understood the local culture, contexts, and services was a significant benefit of this model.

Establishing trust and a long-term relationships is often crucial in rural and remote communities so frequently impacted by a transient workforce.

You just don't have the opportunity to build that relationship as if you would see a person or a family regularly... that trust, having somebody who understands them, who knows the culture, what they need, and that can speak to them on that level was really important...
- Therapist 1

They understand the region... the people in the town. Having a local AHA as somebody who's part of the community, lives in the community, works in the community, they understand where services are lacking ... it's just that rapport you can build with somebody that lives in your town.
- Carer 1

Therapy scope of practice

Therapists reported having many questions regarding the scope of practice when they started working under a therapy assistant model:

- How to stay within their scope of practice
- What were their roles
- What were their responsibilities
- What does the therapy assistant do and what does the therapist do
- How to work collaboratively.

When first establishing the therapy assistant model in the NDIS context, many staff experiences and perspectives were based on the health care sector. However, this setting may involve significantly different tasks and scope from those of a rural therapy assistant in the disability sector.

We discuss here what the work of a therapy assistant looks like from the perspective of multiple stakeholders. Scope of practice is highlighted throughout the remainder of this report, including from the perspective of therapy assistants, routine data collection, and the persons with a disability receiving the services.

Process of service delivery

Therapists described the process for working with a therapy assistant as follows:

- Receive information from the new participant and review their NDIS plan and goals.
- Develop an therapy assistant program, and what it will look like for the therapy assistant.
- Determine how often the therapy assistant will provide supports (weekly, fortnightly, monthly...) and where supports will take place.
- Collaborate with the therapy assistant fortnightly around participants and their progress, what may need to be done differently.
- When going to the rural town, observing how the therapy assistant is implementing the therapy.
- Adjusting strategies in the implementation of the therapy based on how it is affecting the participant's progress.
- After 12 months, write an NDIS report for the participant and start the process again.

Goal setting

In terms of setting participants' goals, the therapist completes the initial goal setting before the therapy assistant starts. Once the therapy assistant has been working with the participant for a time, they are encouraged to collaborate on goal development as part of the review process.

AHAs are able to provide input into that ISP because when we talk about progress towards goals, the AHA is able to talk to that and then AHA will sometimes say to me, "I'm so excited because we now able to take that goal off and move on to other goals."
- Manager 1

Therapy assistants were also seen as the eye on the ground who can update the team on progress and inform longer-term assessments.

... informs us of some tweak strategies if we need to. She helps us to change the goals as well. We would put her also in charge of having those ongoing discussions with families about what do you want to be working towards? The goals obviously will always be changing over time.
- Therapist 6

Therapy scope of practice

In-Scope Practice

The nature of disability therapy support was discussed as having "a very strong **family capacity-building focus**", where the therapy assistant does not necessarily implement the strategies but instead supports the family to implement them.

For example, when the goal is toilet training or improving sleep routines where a therapy assistant can not be present, consideration needs to be made on how a therapy assistant is best utilised in these capacity-building type of supports.

We've been supporting her to think about incidental skills that child might need to learn, like waiting, following sequences, responding to timers... It helps the therapist to think creatively about how the AHA is going to be resourced, so the time can be used efficiently.
- Supervisor 1

Other areas considered within the scope of practice of the therapy assistant were:

- **supporting social skills** such as maintaining friendships, learning how to play with other people, including other people's interests in conversation topics,
- **emotional regulation**,
- **fine motor and writing goals** such as pencil grip, muscle strengthening,
- **communication goals** such as articulation work, speech sounds, generally building confidence, implementing strategies from Hanen More than Words, and early play skills such as increasing interaction lengths, increasing joint attention.

Therapists and managers discussed examples involving levels of complexity, including complex mental health issues, complex families, and behaviours of concern and the suitability of a therapy assistant for these participants.

It's tricky and something we need to be mindful of when picking up new clients... whether they're going to be suitable for an AHA who perhaps doesn't have much experience or understanding around complexities and behavior support... It restricts your practice and everything that goes along with that.
- Supervisor 2

Therapy scope of practice

Behaviour support

Behaviour support at Aspect is delivered by registered behaviour support practitioners who must follow strict policies and guidelines in providing behaviour support under the PBS Capability Framework.

Therapy assistants can provide assistance for behaviour support delivered through Capacity Building Supports as part of a therapy program.

However, they are unable to provide assistance for Specialist Behaviour support delivered under Improved Relationships funding.

Therefore, for people with complex behaviours of concern, the therapy assistant is more restricted in the support they can provide.

There is one client who I am providing behaviour support service for … has been a bit trickier to work out where [therapy assistant's] role is within that … wasn't quite regulated enough and they needed all this background stuff to be done first … now that we're up to implementation of the behaviour support plan, [therapy assistant] was able to go into the school on a weekly basis. But again, she mainly just joined in on the school routine and supports the staff with the behaviour support plan rather than doing that direct intervention and therapy with the child.
- Therapist 3

Supporting participants who have also had acute mental health issues was also raised as something to manage within the scope of a therapy assistants role.

We've recommended [therapy assistant] step back and doesn't directly interact with the families of the clients or that period of time. Just because it's not fair to put her in that situation… It's not expected that she has the skills to deal with that situation … she'll pause until things are settled enough to go back to a place where she is able to support within her means.
- Therapist 3

Interestingly, while home modifications were out of the scope of Aspect's service, a supervisor discussed how this reflected on the generalist role of a therapy assistant in a remote community.

It's really tricky for the AHAs because of the complexities of the [Location]. It's very insular, everyone knows everyone.
If you live [in a remote location] and you're an AHA, you're expected to do a lot of different thing … a family requested some bathroom modifications… but that is outside of our scope of practice.
I guess, for the families, they have no one else to go to. There's no one else coming on to [Location], so that means our therapist has to work on outsourcing, from a major city, services like that.
- Supervisor 2

Collaboration (Delegation)

Assistant therapists reporting on progress

Delegation is commonly referred to in the therapy assistant model as the the process by which a therapist gives work to a therapy assistant or a disability support worker who is deemed capable to undertake that task and who then undertakes that task. The accountability for the task remains with the therapist.

Throughout our project, we adjusted our terminology to recognise the vital role of the therapy assistant in a collaborative team. Shifting the terminology from delegation to collaboration removed the hierarchy often present in a therapy assistant model. It highlighted the equal role of the therapy assistant in the teaming process around the person's goals and progress.

The best person to give feedback about how things are going is that assistant who's been seeing that person regularly.
- Manager 2

The therapy assistant provided feedback to therapists through written records shared in a common folder on the shared drive and through monthly collaboration meetings.

We'll read through [therapy assistant's] notes and get a bit of idea of how the sessions are going, and... if we need to change up what we're doing completely, if we just step up or step down, or if we just need some new ideas and some these strategies to be implementing during the session.
- Therapist 4

Billable supports

There are no set guidelines under the NDIS of how a therapy assistant model should be billed. Stakeholders discussed the billable supports under the therapy assistant model in the current project.

In general, billable supports included all direct supports provided by therapy assistants and therapists (in person or via teletherapy). A small amount of time was billed for indirect work and travel where necessary.

Therapy assistants and therapists also billed for indirect supports, including collaboration meetings and report writing, as part of implementing the goals by the therapy assistant. For more information, refer to the cost analysis section of this report.

Once a fortnight, myself [OT], the speech pathologist, and the AHA will meet on Zoom for an hour... our collaboration time: that's when we review the client's progress, and how we delegate what to do next, and if we need to review the goals or catch up with the family...
- Therapist 2

While direct supports and established collaboration meetings are billable under the NDIS, there were also reports of collaboration that was not billed and took considerable time for both therapists and therapy assistants.

It's only one hour a month, and it's quite rushed. And we don't often get to everything that needs to be talked about. Not even just clinically, but the practical side of things as well ... We text and email multiple times a week when there are more complicated situations. It's always been phone calls, outside of those collaboration meetings.
- Therapist 3

The role of Telepractice

Not surprisingly, telepractice has played a considerable role in the delivery of an outreach therapy assistant model. We asked stakeholders about their use of telepractice within their everyday work. Telepractice was used consistently to maintain the connection between therapists, therapy assistants and participants/families between outreach visits.

We got the AHA to set up out of a laptop, and we observed what the AHA was doing in that session with that family or that client.
- Therapist 5

The families that require more support will jump on and do telehealth sessions, whether it's a meeting with the family to discuss if something new has come up, or if that allied health assistant might need a bit of support implementing one of the strategies we mentioned. We make ourselves available for a session to provide guidance or support. So yeah, we do have telehealth sessions between face-to-face visits.
- Therapist 2

Where COVID impacted the ability of therapists to go on outreach visits, telepractice was seen as a way to bridge the gap in services due to lockdowns and establish and keep the service going.

In an ideal world when the states aren't in locked down, we would go four times a year... We're actually in the process of working out how that's going to look, so we can still provide services and feedback to the clients, but still capacity-building the AHA in a meaningful way, even though we can't be there in person.
- Therapist 4

Telepractice uptake, however, is dependent on the participant and their families comfort and confidence in using online programs. Therefore, telepractice supports need to be individualised and considered for their contextual fit.

We don't force people obviously to use Zoom and to have sessions with us. All we can do is offer and say, "Would you like to meet, have a phone call, have a chat?" And I find that people who aren't computer literate, they're usually more likely to say, "Oh no, I'll wait until you can be here in person." So there's definitely two ends to it, depending on the type of person.
- Therapist 4

It comes down to the individual participant and their needs, and does that fit, and then working around the logistics of what that looks like.
- Manager 2

Therapy assistant and therapist training

Training was discussed extensively, not only in terms of the needs of onboarding and supporting therapy assistants in the role but also to support experienced therapists who may not have previously worked as part of a therapy assistant model.

Therapy assistant training

Therapy assistants come into the role with a significant amount of variation in their skills and experience.

Having worked with three allied health assistants in a small space of time, I found that very interesting because all three have been totally different, with varied amounts of experience. I've been able to gather different perspectives for different allied health assistants.
- Therapist1

Therefore, training and support needs also varied accordingly. Instead of a standard training package, stakeholders talked more about training that responded to the direct needs and priorities of therapy assistants as they got to know their role.

We discussed any of the learning needs the AHA might have and that might be something that we can support internally either through a one-on-one training with the AHA or for example through monthly team meetings... We might have a guest speaker come or we might even look at some external training for our Allied Health Assistants as required.
- Manager 1

[therapy assistant Practice Leader] would meet regularly with the therapists involved within each team so they can identify any ongoing training issue that might be relevant to either that individual Allied Health assistant or the group.
- Manager 2

One of the OTs was doing an emotional regulation [training] for the AHA as a whole team, based on some of this feedback.
- Supervisor 1

TAFE Cert 4

While formal certification training was included as one of the questions during the semi-structured interviews, only a small amount of data focused on this within the current data set. This was mostly related to the relevance of the qualification for the role and the undue pressure it may place on the therapy assistant as a result. There was also concern raised about the lack of recognition of prior learning.

I don't feel like it was necessary that they do have it. However, it's a question we do ask, and we do put them through their Cert IV.
- Manager 3

we don't want that additional study that we're wanting people to do to be something that will tip someone over... We see it as a positive, but to some people it's become a stressor.
- Manager 2

Further insights into formal qualifications is reflected in the interviews with therapy assistants later in this project report.

Therapy assistant and therapist training

Therapist training needs

The therapy assistant model was being established for the first time, with therapists having had no previous experience working with therapy assistants. Therefore, there was considerable discussion in the stakeholder interviews of the "steep learning curve" experience by all as part of the project.

Therapists described areas of steep learning, including logistical considerations such as "collaboration time, how that would look for us, billing to collaborate between the therapist and the therapy assistant, and how much time we would be billing each family" (Therapist 7) and scope of practice in "understanding what was within our OT scope of practice, working with the allied health assistant" (Therapy manager 2).

Other areas centred around how to work with and break down strategies for therapy assistants to implement support programs.

