On Employing Communication Aides in the Rehabilitation of Aphasic Individuals

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Next week at Memphis State University, a 56-year old man with mild aphasia will begin a program that is intended to train him to treat the language deficits of other aphasic individuals. The program is part of a manpower grant, funded by the Veterans Administration and Memphis State, that is to develop a nonprofessional job opportunity for veterans and a model of training for this occupation. We have tried a variety of titles for our trainee, such as "language therapy assistant" or "training aide." However, today I shall use the generally recognized term "communication aide" which was adopted in the 1969 report of ASHA's Committee on Supportive Personnel (1970). In Memphis, we intend to train two veterans who have been disabled by brain injury and two veterans with military medical specialty backgrounds to become communication aides in the treatment of aphasic adults. We hope to determine whether these aides can be a valuable addition to a hospital staff; and if we demonstrate that they can be effective, then perhaps we will have developed a model program for training additional nonprofessionals to treat communication disorders.

The purpose of this presentation is to review a few of the considerations and issues pertaining to (1) the need for communication aides, (2) their role in providing clinical services, and (3) the training required for whatever their role might be. Since this is a subject that attempts to carve into your identity as a professional, we feel that you should assist us in the program's development by offering your input. This input may take the form of questions, such as:

(1) Are we graduating more than enough professionals and will communication aides take jobs away from these graduates?
(2) Will quality of service decline when administered by persons with less than a graduate education?
(3) Would it be easier for a professional to do a task himself than to spend time teaching it to an aide?

Though we have isolated three topics for discussion, it is difficult to discuss need, role, or training independently. Therefore, each of these topics will be a matter of emphasis as we skim the surface of a surprisingly complex subject.

There is a history of employing nonprofessionals to treat communication disorders. Projects have been reported in which supportive personnel have been trained to identify and treat articulation and language problems in the public schools of Colorado (Alpiner, et al., 1970), Ohio (Ham, 1970), Maryland (Lynch, 1972), Minnesota (Strong, 1972), and Georgia (Galloway and Blue, 1975). In hospitals, professionals have been assisted by volunteers (Boone, 1964) and ward personnel. Communication disorders have been treated by a variety of nonprofessionals: a parent or spouse of someone with a speech disorder, someone with a speech disorder in a group treatment setting,

or the undergraduate and graduate student groping about in a clinic training program. Moll (1974) reported that "essentially every state licensure law in our field provides for the use of supportive personnel in accord with regulations specified by the state licensing board." The Florida law, published in Asha magazine, demonstrates one example of the legal distinction established between speech and hearing professionals and speech pathology and audiology aides. Having recognized that aides were treating communication disorders, that other allied health professions and medicine were training and employing supportive personnel, and that the federal government and consumer groups were encouraging development of nonprofessional health-related occupations, ASHA decided to initiate development of its own standards for supportive personnel by establishing its Committee on Supportive Personnel a few years ago. Perhaps we in clinical aphasiology should be developing our own standards for supportive personnel before someone else does.

Need for Communication Aides

The need for communication aides in general probably was related to somewhat independent observations. The first observation was the tremendous need for clinical services that was not being met by our profession. The supply of professionals was not and is still not meeting the demand for services. The second observation was that many tasks performed by the professional can be done effectively and safely by someone with a high school education. The outcome of these two observations was that parents, volunteers, and high school graduates were trained quickly and economically to expand clinical services to greater numbers of clients.

Society developed another need for which the federal government looked to the professions for assistance. A reduction in traditional nonprofessional or blue-collar jobs has required the development of new types of nonprofessional employment. Psychology and social work, for example, have successfully employed people from poor communities to help provide services to their neighbors (Watts, 1967). Nevertheless, today I wish to explore the justification for communication aides which relates to the curious notion of manpower needs.

The notion that there is a manpower shortage in speech pathology may seem bewildering since some graduates seem to be foraging desperately for jobs. However, two points must be made related to what appears to be the over-supply of professionals. The first was emphasized in Curlee's (1975) recent report which estimated future manpower needs of our profession. He noted that job availability has little relationship with unmet clinical service needs. There may be more speech pathologists looking for jobs than there are jobs available; however, there are neither enough jobs nor enough professionals to meet the need for clinical services. We know that there are VA and private hospitals without speech services. Recently I heard of one clinician who was asked to organize a speech treatment program for 40 nursing homes. Nevertheless, if Curlee's estimates are correct, our profession may meet service needs with an appropriate supply of professionals by 1985 or sometime thereafter. Therefore, we could minimize the concern over manpower needs on the basis of job market saturation and predictions of a bountiful supply of professionals in the future. However, the second point to be made about the seeming oversupply of professionals is that the maldistribution of professionals is likely to remain. We have an oversupply of speech pathologists in metropolitan areas and a minimum of clinical

services in underdeveloped counties. The problem of maldistribution was attacked, for example, by the Ohio Project (Ham, 1970) in which high school graduates were trained to treat articulation problems of school children in Appalachian communities.

So far I have discussed the need for communication aides primarily in relation to serving more people and to serving in areas where few professionals can be found. On the other hand, when considering the treatment of aphasic individuals in a hospital setting, there may be a different value in developing the position of communication aide. Rather than providing services for more patients, the communication aide for aphasic patients, in our view, should enable the professional to provide more service for each patient. That is, at Memphis State, our initial hypothesis concerning the justification for communication aides in aphasiology rests on the contention that they will extend the professional's capacity to provide service for his clients. In Ptacek's (1967) unusual discussion of supportive personnel as an extension of the professional worker's nervous system, he concluded that the aide could "offer the professional worker an opportunity to extend his effectiveness and productivity. . . ." Therefore, the value of a communication aide may be found in the particular role for which he may be trained.

Role of the Communication Aide

We shall begin to define the role of the communication aide by making him an assistant to the speech pathologist rather than a replacement for the speech pathologist. We intend to train our communication aides to become technicians, supervised by speech pathologists. Our view is that persons with a graduate degree have been trained to be decision-makers, planners, communicators, and creators of improved technical procedures. When we started thinking about this program at Memphis State, we wondered that, if we train high school educated or brain-injured adults to flip object pictures and work Language Masters, then what would be left for us to do? One discovery we made was that we professional clinicians do a lot of intelligent and creative things with a cognitive capacity that may have been cultivated by a graduate education. One clinician with years of experience expressed to me the frustration of having to spend too much time with routine, stereotyped tasks and of not having enough time to plan a better program for a patient or create a better task. Ptacek (1967) wrote that "for those professional workers who approached their tasks in a routine, stereotyped manner, supportive personnel can, and will, perform many of these routine and stereotyped functions."

To elaborate on an apparent concern that no one should ever believe that a communication aide can assume the role of a speech pathologist, we present Richard Ham's (1970) variation of the Peter Principle, called the "Ham Hypothesis." The Ham Hypothesis states that a profession declines to the level of its competence. Dr. Ham explained as follows:

> Unfortunately, hearing/speech/language professions stand in danger of declining to a level of competence because there is a tendency to equate all types of diagnostic and remedial contacts and require for all a single level of competence based on rigid criteria, such as specified length of formal training." (p. 9)

That is, we risk declining