The other really interesting thing for me as a therapist, … was how many skills I take for granted, that I do automatically in my direct therapy sessions, that … needed to be written or explained so the Allied Health Assistant was able to implement those without much modeling, or because we mainly communicate via distance rather than in person.
- Therapist 3

Stakeholders describe how an induction module was developed for therapists as an introduction to working with therapy assistants. This also became a part of induction for all new staff joining the team.

The induction module provided more understanding of what the program is, who therapy assistants are, and how therapists work with them under an outreach model (See Appendix A). This module and accompanying guidelines contributed to more clarity.

Now that we have those really clear guidelines of what we're doing as a therapist in comparison to the AHA's role, that's really brought everything together nicely.
- Therapist 5

Challenges for sustainability

Retention

One of the major challenges of the current project has been the high turnover of therapy assistants in some regions.

Reasons for high turnover were reported to be remuneration and working conditions, work cars, or offers of full time employment.

I have struggled with the high turnover of staff... It's probably the one challenge I didn't anticipate... They've definitely been touted by other organisations, who've been able to offer them more in terms of remuneration, in terms of cars, full-time employment. All things we weren't able to offer.
- Manager 3

This poor retention was reported to have a negative impact on the local community where Aspect as a service had worked hard to establish trust and a presence in the area.

It took a lot of time to build that trust that we would be providing a culturally sensitive service and that we were going to keep coming back, and that we were going to keep providing that support in a way that we had promised to them. Yeah. Having that inconsistency then with different allied health support workers had made it extremely difficult.
- Therapist 1

Stakeholders reported on the considerable workload for a therapy assistant in a rural and remote model. There was an expectation that outreach visits were organised by the therapy assistant who lived locally and had direct contact. This involved a considerable amount of unbillable hours, including communicating with staff members, rostering a schedule, and organising logistics for incidental workshops, including catering and marketing. This had a direct impact on their levels of stress and burnout.

It's not that they didn't enjoy the direct work they did with the families, but it was the expectations that were put on them. They were far too great to manage in that role.
- Therapist 1

I don't know the financial situation of how sustainable it is, but I know that the load that [therapy assistant] carries is one that it will burn her out.
- Therapist 6

Another workload challenge is based on the need to bill participants and reach targets for utilisation under a sustainable model. While also fitting in formal training, therapy assistants are expected to bill a certain amount of hours per day.

I think she feels a lot of pressure to bill lots and lots of clients for the day. Because there is an underlying worry that the program has to be sustainable from a financial perspective.
- Therapist 3

For more information on the utilisation expectations in the therapy assistant role, refer to the section on cost analysis of the therapy assistant model (page 54).

Challenges for sustainability

Therapist workload

There were learnings throughout the project regarding balancing the therapist workload. It was identified as being "the biggest limitation or barrier". If the therapist doesn't have enough time with the therapy assistant, the therapy model won't be successful. At the beginning of the program, the therapists were taking on a large caseload of participants.

We have a therapist, we have one day a week assigned to the Allied Health program officially. And that's technically 16 clients... just the admin around that and the amount of communication, especially for those more complex situations, it can be quite time consuming.
- Therapist 3

Over time, managers realised the impact of these high caseload numbers and set guidelines and time allocation when delivering therapy under a therapy assistant model.

We've learned from all of that. We know now that if you have under seven participants allocated to an AHA, the Therapist needs half a day a week to be able to manage the work between visits. If you have more than seven, you need a full day allocated in your week, so things like that. We didn't know when we first started.
- Manager 1

Another challenge in the therapy assistant model was the impact on a therapist workload during outreach visits. When on outreach, therapists were expected to see multiple participants per day and complete reporting often at night.

While this had a positive impact on billable time, it also negatively impacted well-being throughout the trip and made this time less attractive. This experience, however, was not consistently reported across all therapy assistants.

THE WORK
OF A RURAL, COMMUNITY-BASED THERAPY ASSISTANT: INSIGHTS ACROSS FOUR SITES

Aim

It is expected that the role of a therapy assistant working remotely from their delegating therapist in the disability sector would differ from those working in health and aged care, in clinical or on-site settings.

This mixed methods research aimed to identify the "work of a remote, community-based therapy assistant working under the NDIS with people with a disability".

The interviews also captured the experiences and perspectives of the therapy assistant on their role and its future in the disability sector.

Method

We collected data on participant goals and progress via routinely collected data outlined in the participant's individual support plan and progress report. All participant data were de-identified prior to analysis.

We conducted semi-structured interviews with four therapy assistants. The interviews were conducted online using a semi-structured interview guide for up to 30 minutes by one of the research team. Interview data was analysed thematically[1] to elicit new concepts and ideas in this emerging service delivery model.

Qualitative interview data was transcribed to ensure accuracy and entered into nVivo for qualitative analysis. The researchers read through the entire data set to understand the full breadth of the data.

Preliminary analysis identified a broad set of categories. Using a constant comparative approach, sections of the text were identified under each category. Relationships within and between categories were explored and then grouped to form several central themes. Themes and categories were synthesised to develop a story to connect the entire data set[1].

Rigour in the data analysis was ensured by constant comparison with the original data set and confirmation of the coding and thematic structure by a second researcher who coded and analysed 20% of the transcripts.

1. Clarke & Braun 2017

Results

Individual data related to goals and progress was collected from 40 participants across four sites. A total of 97 goals were included in the analysis.

Four therapy assistants across three sites were interviewed. Participant details are outlined in Table 2.

Participant	Time in role	Location (MMM)
Therapy assistant 1	15 months	4
Therapy assistant 2	13 months	3
Therapy assistant 3	18 months	3
Therapy assistant 4	5 months	3

Table 2. Stakeholder interviews participant details

Therapy assistant goals in the community-based disability context

Examples of goals included being able to:

- independently express his needs, wants and feelings to familiar and unfamiliar adults in the home, community, and school settings.
- Develop skills in reading social cues, develop positive social responses and friendships with peers.
- Be able to cope with separation from my mum and develop my independence.
- Learn how to communicate my wants and needs in a more positive way.
- Learn how to live independently and live away from home by the time I'm 24.
- Maintain my car and learn about finances.
- Access the community.
- Manage his emotions and follow calming strategies when feeling overwhelmed.
- Increase her attention span to be able to complete activities and begin.
- Engage in more imaginary/pretend play.
- Improve his self-care skills for example she would like [child] to have a Regular sleeping pattern so he can have good night sleep and eat a wider variety of foods.

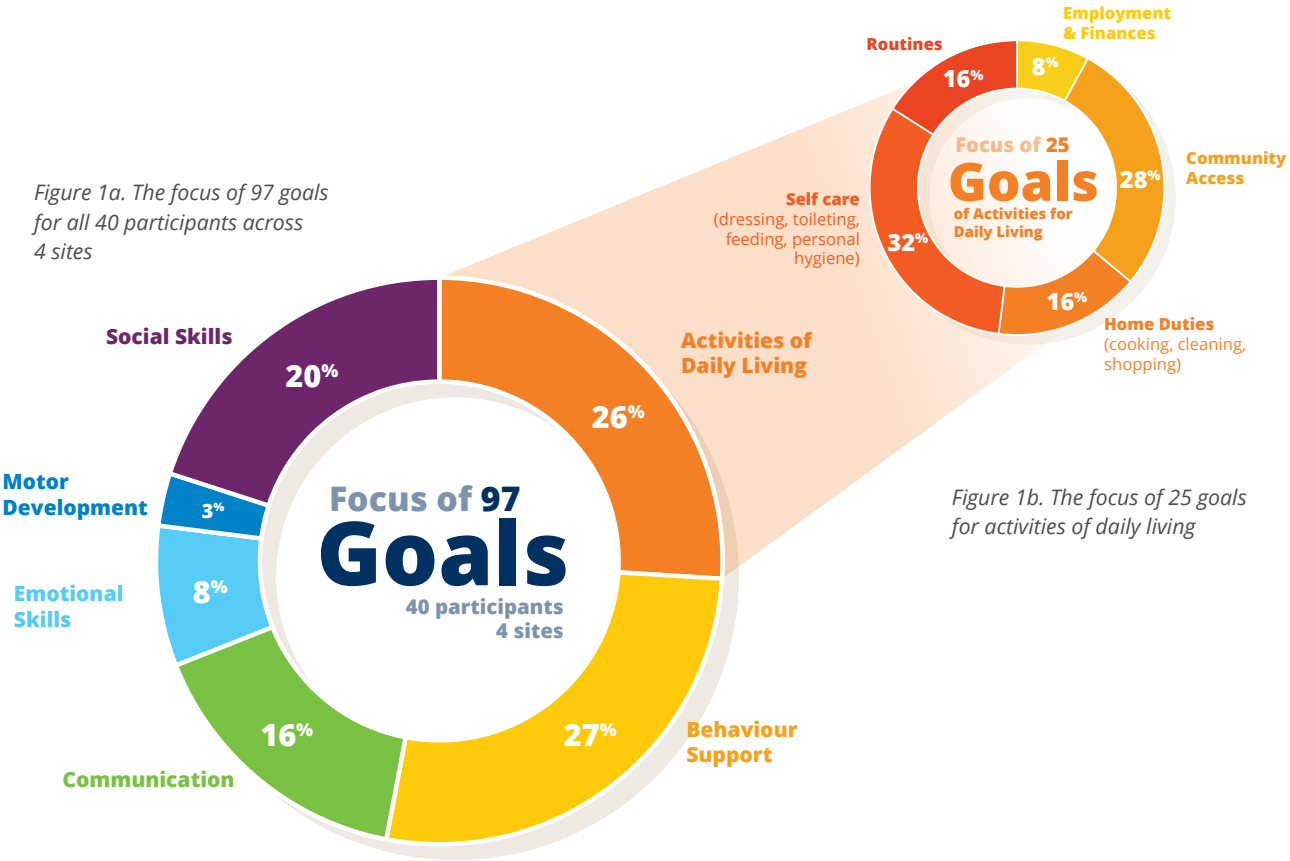


Figure 1a. The focus of 97 goals for all 40 participants across 4 sites

Figure 1b. The focus of 25 goals for activities of daily living

Progress of goals

Community access

- Make a decision to cross the road when there are no near approaching vehicles in either direction.
- Join a local community soccer team, which he loves to play on weekends.

Communication

- Tap mum on the shoulder and say, 'excuse me' and wait for 30 seconds.
- Use his Liberator Rugged 7 communication device with Words for Life Software to communicate his needs across a variety of environments 90% of the time when given a partial verbal prompt.
- Using key word sign "stop", some single words, expand play repertoire, allowing others in play space, parallel play.

Social and Emotional Skills

- Engage in conversations during class activities and familiar adults and friends in intimate settings.
- Independently greet others, initiate conversation, and ask three questions in a structured therapy session.
- Join in and play with other children at break time or at a recreation activity. Follow lead of other children, parents able to socialise at recreation activity.

Behaviour and emotional regulation

- Access a safe space with minimal prompting on 2-3 occasions to regulate his emotion within the classroom rather than absconding or using physical behaviours.
- Recognise basic emotions, his own body signals and preferred regulation strategies when discussing theoretically.
- No longer abscond from home especially when the routine was consistent. Observed to engage in all required activities as part of the class routine at school.

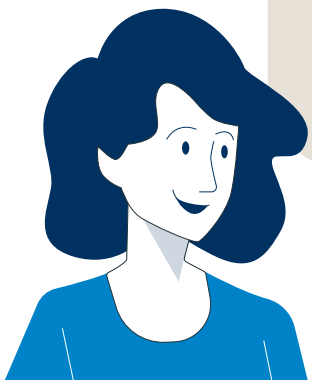
Activities of Daily Living

- Vacuum small areas of her house and tidy her bedroom with support
- Develop shopping list and take when shopping, follow a recipe card, Recognise/request appropriate amounts from recipe card, organise all items used or cooking and tidy up afterwards.
- Get dressed independently – occasionally requiring prompting to remember to put on her underwear.
- Put clean washing away, make bed, tidy bedroom, hang washing on the line with prompting.
- Independently pay for shopping.
- Participate in a "Safe Food Handling Course" online, to acquire product knowledge around the items for sale in the deli.

Therapy assistants' perspectives
on the therapy assistant model

We interviewed four therapy assistants on their perspectives and experiences of working in their role.

Seven themes were identified:



The work of a remote therapy assistant

Typical day

Therapy assistants talked about their typical day, saying that "Every day's a little bit different". They generally reported that they started with gathering resources, reading notes, and doing emails and phone calls before setting off for the day. After that, therapy assistants would typically see three to four participants a day, travelling between the participants' home, school, preschool, or out in the community. Each session was individualised.

Basically, it is looking at that individual's needs, and what the therapist and I have discussed, and what we're going to do that particular week or fortnight to support that person to work towards their therapy goal.
- Therapy assistant 3

Afternoons were spent writing up progress notes, responding to emails and phone calls, and preparing for the following day.

Therapy assistants spoke about the need for good organisational skills to keep up with the workload, especially administration and notes. They reported that writing up progress notes was particularly difficult to keep up with when starting in their role, but with guidance and support from their team, they could find ways that suited them.

I was finding it tough to fit everything in and get everything tidied up and finished for the day. But again, I spoke to my therapist and my supervisor and they helped me to create a schedule that fits me better, and to not feel as stressed and anxious about getting everything done.
- Therapy assistant 1

Over the course of the project, a template was introduced (see appendix B) that supported therapy assistants in this area.

We'd have our session goal strategies from the therapist to implement, and then our follow up notes and feedback notes, all in the one template.
- Therapy assistant 1

There were, however, some discussions on the sometimes-insufficient billable time associated with the reporting on progress that may have impacted therapy assistants' workload and working towards their individual targets hours (utilisation).

The report side isn't actually provided for … and depending on what kind of client you've had, it can take up to half an hour … I feel under the pump sometimes. Especially if you've had a full day and you're working towards utilisation.
- Therapy assistant 4

Therapy assistants discussed their day's typical travel, which ranged from short amounts of time to longer stretches (<30 minutes) when visiting school or families out of town. This was all reported to be covered by participant NDIS funding.

The work of a remote therapy assistant

Impact

Therapy assistants reflected on the changes they saw and the impact of the locally-based therapy assistant model.

Examples are given below from each therapy assistant interview.

Three year old nonverbal, non interactive [child] ... 12 months later, she's four years old, she's attending childcare, she's got friendships, she's laughing, playing, joining in play ... I just really, really loved being able to support her to develop in that way.
- Therapy assistant 1

He's gone from spending most of the day in an office to actually he's doing four days a week in the classroom now.
- Therapy assistant 2

We had a child who was about three or four and wouldn't use the toilet at all... We put in a couple of tweaks, a couple of ideas, suggestions, recommendations, and it has now progressed to where they're able to go the toilet.
- Therapy assistant 4

The main goal is to get him back to school, but we've also been working on regulation, emotional regulation... He's also had a lot of people come and go in his life, so I think he thought initially I was going to be one of those people. Yeah, we've got a lovely trust, and we feel, all of us, that work with him that we need that level of trust to support him with his goals.
- Therapy assistant 3

Therapy assistants reflected on the benefits of the model, including the focus on capacity building in natural communities rather than direct supports in a clinical setting. This was reported to have a significant impact on the child and their development.

I think it gives families a really... It gives them an option to have regular support coming into their home, that sort of capacity-building with continuity.
- Therapy assistant 3

Therapy assistants also reported being the "boots on the ground" and knowing what the family's going through and what the participants are doing each week and then reporting back to the therapist.

Getting services off the ground

The therapy assistants were the first Aspect staff member to live and work in the local area. Therefore, they also had the task of establishing and growing the services from the ground up.

Therapy assistants reported on a range of activities they engaged in to establish their caseload, including offering free training sessions on autism when the therapists visited, meeting with local services, including support coordinators, dropping off information to schools and "talking to anybody who would listen".

Therapy assistants reflected on their success in establishing a local presence and reported that word-of-mouth and being known in the community had a positive impact.

I think that it will just keep growing because word of mouth in a small town as well, knowing that someone is here for, to support the families is really great.
- Therapy assistant 1

It was more that somebody knew me. It's kind of like they know your brand, so they're going to attach to you and see whether this works out for them. In my experience, that's how we've been able to market.
- Therapy assistant 3

Therapy assistants also spoke about the value of being a local and offering locally based services and how that directly impacts the establishment of services.

The fact that I'm a born and bred local helps. In regional towns, a lot of organisations come out here and promise the world … and then they're gone again.
- Therapy assistant 2

Feeling part of a collaborative team

Therapy assistants reported on how they worked with the therapists under the model. Again, the word collaboration was used extensively throughout the discussion in the absence of the word “delegation”. They reflected on their role and felt like a valued part of the team when working with therapists.

Even though it is, I guess, a bit of hierarchy I’m the assistant and then sort of have therapists and supervisors...
But I’m not made to feel like that.
I am made to feel like a part of a team... an integral part of the team.
- Therapy assistant 1

That’s the biggest thing coming here... It actually feels like you’re on a team... It is really about the therapy itself and the collaborative experiences, and about trying to provide the best supports that we can... We’re all on the same level, we’re all just filling out different roles and that I think is a very important component.
- Therapy assistant 4

There were references to the role of training in supporting the knowledge and understanding of the therapy assistant model, and how to work effectively as part of the collaborative team (See appendix A).

The role of telepractice

Telepractice was used in a variety of expected and unexpected ways to support the therapy assistant model. Expected uses included for the team to meet regularly to discuss progress after the initial outreach visit and for therapists to observe the therapy assistant implementing the program and offer collaborative support for participants and families.

If the family wants, and asks for it, we can do a teletherapy check in with the Therapist while I'm there.
- Therapy assistant 1

My OT joined in [via Zoom] on the first one to support me... Obviously very different to, face to face, but we were still able to get out of it what we needed to.
- Therapy assistant 1

Unexpected uses included where telepractice was used to extend therapy assistant support across regions where a therapy assistant had resigned.

Another Allied Health Assistant in another region... she's left. So I've started to see a couple of clients in another region as well, just via teletherapy... And I think it was really exciting and it's been really exciting to be able to help out in a whole other regional area, because there's just so much need for it in regional areas.
- Therapy assistant 2

The onset of COVID 19 during the project timelines also impacted the ability of therapists to go on outreach visits.

For established sites, this was not reported to be an issue; however, interestingly, one site was established purely under a telepractice model due to the onset of sudden lockdown restrictions. The local therapy assistant reported on the successful use of telepractice in the absence of in-person visits.

Generally, it starts off with an initial session, so we get to know each other, maybe write down some goals that people have, and then there is a follow-up meeting, and then every couple of months in line with when they might come to town ... they do a zoom session, and we observe, and I set up it so that they can see and all kind of thing.
- Therapy assistant 4

Therapy assistant training

All therapy assistants were offered and accepted the opportunity to complete their Certificate IV Allied Health Assistance as part of their position. Therapy assistants were asked an open-ended question about their experience and perspective of the training. We found that most of the discussion centred around the relevance of the units to the work of a community-based therapy assistant supporting people with disabilities.

Honestly, it's very hospital-specific. So it's been super interesting, but I don't know that I could tell you how relevant it is to what I do on a day to day basis ... there are some units that aren't really appropriate to us in the disability sector. So that's been a little frustrating...
- Therapy assistant 2

I think at this present time, I don't think as much effort as it's put into is as relevant, but obviously later on down the track, when we are not doing the anatomy, it will be a bit more relevant.
- Therapy assistant 4

Even now with the study, I'm ticking the boxes, but I don't even feel as though the study is giving me the tools that I need. It's basically ticking some boxes. I'm doing biology at the moment, and it's been very, very complex and very stressful.
- Therapy assistant 3

There's maybe two or three units out of, is it 14 or 17 in a Cert IV, that I can actually go back and go, "All right. I can use this in my job."
- Therapy assistant 2

There was also poor recognition of prior learning, with two therapy assistants advising they were unable to receive any for their previous certification. One of them reported having a Diploma in Case Management and Community Services.

Responding to training needs

Therapy assistants discussed the value of the training they received as part of their induction and internal professional development and the training they received "on the job" working with the therapists themselves. This training included subjects such as sensory processing, zones of regulation, positive behaviour support, reflective practise, supporting a therapist's implementation of AAC, and supporting social skills.

Moving forward it would be good to have more training and information around the day-to-day stuff, the conversations you're going to have with your [therapists], the programs you're going to be using regularly, resource development.
- Therapy assistant 3.

Therapy assistant training

One area discussed in the interviews was the role of the therapy assistant working as part of a collaborative team implementing Positive Behaviour Support (PBS).

Therapy assistants reported they were provided training on PBS. However, they then found out they could not implement this with their participants.

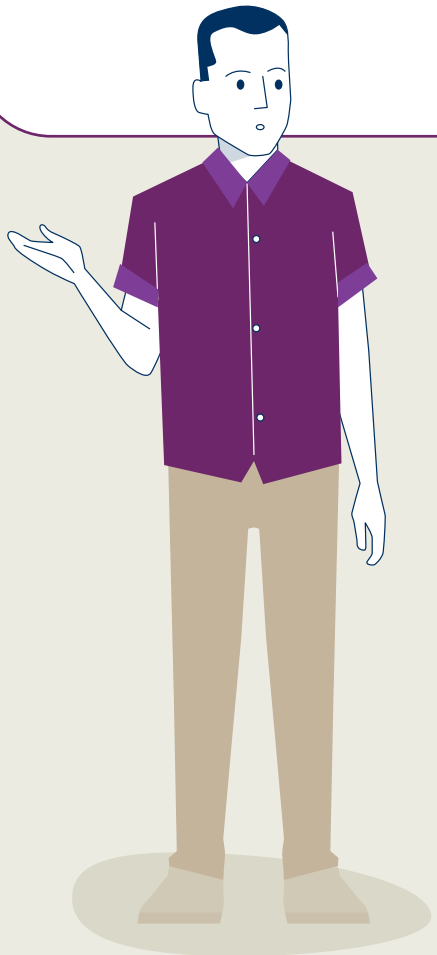
PBS is regulated by the NDIS Quality and Safeguards Commission and requires staff to deliver a comprehensive assessment. Intervention for challenging behaviour are conducted by tertiary-qualified professionals with training and experience in delivering PBS.

While the therapy assistant is unable to engage with the family in the assessment or development of behaviour support plans, their role in implementing a plan is currently unclear.

I feel like as an AHA with this client, I don't actually do much. So the Therapist did the plan, the behaviour plan. She's done all the paperwork, all the stuff in the background … and then it's been given to the school. And so I'm just kind of going there, monitoring the school.

- Therapy assistant 3

Therapy assistants reported being able to support the PBS team to develop and implement plans; however, further exploration is needed on what that will look like.



Challenges of working as a therapy assistant

Therapy assistants reported several challenges in their role. These included when they had a change of therapist and had to build the relationship from scratch, adapting to changes in therapy style or strategies, isolation in the role being the only team member living and working in the local area, as well as COVID lockdowns and their impact on outreach visits, further exacerbating the feeling of isolation.

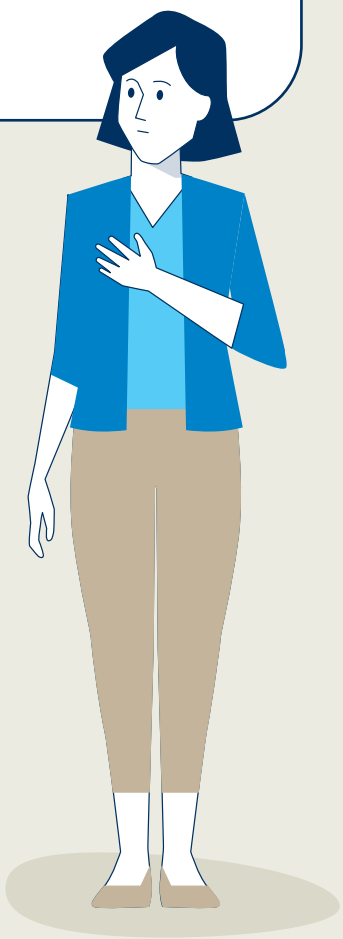
However, one of the major challenges in the role centred on the lack of career progression and inadequate remuneration in the therapy assistant role.

My two [family members] are support workers and they get paid under an award that is a higher grade scale than my hourly rate. And they've got their first aid, and also only doing a Certificate III... So I feel like we need to be more qualified, but we're not rewarded with it.
- Therapy assistant 3

I would like a progression path. Obviously it's a very fresh role, but providing avenues, not only to scale up and maybe not only moving into other areas, but maybe into a more open area to have even more of an impact within scope.
- Therapy assistant 4

By underpinning it as an actual conduction of therapy and paying accordingly, I think it would go a long way in providing quality supports, but also in attracting people to an industry that is newly forming.
- Therapy assistant 4

For more information on therapy assistant pay scales and career comparisons, see section on cost analysis (page 54).



PERSPECTIVES OF AUTISTIC YOUNG PEOPLE

RECEIVING THERAPY ASSISTANT SUPPORT IN AN AUSTRALIAN RURAL COMMUNITY: A PRELIMINARY ADAPTED PHOTOVOICE PROJECT

A research study by a University of Sydney Occupational Therapy final year honours student in collaboration with Centre for Disability Research and Policy (CDRP) and Autism Spectrum Australia (Aspect).

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Secondary authors: **Dr Kim Bulkeley** (CDRP) and **Dr Genevieve Johnsson** (Aspect)

Aim

It is important to seek feedback on models of services from the people who use them. We aimed to gather information directly from NDIS participants on their experience of working with their therapy assistant and its impact in their lives.

Methods

Photo elicitation with NDIS participants was engaged in this participatory action research approach to enhance communication. A training phase was undertaken with each participant to develop their photography skills and understanding of consent for any others included in their photos[1]. Participants were asked to take photographs of their experiences of working with the therapy assistant. These photos were used as a communication device to explore the experience of the NDIS participant in a more accessible format for participants with communication difficulties. Conversations about the photos were digitally recorded and thematically analysed[2]. Data was de-identified and a pseudonym was used in the reporting of results.

This is a qualitative approach designed to increase participation of people with communication difficulties[3]. Photo elicitation engages the participant in analysing the photos and describing what the photo is about. These conversations were recorded and transcribed for further analysis of the concepts expressed. The conversations' interpretation was 'member checked' with each participant to confirm a shared understanding of the meanings ascribed to the images.

1. (Lam, 2020)
2. Clarke & Braun 2017
2. Booth, 2003

Results

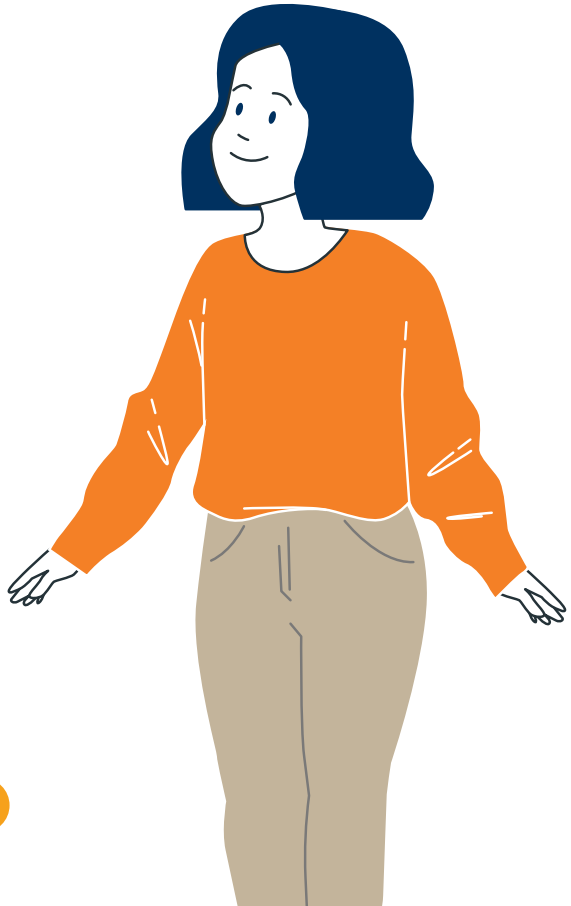
Analysis of the interviews revealed three themes about the therapy assistant service:

1) Getting the help I need,

2) Does she come today, mum?, and

3) We had no one.

We also identified a number of subthemes as depicted below.



Getting the help I need

The data revealed this theme about how the therapy assistant model provides person-centred therapeutic supports that are specific, tailored and individualised to each participant. Participants reported that this enabled them to achieve important and meaningful goals. The data clustered into three sub themes: Interdisciplinary practice, tailored intervention, and choice of location.

Interdisciplinary practice

For both participants, the therapy assistant engaged regularly with the parent, the OT and SLT to plan and organise the most suitable interventions:

[The therapy assistant, SLT, OT and I] have regular meetings... via Zoom call. And we go through strategies [on] how to move forward and what would be best for Dylan.
- Dylan's mother

This enabled an interdisciplinary approach to be undertaken during therapy assistant sessions as expertise and input from all team members were combined and integrated to achieve participant-identified goals.

Tailored interventions

Both participants described specific interventions facilitated by their therapy assistant that were tailored to their needs. Each intervention was also collaboratively developed, meaning participants were included in the process of refining the interventions that worked well for them.

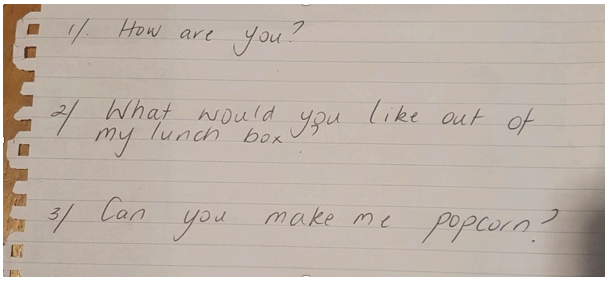


Figure 2. Three questions Abby can ask her boyfriend

Abby was supported by the therapy assistant with building communication skills (Figure 2). Abby illustrated her acute awareness of the importance of her goals and how her therapy assistant assists her in achieving them:

[My therapy assistant] helps me think of questions that I can start asking people every day, like "how are you?". ....to help me talk to people more because I don't really talk to people that much. I don't ask questions during class, I don't ask for any help...I am struggling with it.
- Abby

When shown their photo during the interview (figure 2), Abby laughed and said, "That's the questions I had to ask [my boyfriend]". Her enthusiasm when discussing this topic indicated a sense of joy participating in this task.

This approach to developing communication skills was tailored by her therapy assistant, in collaboration with Abby who was involved in the process of coming up with the questions, demonstrating a joint effort in implementing the intervention strategy.

Abby confirms she regularly uses this intervention strategy, saying "I always ask him the third one, whenever he comes over I always get him to make me popcorn", further supporting the appropriateness of the collaborative therapy assistant approach.

This illustrates the functional impact of achieving this goal on her day-to-day life in improving interactions with her boyfriend, thus, demonstrating the importance of the therapy assistant intervention in achieving her overall goal of improving communication skills.

Getting the help I need

Another tailored intervention facilitated by the therapy assistant (figure 3) was identified by Abby and her mother:

"That's my whiteboard that ... [has] my jobs on for either afternoon, or in the morning when I'm getting ready for school."
- Abby

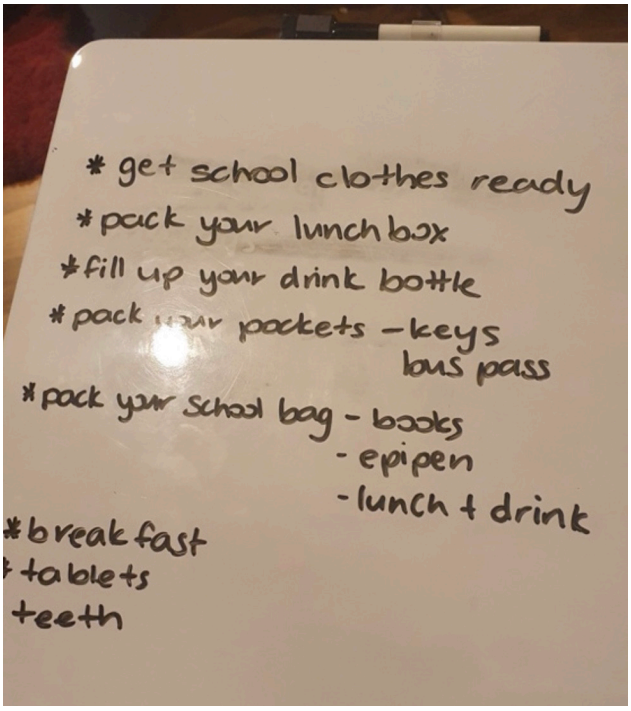


Figure 3. Whiteboard outlining Abby's morning routine/to-do list

Whenever she [Abby] needs to get organised for something, we put everything on there and then she rubs them off when she has done them... When she's got an empty board, she knows she's ready and organised.
- Abby's Mother

This strategy was implemented collaboratively with Abby, her mother and the therapy assistant and resulted in improved ability to remember her routine.

With therapy assistant support, it is a stepping stone to achieving Abby's overarching goal of "developing independent living skills".

Abby's mother also described how numerous interventions were trialled in the past to help Abby remember her routine, however the whiteboard has been the only successful one:

We've tried lots of different things to keep her in a routine and get her ready for school. So, that, one day she can do it by herself without me. And nothing's stuck, it would work for a week or so, and then it would just go pear-shaped. The whiteboard, seems to be the magic thing.
- Abby's Mother

Getting the help I need

For Dylan, working with his therapy assistant to build awareness of emotional state and learn self-regulation strategies was identified as an important goal (Figure 4).

Figure 4. Dylan learning red, green and yellow emotions in the Zones of Regulation™ with his therapy assistant

Due to previous difficulties with expressing his needs and understanding how he is feeling, a simplified approach using colours and visual prompts was adapted for use in therapy assistant sessions, with the intention of implementation in everyday activities.

Dylan was able to showcase this skill during the interview, despite his limited verbal capacity, describing: "[The red zone is] when you're angry and scared... [The blue zone is] when you're feeling sick or whatever... [The green zone is] when you're happy and calm." He was able to articulate that the green zone is the one he likes being in most, demonstrating his increased insight into his emotional state.

This illustrates how his engagement with therapy assistant support has fostered improvement and enabled him to work towards important and meaningful goals.

Working regularly with the therapy assistant on these emotional and self-regulation strategies at school and home has been extremely beneficial in reducing behaviours of concern that had previously impeded his ability to attend school and interact with his siblings. His mother described the improvement in his self-regulation and awareness of his emotional state: "Majority of the time, he can now self-regulate... He really thinks about what he's doing before he does it." His mother also described how the collaborative and responsive nature of the therapy assistant session promotes his engagement by enabling him to explore his interests:

It's not just telling Dylan what he has to do, it's incorporated so that they're doing the zones first and then he gets to choose an activity, which is really good because he really struggles with the stuff that he doesn't want to do.
- Dylan's mother

Dylan's mother described how the intervention greatly improved the family dynamic:

Since [the therapy assistant] and Aspect have been working with [him], it's probably the most smooth, happiest [my family has] been as a whole.
- Dylan's mother

This illustrates how supports provided by the therapy assistant has not only fostered improvement for Dylan on the individual scale, but also had a positive impact on his wider social environment. The therapy assistant supports were provided in an accessible and consistent manner in both home and school environments that has increased the implementation of helpful strategies to regulate himself and increase interaction with his peers and family.

Getting the help I need

Choice on location

The locally based therapy assistant model provided a choice on the location where therapeutic supports would occur, as described by Abby's mother: "it would be easiest to [have therapy assistant supports] at home. But we could have gone to her, or she could have come to the school... we had the choice."

This meant that participants and their families could choose the most comfortable environment to promote their engagement. Abby expresses how having therapy assistant supports in the home is highly beneficial for her as she does not like leaving the house:

I don't like going out of the house...
I like having her come to my house.
- Abby

Dylan receives therapy assistant supports within the home and school:

[Our therapy assistant] works with Dylan every Wednesday at school and she also does an at-home appointment with Dylan ... every Thursday.
- Dylan's mother

This illustrates the flexibility of therapy assistant supports as they can be delivered in environments that most suit participant needs. This feature of the service was valued by both participants and supported achieving their goals.

Does she come today, mum?

The data spoke to the positive and constructive relationship participants share with their therapy assistant and how therapy assistants act as a link between participants and their families, therapists and other local stakeholders such as education staff.

Both participants described a positive relationship with their therapy assistant. They describe her as a "friend" and someone who they liked to spend time with. Abby's mother contextualises this relationship through a description of her engagement with the therapy assistant:

[Abby] has a good time. If she didn't want to do it, she'd just disengage herself and she wouldn't talk.
- Abby's mother

Dylan's mother described her child's reaction to working with the therapy assistant:

He will ask on a daily basis, 'Does she come today, mum?'
- Dylan's mother

This description of his constant questioning shows his eagerness towards working with his therapy assistant on a frequent and consistent basis. This frequency and consistency was noted to be a significant facilitator in fostering improvement for both participants; it enabled them and their families to have therapeutic supports in the same setting with the same therapy assistant and therapists.

Abby noted that having her therapy assistant come each fortnight was very helpful in helping her remember the skills she has learned and what to practice between each session to further develop these skills.

Dylan's mother described the bond that her child and the therapy assistant shares that enables the therapy assistant to facilitate Dylan to achieve his goals:

She's so calm and compassionate with him... he's formed such a great bond with her... She definitely pushes him to the max as far as she can... She's good at recognising whether he's not in a such a good place and she won't push as hard...
- Dylan's mother

However, this bond was only possible due to a slow and gradual process of interacting with Dylan in ways that was comfortable for him:

[Developing their bond] very slow and gradual... to begin with, [the therapy assistant was] watching Dylan play his video games.... interacting with [him], going out to meet his chooks.... it was a very slow process and very short periods.
- Dylan's mother

Once they had formed this bond, his mother noted that :

He gets quite emotional when [the therapy assistant] is unable to come... [the therapy assistant] had to have some time off... and he really struggled without her.
- Dylan's mother

This emotional reaction from Dylan demonstrates how important consistent therapy assistant support is in his life and the significant relationship they share.

Does she come today, mum?

For both participants, their therapy assistant acted as a link with their families and therapists, as described by Abby's mother:

The [OT and the SLT] got together and they've written a plan for [the therapy assistant] and us to follow. And then [the therapy assistant] reports back to them, and they give her what needs to be done next.
- Abby's mother

Similarly, Dylan's mother described the therapy assistant as the local on the ground person who enacted plans made by therapists:

The specialists guide [the therapy assistant] on what to do... and then [the therapy assistant] puts everything into place. So she's the main go-to grounds person, but the [OT and the SLT], are actually giving instructions.
- Dylan's mother

Dylan was experiencing significant challenges with participation at school due to the lack of specialised support provided at the school. For Dylan's family, having the support of the therapy assistant and therapists was important in advocating for his needs within the school environment:

Previously to [the therapy assistant, OT and SLT] coming on board, it was me fighting alone... now, I have backup: I have these wonderful people supporting me, so the school doesn't really have much of a choice but to listen and take [Dylan's] needs seriously.
- Dylan's mother

This illustrates how the therapy assistant was important as both the internal link with Aspect therapists, but also being an external link by providing support with other stakeholders such as advocating Dylan's needs to education staff.

We had no one...

The data identified the many barriers that participants experienced in accessing therapy in the past, and how Aspect's therapy assistant service enabled them to receive timely, frequent and consistent therapy services for the first time.

Both mothers stated numerous barriers to accessing therapy services in their rural town. One of these was long waitlists:

There's really long waiting lists. If we hadn't found out about Aspect we'd still be waiting.

Another was limited place-based clinicians resulting in having to travel long distances to reach therapists:

If we hadn't gotten onto [Aspect's therapy assistant service], we would've... had to go to [another town], which is a couple of hours away.

Dylan's mother expressed how another one of her children who has an NDIS plan is still unable to access OT services despite being on the waiting list for two years:

My daughter's just turned 16... we've been on the waiting list for a new [OT] assessment for her for the last two years.

Due to limited place-based clinicians, Dylan previously used the FIFO model for a couple of years to receive OT services as it was the only option available:

[the OT would] fly in and fly out... once every three months.
- Dylan's mother

Upon reflection of this service delivery model, Dylan's mother stated:

It definitely didn't work well, because by the time she'd come back for the next visit, new issues had [arisen] and there was no help in between, it was just me trying to battle it all alone.
It was quite complicated because by the time she came back, Dylan would forget everything because there was nothing repetitive. We'd have to basically start from scratch each and every time.
- Dylan's mother

We had no one...

The lack of therapeutic support is the norm in this rural community. Abby said that prior to Aspect's therapy assistant service "*we had no one*", again reinforcing the valued role of the therapy assistant for these families.

Both participants received therapy assistant support for the first time through Aspect's services.

For Abby, this therapy assistant support was the first time she had received therapy services as a whole.

The initial awareness of Aspect's therapy assistant service was difficult to come by for both families. However, once they had made contact with Aspect, setting up therapy assistant supports occurred relatively quickly:

The wait lists for OT and speech therapists were ridiculous... [Aspect] said there's telehealth services, so I started looking into those, and then she mentioned this therapy assistant thing... so I emailed [the therapy assistant] and we got in... it was about six weeks and we were up and running.
- Abby's mother

For Dylan, his previous OT under the FIFO model of care was unable to continue delivering services due to COVID-19 restrictions, which prompted his family to source other therapeutic supports:

It was my NDIS coordinator at the time, who's also friends with [the therapy assistant]... Because of COVID, our regular OT is no longer working in [our town]. And [the therapy assistant] had just started working for Aspect... Dylan's NDIS coordinator got on to it straight away for us... we got approved straightaway.
- Dylan's mother

In this way, the timeliness of Aspect's therapy assistant service overcame rural barriers by enabling the provision of frequent and consistent therapeutic supports for both participants.

COST ANALYSIS

OF THE THERAPY ASSISTANT MODEL TO ADDRESS DISABILITY WORKFORCE SHORTAGES IN REGIONAL AND REMOTE AUSTRALIA

Aim

This research aims to conduct a cost analysis of the community-based therapy assistant working under the NDIS in regional and remote communities of Australia to address workforce shortages in these areas.

This will help to support the monetary risks and barriers associated with establishing the therapy assistant model of service in rural and remote areas under the NDIS, and establish ways to maintain a sustainable service beyond the project funding period.

Methods

This research is part of a broader project investigating the therapy assistant model in the NDIS disability sector. It incorporates findings from interviews with key stakeholders and a review of key documents to identify and value the economic costs of establishing and delivering a therapy assistant service to people with a disability in rural and remote areas.

Further data was extracted in this study on financial modelling of the therapy assistant role, as well as billable and non-billable costs associated with the delivery of the therapy assistant service across four regional and remote sites.

As part of measuring costs, de-identified data was extracted from Aspect client's management system on:

- Hours of billable service delivery for all therapists, supervisors, and practice leaders. This was further broken down into direct intervention by the therapy assistant (face to face and telepractice), direct intervention by the therapist (face to face vs telepractice), collaboration, administration, and travel.
- Hours of non-billable service delivery for all therapists, supervisors and practice leaders including professional development (internal and external training), supervision, and meetings.

De-identified information was also gathered from Aspect Finance and Human Resources on the financial modelling of the therapy assistant service including salaries and minimum billable hours.

Finally, publicly available information was gathered from relevant websites comparing therapy assistants' role to similar roles.

Results

Salary and oncosts of employing a therapy assistant

Guidance from the health sector

In deciding on salary, we considered the role of therapy assistants working in the health sector employed under the *NSW Health Service Allied Health Assistants (State) Award 2021*.

The levels and salary are outlined in Table 1 below:

Classification	Rate to apply prior to ffppoa 01/07/2021 **$ per week**	Rate from ffppoa 01/07/2021 **$ per week**
Allied Health Assistants		
Level 1		
Entry	1,011.01	1,031.63
Level 2		
1st Year	1,035.28	1,056.40
2nd Year	1,054.62	1,076.13
3rd Year	1,068.28	1,090.07
Level 2		
1st Year	1,101.58	1,124.05
2nd Year	1,123.69	1,146.61
3rd Year	1,151.44	1,174.93

Table 1. NSW Allied Health Assistant levels and salaries

Level 1:
A Level 1 Allied Health Assistant engages in basic patient care, clinical duties and/or administrative support under the supervision of the designated Allied Health Professional. The Level 1 Allied Health Assistant is developing skills and progressing from working under direct supervision to undertaking tasks under indirect or remote supervision. An Allied Health Assistant at this level:

- has completed less than 12 months' service as an Allied Health Assistant; and
- does not hold the qualification of a Level 2 or Level 3 Allied Health Assistant.

Level 2:
A Level 2 Allied Health Assistant undertakes clinical duties and/or administrative tasks under direct, indirect or remote supervision. An Allied Health Assistant at this level:

- has completed 12 or more months' service as and Allied Health Assistant Level 1; or
- has completed a relevant Certificate III qualitication or other qualification deemed equivalent by the employer or where they have been successfully assessed as possessing the competencies required for Certificate III by way of RPL.
  Progression to Level 2 will apply from the date that the employee notifies the Employer and provide evidence of having attained the equivalent qualification of Statements of Attainment.

Level 3:
A Level 2 Allied Health Assistant undertakes clinical duties and/or administrative tasks under direct, indirect or remote supervision and has completed a relevant Certificate IV qualification or other qualification deemed equivalent by the employer or where they have been successfully assessed as possessing the competencies required for Certificate IV by way of RPL. Progression to Level 3 will apply from the date that the employee notifies the Employer and provide evidence of having attained the equivalent qualification of Statements of Attainment.

(NSW Health Service Allied Health Assistants (State) Award 2021)

Transferred to the disability sector

Therapy assistants were employed under the same award for therapists within Aspect: the *Health Professionals and Support Services Award 2010*. Therapy assistants were classified as support services employees at a Level 5 with additional salary for Certificate IV qualifications.

The classification and salary are outlined below. This salary is commensurate with a Level 1 and Level 3 Allied Health Assistant working under the *NSW Health Allied Health Assistant Award 2021*.

During our project, there were many costs associated with employing a therapy assistant above that of employing a therapist, including travel and higher training and induction costs. These are outlined in Table 2 below.

Support Services employee—Level 5:
An employee at this level:

- is capable of functioning semi autonomously, and prioritising their own work within established policies, guidelines, and procedures
- is responsible for work performed with a substantial level of accountability
- works either individually or in a team
- in the case of an administrative/clerical employee, requires a comprehensive knowledge of medical terminology and/or a working knowledge of health insurance schemes
- may require basic computer knowledge or be required to use a computer on a regular basis
- possesses administrative skills and problem-solving abilities
- possesses well developed communication, interpersonal and/or arithmetic skills
- requires substantial on-the-job training and may require formal qualifications at trade or certificate level and/or relevant skills training or experience

(NSW Health Service Allied Health Assistants (State) Award 2021)

Metric	Therapy Assistant (Unqualified)	Therapy Assistant (Qualified)	Therapist
Type of employment	Salaried (1EFTL)	Salaried (1EFTL)	Salaried (1EFTL)
Insurance	Org	Org	Org
Base pay based on Award	Health Professionals award (Level 5) $53,331	Health Professionals award (Level 5 Q) $58,331	$70,000 - $105,000
5% oncosts	$2,667	$2,917	
Other costs	$14,940 (TAFE, travel costs, equipment, set up)	$9,940 (Travel costs, equipment, set up)	
Total cost	$70,938	$71,774	
Business days per year	243	243	243
Available Business days (after leave)	216	216	216
Training/Meetings	53 (incl. 30 days induction)	42 (incl. 20 days induction)	23
Available FFS days	163	173	193
NDIS Travel rate (15 mins)	$21.69 (MMM 1-3) $30.38 (MMM 4-6)	21.69 (MMM 1-3) $30.38 (MMM 4-6)	$48.50 (MMM1-3)
NDIS Travel reimbursement	85c per km	85c per km	85c per km

Table 2. Costs associated with employing a therapy assistant based on award wage (comparison with a therapist)

Similar career comparison

There are several roles similar to that of a therapy assistant working with people with a disability. To understand the attraction and retention of the therapy assistant's role, we explored the current pay conditions and associated charge out rates under the NDIS. These are outlined in Table 3 below:

Metric	Disability Support Worker	Teacher's Aide	Therapy Assistant (Unqualified)	NDIS Support Coordinator
Type of employment	Casual	Salaried	Salaried	Casual
Insurance	Own	Org	Org	Own or Org
Base rate salary (per hour equiv.)	$57,538 ($29.12)	$70,855 ($31.74)	$53,331 ($27.00)	$74,175 ($37.54)
NDIS charge out rate	$57.10 (MMM1-3: Level 1 weekday daytime) $79.94 (MMM4-6)	-	$86.79 (MMM 1-3) $121.51 (MMM 4-6)	$100.14 (MMM 1-3) $140.19 (MMM 4-6)

Table 3. Comparison of salary and charge out rates across four similar roles

Organisational induction

Given that the remote therapy assistant is working in isolation without direct supervision of therapist or practice leaders, training and induction is vital in the integrity and success of the service. Therefore, one of the goals of the current project was to develop an intensive induction program that would meet the needs of the therapy assistants coming into the role with a broad range of skills and experience.

This intensive induction is outlined below and was developed into a set of learning modules that were both self-paced and facilitated by the practice leader.

Module/Activity	Time
Welcome and IT setup	3.5 hours
Client Management System Training	4.5 hours
Internal Systems Training (Expense manager, riskman, aurion, kit)	4 hours
E-learning modules	
Acknowledging and Recording Feedback and Complaints	.5 hour
Workplace Bullying Prevention for Staff	.75 hour
Aspect Child protection	1 hour
Aspect Code of Conduct	.5 hour
Child Protection Training	1 hour
Introduction to Autism – Positive Partnerships	2.5 hours
Safeguarding the People We Support	1 hour
Supporting People on the Autism Spectrum using the *Five Point Star*	1 hour
Learning Modules	
Introduction to Aspect	3 hours
Aspect Culture and Practices	1 hour
Aspect Therapy's Scope of Practice	1.5 hours
First Meeting with Participant and Family/Carer	2 hours
Safe Home Visits	1 hour
The Aspect Comprehensive Approach	1 hour
The ISP & Reporting	1 hour
Best Practice Customer Service and Communication	1 hour
ICS Practice Standards	1 hour
Working Collaboratively across Disciplines	1 hour
Coaching Conversations with Families	1 hour
ICS Business Plan for 2021	.5 hour
TOTAL	**35.5 hours**

Table 4. Aspect therapy assistant induction training program

Billable hours (per participant)

Sustainability was a goal of the therapy assistant model from the outset.
During the course of the early learnings, billable hours of both the therapist and therapy assistant needed to be established and outlined with families as part of a signed service agreement.
These are outlined in table 5 below:

Activity	Time	Frequency
Therapy assistant		
Direct participant supports	Agreed time	Agreed frequency
Travel	As per location	Per session
Indirect participant supports	Agreed time	As necessary
Collaboration time (per discipline SP/OT)	30 mins	Monthly
Therapist		
Direct participant supports	Agreed time	Agreed frequency
Indirect participant supports	Agreed time	As necessary
Collaboration time	30 mins	Monthly

Table 5. Billable hours in a therapy assistant model (per participant)

Non-billable hours

Many activities in the therapy assistant model were not directly billable to participants and therefore needed to be factored into the financial accountability of the role. These are outlined in table 6 below:

Activity	Time	Frequency
Therapy assistant		
Outreach team meeting	60 mins	Monthly
Support & supervision (AHA Practice Leader)	60 mins	Monthly
Therapy assistant team meeting	60 mins	Monthly
Therapist		
Outreach team meeting	60 mins	Monthly

Table 6. Non-billable hours in a therapy assistant model

Charge out and utilisation targets

Based on the previous information, financial modelling was conducted to determine the daily utilisation rates that would enable a sustainable therapy assistant model. This is outlined in table 7 for both qualified and unqualified therapy assistants in comparison to the therapist:

Metric	Therapy assistant (Unqualified)	Therapy assistant (Qualified)	Therapist
NDIS charge out rate	$86.79 (MMM1-3) $121.51 (MMM4-6)	$86.79 (MMM1-3) $121.51 (MMM4-6)	$193.99 (MMM1-3)
Billable hours at breakeven working 3 days per week (Percentage utilisation)	MMM 1-3 6 hours (79%) MMM 4-6 5 hours (66%)	MMM 1-3 5 hours (66%) MMM 4-6 4 hours (53%)	3.8 (50%)

Table 7. Charge out and utilisation targets in a therapy assistant model

Organisational costs of recruiting therapy assistants

The following costs (table 8) are an estimate of the costs in establishing and recruiting a new therapy assistant in a new location. This involves visiting the location prior to recruitment to develop relationships, market the service and discuss with possible candidates.

Item	Cost
Flights and accommodation to market services and develop relationships prior to recruitment	$4,000.00
Flights and accommodation during recruitment process	$4,000.00
Therapy assistant learning & development	$5,000.00
Other costs (laptop, printer, phone, iPad, uniform, resources and stationery)	$2,000.00
TOTAL	**$15,000**

Table 8. Organisation costs of recruiting a therapy assistant

Due to COVID lockdowns, location visits were not always possible. Therefore, we relied heavily on telepractice to market, recruit and induct new therapy assistants. While an ideal scenario would have been to visit the locations to develop the relationships, we found that when we had selected the right candidate with good community connections our service was able to be established without the team visiting. This has implications for setting up further new locations in a sustainable way.

Aspect identified a number of factors impacting new therapy assistants' onboarding and how quickly they were able to establish a caseload. When recruited to an existing location, therapy assistants can begin to roster billable sessions from the third week of their induction period, with gradual pick-up of existing cases. In new regions where there are existing referrals and therapists have been able to start engaging with new participants, we can allocate cases more quickly without waiting for the end of the induction period.

In some situations, the therapy assistants have been involved in building the caseload and profile. This has lengthened the time from commencement until sessions have been completed.

Previous experience in similar roles is another important factor influencing onboarding. In some locations, it has been more challenging to recruit therapy assistants with disability experience and a more gradual and supportive induction process has been required to ensure that they are set up for success when starting to see participants.

Induction and onboarding processes need to be able to be adjusted to meet the unique situation of each site, including: knowledge, skills and experience of the therapy assistant, and the location and level of previous engagement of the provider.

Poor retention and associated costs

In the current project, the therapy assistants' caseload gradually built up over the three-month induction period. During our current project, Aspect had five resignations over three years, one in their first three months of employment, and two in their first six months of employment.

Reasons for resignations where a subsequent job or role was specified included:

- Offer of full-time employment in a different role by another organisation offering better remuneration
- Wanted to spend more time with young son; focus on completing education studies; pay was too low
- Pay was too low - picked up additional teacher aide work
- Further studies in exercise physiology, moving into Physiotherapy specific therapy assistant role.
- Too much travel
- Offered full time employment in a different role with work vehicle

Further information was gathered on the barriers to remaining in the role and are outlined below.

Barriers to remaining in the role of therapy assistant:

Targets/Utilisation/Billing

- **Perceived pressure** to meet targets
- **Stress** – fear of "getting into trouble" if targets/utilisation is not met; especially during school holidays when families are not available to receive supports
- **Values** perceived to be "compromised" – like to "serve" while feeling like having to "build a business"; "I felt my integrity was compromised because I had sales targets"
- **Difficulty billing for time** when families have limited funds in their NDIS plan – "moral" challenge
- **Lack of rewards and recognition program** for therapy assistants who meet utilisation targets – only for therapists
- **Expected ratio of participants to hours** too high – discussion of 6 hours/7.6-hour day

Administrative tasks

- **Time spent on scheduling appointments** in client management system, and then having to reschedule when families cancel/reschedule; also spending time to complete sessions
- **Strengths in "hands-on" work, not in "organisational stuff"**, such as bookings, documenting progress notes etc.
- **Time spent on completing progress notes** and documenting session, with "bottleneck" of session notes to be added to client management system at the end of a workday
- **Amount of preparation time** for sessions

Working in regional and remote community

- **Difficulties working from home** – home office – due to storage and family
- **Isolation** – despite weekly support and supervision – no immediate "debrief" opportunities as a "people person"
- **No opportunities to join regional teams for functions**, such as Christmas lunch
- **No opportunities to join regional team meetings** – and if they did, would the content be relevant?
- **Feeling like "no break" from participants** – can't "get away" from participants and difficulty steering conversations away from work

Role recognition

- **Unattractive pay scale** (when compared to hourly rate of e.g., teacher's aide)
- **Lack of progression opportunities**
- **General lack of communications**, e.g., emails based on therapist, not therapy assistant – do not feel part of the "team" because emails aren't addressed to them and most of the time are irrelevant to therapy assistants
- **No professional development days allocated** to therapy assistants completing their Certificate IV – therefore no funding for training outside of Certificate IV and what is offered internally.

TOWARD A SUSTAINABLE THERAPY ASSISTANT MODEL FOR THE DISABILITY SECTOR:

CALL TO ACTION

Based on our research, we can see the therapy assistant model works within the disability sector. In addition, we know the therapy assistant model has been identified as a priority under the *NDIS National Workforce Plan 2021-2025*. However, to be successful, we need to know how we can continue to make it work for the disability sector and everyone involved.

The findings from our research aimed to identify these key factors contributing to the sustainability of the therapy assistant model of service in rural and remote areas for people with a disability under the NDIS.

When weighing up costs and benefits in the social model for disability, it is difficult to fathom placing costs above and beyond that of the progress of any individual with a disability towards meeting their goals. However, the current NDIS marketplace, with its emphasis on billable hours, makes organisations, even not-for-profit ones, do just that. "Not for profit" has had to make the shift to "profit for purpose" to remain sustainable in the disability sector and be able to continue to deliver services to some of our most disadvantaged and vulnerable populations in Australia.

Significant and ongoing workforce shortages further compromise the needs of people with a disability in regional and remote areas. Alternative models of service delivery are needed to fill the gap in services.

Traditional fly-in, fly-out services have long been utilised in these regions to bridge this gap however, people in remote areas have reported "enough is enough". They want local, long-term services to meet the needs of themselves and their family members with a disability. Therapists, including speech pathologists, occupational therapists and behaviour support practitioners, however, will not be a viable local option considering the chronic lack of these professionals across the whole of Australia, including metropolitan areas and poor future projections of the growth of the workforce to alleviate this issue.

Therapy assistants are a way to provide a quality local service that is implementing the work of a therapist by a person local to the community. Throughout our project, we have witnessed and had reported many benefits of the therapy assistant model through our interviews and data collection that would not have been realised should we have continued as business as usual.

While the benefits seen across the two-year therapy assistant project are numerous and abundantly clear, several barriers associated with the service place significant pressure on the implementing organisation and compromise its ability to move forward with the model into the future as a sustainable service. Therefore, before the benefits can significantly outweigh the barriers of the therapy assistant model, several areas will need to be recognised and addressed.

It's definitely not about the pay, and it's not really about the career pathway either!

A therapy assistant undertaking their Certificate IV is charged out at and paid a salary in which they must bill participants a minimum of 6 hours per day to break even in their role. This places them at 79% utilisation. When we think about any extra unbillable travel, this leaves very little time in a 7.6-hour day for the large amount of indirect work and preparation we have found is associated with the role. This includes writing sessions notes, updating the client management system, and keeping up with emails. On top of this is the need to record possible incidents, complete training, and attend supervision and meetings.

As an organisation aimed at being an employer of choice, we pay above-award salaries. However, as seen within our costs analysis, this significantly impacts the sustainability of the role.

Let's compare the role of a therapy assistant to a teacher's aide: a teacher's aide annual salary is 1.3 times more than that of a therapy assistant. The teacher's aide is paid to work a total of 5 hours per day, with little travel, admin or preparation work. As a career pathway, there is currently no progression in either role.

Therapy assistants are attracted to the role for the impact it can have on people with a disability in their community, on the person's participation in activities meaningful to them and on their quality of life. Therapy assistants working in the community offer greater flexibility and enhanced access, even for the most vulnerable participants with a disability. This access can be life-altering, particularly for participants who have very little access to locally based therapy supports.

However, working in the local community as a therapy assistant also presents a raft of challenges, including extra travel, working in isolation and a decrease in incidental supervision.

When we compare the workload of a therapy assistant to a disability support worker or NDIS support coordinator in the disability sector, we see a marked difference in the pay scale to workload ratio. A disability support worker is paid marginally more, and a support coordinator 1.4 times more than a therapy assistant, without the preparation, administration, responsibility of implementing a set program, and significant on-costs to the employer.

There needs to be further consideration of the pay scale of the community-based therapy assistant role if we are to attract and retain this valuable workforce. This cannot be achieved unless we address the following:

ACTIONS

- **Introduce a community-based therapy assistant pay scale** that recognises the significant workload and responsibility of therapy assistants working in the disability sector, i.e outside of tertiary/ clinic-based settings.
- **Introduce career pathways and areas of specialisation** to increase attraction, recruitment, and retention in the role.
- **Review salaries** so they are commensurate with the work of a community-based therapy assistant and specialist skill set.

More than just an assistant - the work of a community-based therapy assistant

Community-based therapy assistants are implementing therapeutic supports autonomously 95% of their working week and are poorly recognised and compensated for this.

The work of a therapy assistant goes beyond "assisting" and it would therefore be useful to consider the term ***therapy implementer*** as an adjunct title.

> [Oxford Dictionary definition] ***Implementer :*** *Someone or something that puts a decision, plan, agreement, etc. into effect.*

Therapy assistants are the boots on the ground, implementing all therapeutic supports, and should be recognised and valued for the central role they play as part of a collaborative allied health team.

During our interviews and through our analysis of routinely collected data, we have found that therapy assistants working in the community with people with disabilities take on a lot more than expected.

Therapists reported throughout our project that therapy assistant services are as high quality as those of therapists themselves. They hadn't noticed much difference between a therapist implementing the interventions compared to how a therapy assistant would do when appropriately supported.

Hearing from caregivers and participants about their service experiences and relationships with their local therapy assistant, it is clear this model has a significant impact on rural and remote communities.

The role of therapy assistants working in the community under the NDIS is very different to the role of a therapy assistant working in the health sector in a clinic, hospital or even in a community setting. Community-based therapy assistants working in the disability sector under the NDIS have a high level of autonomy, relying on relevant skills and experience to implement therapy supports for every participant in their natural environment with a high level of fidelity.

Current charge out rates do not reflect this and undermine the value provided by a therapy assistant in supporting participants with a disability and their families. At Aspect, therapy assistants need to bill a minimum of 6 hours per day to break even in their role. Aspect therapists on the other hand are only required to bill 3.8 hours due to their higher charge out rate. This inequity does not go unnoticed by the therapy assistant workforce.

Therapy assistants increase access to therapy supports for people with a disability in their local community. They are cheaper than a therapist, so families get more hours in their plans.
But this should not be at the expense of our therapy assistants' wellbeing and feeling valued as significant members of the team.

NDIS has created a system that relies on billable hours, targets, and utilisation. The problem is when the financial modelling of service is so tight that extreme expectations are placed on staff just to break even.

There needs to be further consideration of the NDIS price guide and the charge out rates for therapy assistants who not only work in rural and remote locations, but also work remotely from their therapy team.

ACTIONS

- **Review the NDIS price guide** to reflect the work of a community-based therapy assistant (as opposed to clinic or tertiary based) and develop an equitable system that builds a strong and valued therapy assistant implementation workforce.
- **Introduce a remotely-based therapy assistant pricing schedule** whereby therapy assistants working at a distance from the therapy team are charged at a higher rate to reflect the autonomous nature of their role.

The right training for the job

Based on feedback from the current project, the Certificate IV in Allied Health Assistance in its current form did not provide a relevant basis for working as a therapy assistant working in the community in the disability sector. Despite working with TAFE Victoria to adapt the current Certificate IV with more relevant units, there is still a considerable lack of relevancy to the role.

Many therapy assistants working the local communities have a wide range of skills and experiences. Through our scoping review and stakeholder engagement, we have found that soft skills were highly valued in the community-based role. Therefore, therapy assistants came into the role with a variety of backgrounds such as education, community services or disability support. Many had engaged in training as part of these previous roles, however this was not recognised as prior learning within the current Certificate IV in Allied Health Assistance.

The Certificate IV in Allied Health Assistance remains considerably geared towards the health sector and needs a significant overhaul to meet the needs of therapy assistants and build a quality workforce under the NDIS.

There is currently an ongoing consultation on the Certificate IV Allied Health Assistance being conducted by SkillsIQ. See below the latest draft below (Draft 2.0) with a traffic light system for relevant core units within our therapy assistant model within the disability sector:

- **green – core,**
- **orange – elective,**
- **red – irrelevant in disability sector.**

We recognise this does not reflect the needs and ideas of the broader population and therefore is a reflection for consideration only.

Certificate IV in Allied Health Assistance (Draft 2.0)

CORE UNITS

- **Respond effectively to behaviours of concern**
- **Support relationships with carer and family (in draft)**
- **Facilitate the empowerment of people receiving support (in draft)**
- **Work with diverse people**
- **Assist with an allied health program**
- **Engage with clinical supervision and delegation**
- **Identify impact of health conditions**
- **Comply with infection prevention and control policies and procedures**
- **Follow safe work practices for direct participant care**
- **Use medical terminology in health care**

ELECTIVES

Group A electives – (Movement and Mobility Support) specialisation

- Assist with movement
- Deliver and monitor physical and manual therapy programs
- Assist with the development and maintenance of an individual's functional status
- Deliver and monitor a hydrotherapy program
- Support the fitting of assistive technology

Group B electives – (Nutrition and Dietetic Support) specialisation

- Assist in the development of meals and menus to meet dietary and cultural requirements
- Assist with the monitoring and modification of meals and menus according to individualised plans
- Support food services and dietetics in menu and meal order processing
- Assist with screening and management of nutritional risk
- Support the provision of basic nutritional advice and education

Certificate IV in Allied Health Assistance (Draft 2.0 - Continued)

Group C electives – (Communication and Hearing support) specialisation

- Assist with communication using augmentative and alternative communication methods. (in draft)
- Develop and use strategies for communication with augmentative and alternative communication systems. (in draft)
- Support the development of speech and communication skills
- Assist and support the use of augmentative and alternative communication systems
- Support and deliver individual hearing rehabilitation program

Group D electives – (Rehabilitation and Reablement Support) specialisation

- **Support independence and community participation**
- Assist in rehabilitation programs
- Conduct group sessions for individual outcomes
- Support the fitting of assistive technology
- Work within a community rehabilitation environment

Group E electives – (Medical Imaging Support) Specialisation

- Assist management of people in medical imaging
- Support the medical imaging professional
- Process reusable medical devices and equipment

Group F electives – (Psychosocial Support)

- Provide support to people living with dementia (in draft)
- Support independence and wellbeing (in draft)
- Work with people with mental health issues
- Assist with social work

Group G electives – (Podiatry Support)

- Assist with basic foot hygiene
- Assist with podiatry assessment and exercise
- Assist with podiatric procedures
- Process reusable medical devices and equipment

Other electives

- Maintain patient records
- Recognise and report risk of falls (in draft)
- Implement falls prevention strategies (in draft)
- Address the needs of people with chronic disease
- Visit client residence (in draft)
- **Promote Aboriginal and/or Torres Strait Islander cultural safety**
- Work collaboratively to maintain an environment safe for children and young people
- Administer and coordinate Telehealth services (in draft)
- Provide support in dysphagia management
- Provide allied health assistance in remote or isolated setting
- Assess hearing
- Develop and implement individual hearing rehabilitation programs
- Dispense hearing devices
- Maintain inventory
- Conduct manual tasks safely

Interestingly and of note, the Skills IQ drafted Certificate IV in Disability Support (Draft 2.0) offers a range of very relevant units for working as a community-based therapy assistant under the NDIS. We have provided the proposed core and elective units for further discussion below:

Certificate IV in Disability Support (Draft 2.0)

CORE UNITS

- Follow established person-centred behaviour supports
- Develop and provide person-centred service responses
- Facilitate community participation and social inclusion
- Facilitate ongoing skills development using a person-centred approach
- Provide person-centred services to people with disability with complex needs
- Manage legal and ethical compliance
- Maintain work health and safety

ELECTIVES

- Facilitate the interests and rights of clients
- Provide advocacy and representation service
- Provide services for older people
- Provide support to people living with dementia
- Work in an alcohol and other drugs context
- Address the needs of people with chronic disease
- Assess co-existing needs
- Conduct individual assessments
- Facilitate individual service planning and delivery
- Develop and implement service programs
- Develop strategies to address unmet needs
- Maintain a high standard of service
- Provide loss and grief support
- Provide suicide bereavement support
- Recognise and respond to crisis situations
- Assist with movement
- Transport individuals
- Identify and report abuse
- Support individuals with autism spectrum disorder
- Support relationships with carer and family
- Visit client residence
- Coordinate and monitor home based support
- Prepare meals
- Support positive mealtime experiences
- Use communication to build relationships
- Develop and use strategies for communication with augmentative and alternative communication systems
- Develop and promote positive person-centred behaviour supports
- Prepare for NDIS support coordination
- Coordinate NDIS participant support
- Provide specialised support
- Promote Aboriginal and/or Torres Strait Islander cultural safety
- Manage and promote diversity
- Meet statutory and organisation information requirements
- Develop, implement and review quality framework
- Manage partnership agreements with service providers
- Work with people with mental health issues
- Deliver care services using a palliative approach
- Plan for and provide care services using a palliative approach
- Confirm physical health status
- Follow basic food safety practices
- Assist clients with medication
- Manage work health and safety
- Lead effective workplace relationships
- Demonstrate leadership in the workplace
- Implement continuous improvement

Based on our findings, we propose the addition of **Group H electives - Allied Health Assistance (Disability Support)** based on units from the Certificate IV in Disability Support identified as part of an extended consultation process across the disability sector implementing community-based therapy assistant supports.

A number of units within these electives will also contribute to the career development and specialisation of therapy assistants including in areas such as employment support, positive behaviour support, AAC, autism spectrum disorder, and early childhood supports.

Positive Behaviour Support is an area of significant undersupply within the disability workforce. Therapy assistants represent an unrealised opportunity for developing a behaviour support implementation workforce under the NDIS Quality and Safeguards Commission to alleviate this gap in service provision. There is currently a Disability Work - Behaviour Support Skill Set under draft by SkillsIQ that would assist in supporting this.

Relevant and meaningful training units including micro-credentials, positive career pathways of specialisation, recognition of prior learning are important factors that will help retain a quality therapy assistant workforce.

ACTIONS

- **Add Group H electives - Therapy Assistance Disability Skill Set** based on Certificate IV Disability Support units identified as part of an extended consultation process across the disability sector implementing community-based therapy assistant supports.
- **Offer therapy assistant training pathways including micro-credentials,** and NDIS Quality and Safeguards Commission registration eligibility for delivering Positive Behaviour Support under the NDIS as part of a collaborative team.

Recruitment and retention – mitigating the risk through funded incentives and traineeships

As discussed, the utilisations rates for unqualified therapy assistants is higher than for qualified therapy assistants. This is due to the significant training and onboarding costs associated with the role.

As an organisation, Aspect places great value in onboarding staff. This is highly important for maintaining high quality supports in an itinerant role, working with high levels of autonomy.

During the project, an induction was run over 12 week period while therapy assistants incrementally increased their caseload.

By the end of the induction period, we sought to ensure our staff were able to provide families with good quality information that is respectful for people with a disability and their families.

The expectations for billables during this induction period meant we ran at a considerable loss for the first 8 weeks of employment.

While we were able to cover these costs under our funded project, this places us at great risk in the future should the therapy assistant resign within the first 3 to 6 months of employment as we saw in our current project.

As an organisation, this does not provide Aspect with an incentive to continue to employ therapy assistants under salaried conditions.

There needs to be further consideration of how organisations can be supported to offset the costs associated with employing and training therapy assistants so that the model is attractive to employees and a strong and skilled workforce can be developed.

ACTIONS

- **Establish a Workforce Development Incentive Scheme** to provide organisations with funding to support therapy assistants' onboarding.
- **Offer fee-free traineeships** to encourage organisations to take on new therapy assistants and cover the costs of formal training.

Establishing a disability therapy assistant framework

Drawing on the insights from the scoping review, underlying NDIS policy settings and stakeholder interviews, we identified key principles and factors to be considered when designing a disability therapy assistant model which will assist in developing localised, contextually relevant therapy assistant services.

Below is a summary of the draft disability therapy assistant framework:

Principles

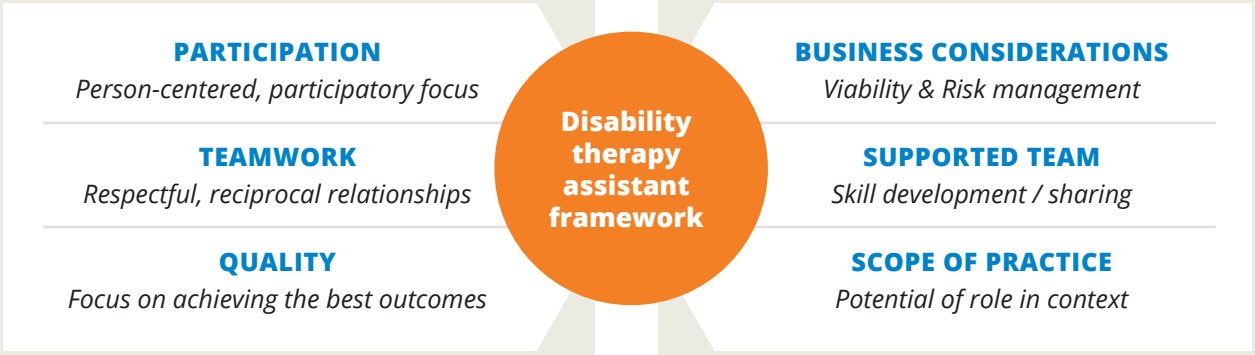
The underlying principles forming the foundation of the therapy assistant model are unique to the disability context, applying a lens grounded in the social model of disability.

The collaborative, person-centred team lead by the NDIS participant is a key driver of quality therapy assistant service design.

Factors

Service design factors must be considered mindful of the NDIS policy settings based on a billable hours, business model, with the need for ongoing skill sharing and skill development.

The therapy assistant scope of practice is developed in response to contextual factors, both geographic and relational.



ACTIONS

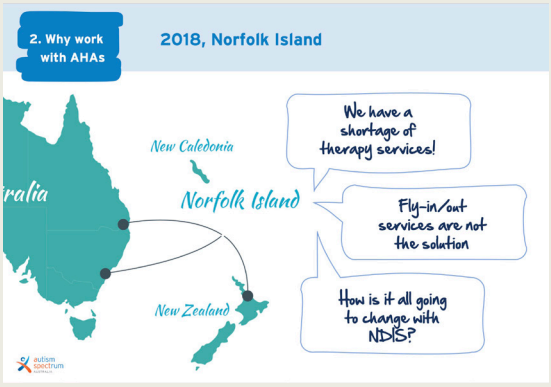
- **Set up a round table forum** with interested NDIS participants, providers and other stakeholders to explore the therapy assistant model, and starting a national conversation about this workforce's contribution around the draft framework.
- **Develop resources** describing examples of responsive, tailored and flexible therapy assistant models that have been applied in the NDIS context, to support broader uptake of this model.
- **Collaborate across the disability sector** to develop freely available training and support resources for organisations, therapy assistants and therapists to build workforce capabilities in this model of service that are high quality and cost effective, incorporating the components articulated in the above framework.

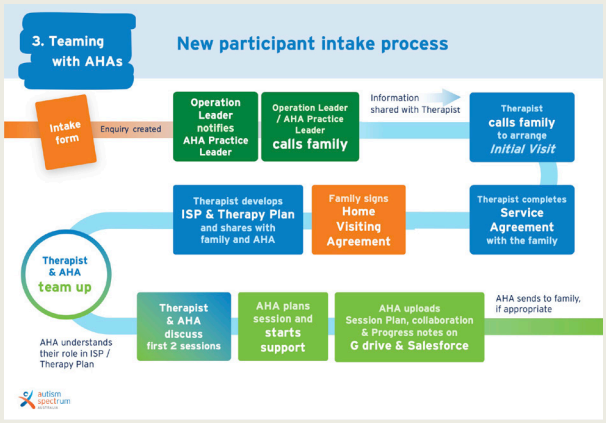
APPENDIX A

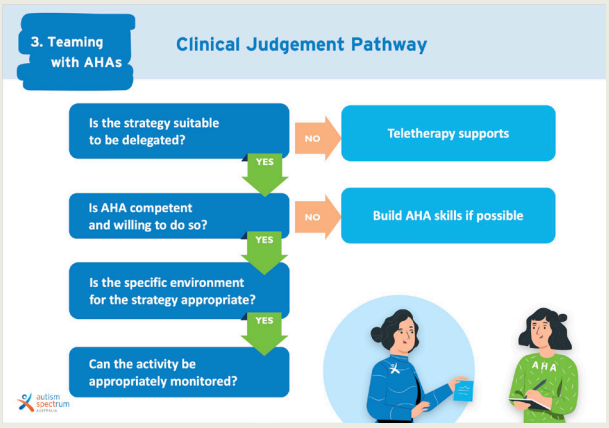
ASPECT THERAPISTS INDUCTION

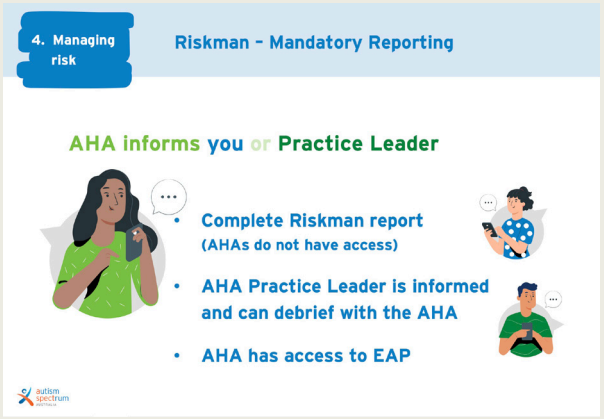
LEARNING MODULE

(SAMPLE SLIDES)

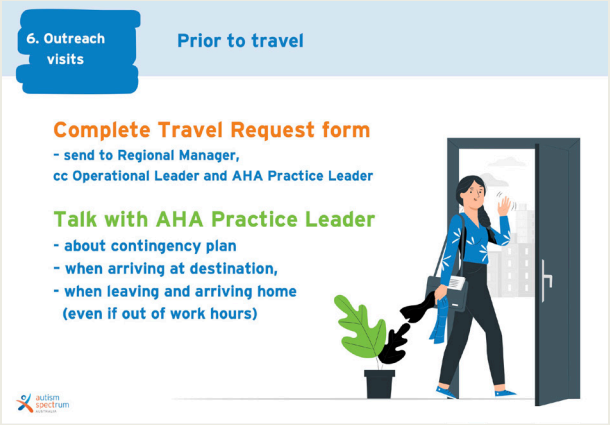



3. Teaming with AHAs
New participant intake process
Intake form
Enquiry created
Operation Leader notifies AHA Practice Leader
Operation Leader / AHA Practice Leader calls family
Information shared with Therapist
Therapist calls family to arrange Initial Visit
Therapist completes Service Agreement with the family
Family signs Home Visiting Agreement
Therapist develops ISP & Therapy Plan and shares with family and AHA
Therapist & AHA team up
AHA understands their role in ISP / Therapy Plan
Therapist & AHA discuss first 2 sessions
AHA plans session and starts support
AHA uploads Session Plan, collaboration & Progress notes on G drive & Salesforce
AHA sends to family, if appropriate


3. Teaming with AHAs
Clinical Judgement Pathway
Is the strategy suitable to be delegated?
NO
Teletherapy supports
YES
Is AHA competent and willing to do so?
NO
Build AHA skills if possible
YES
Is the specific environment for the strategy appropriate?
YES
Can the activity be appropriately monitored?
AHA


4. Managing risk
Riskman - Mandatory Reporting
AHA informs you or Practice Leader
Complete Riskman report
(AHAs do not have access)
AHA Practice Leader is informed and can debrief with the AHA
AHA has access to EAP


5. Building AHA skills
Building AHA Competency
Formal learning
Registered Training Organisation
or internal training
'On-the-job' experience
Direct support and supervision
(more frequent in early stages)


6. Outreach visits
Prior to travel
Complete Travel Request form
- send to Regional Manager,
cc Operational Leader and AHA Practice Leader
Talk with AHA Practice Leader
- about contingency plan
- when arriving at destination,
- when leaving and arriving home
(even if out of work hours)


6. Outreach visits
PBS support
If no capacity for visit on site,
PBS via teletherapy
may be possible

APPENDIX B

COLLABORATION / PLANNING TEMPLATE

Aspect Therapy

autism spectrum AUSTRALIA

Allied Health Assistant – Therapy			
Client:		Team:	Choose an item.
Date/time:	Click or tap to enter a date.	Therapist/s:	
Session type:	Choose an item.	Attendees:	
Location:	Choose an item.	Billable time:	Choose an item.

Session Planning with Therapist/s [insert name of therapsits) - Click or tap to enter a date.	**Session Delivery by AHA -** Click or tap to enter a date.
[Insert Client Name] Current Therapy Goal:	

Objectives:	**Strategies/Plan:**	**Comments/Observations:**
1		
2		
3		
4		
5		
Additional notes:		
Plan:		
Next session:	Click or tap to enter a date.	
Signed:		

The contribution of therapy assistants in the delivery of high quality therapeutic supports to NDIS participants is a potential as yet unrealised.

This report highlights the lessons from Aspect's experience of delivering therapy assistant services over the past two years. There is more work to be done in growing this workforce.

References

Clarke, V., & Braun, V. (2017). Thematic analysis. The journal of positive psychology, 12(3), 297-298. https://doi.org/10.1080/17439760.2016.1262613

Creswell, J. W., & Miller, D. L. (2000). Determining Validity in Qualitative Inquiry. Theory Into Practice, 39(3), 124-130. https://doi.org/10.1207/s15430421tip3903_2

Page M J, McKenzie J E, Bossuyt P M, Boutron I, Hoffmann T C, Mulrow C D et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews BMJ 2021; 372 :n71 doi:10.1136/bmj.n71

Peters, M., Godfrey, C., McInerney, P., Baldini, S., Khalil, H., & Parker, D. (2017). Chapter 11: Scoping Reviews. In E. Aromataris & Z. Munn (Eds.), Joanna Briggs Institute Reviewer's Manual. The Joanna Briggs Institute.

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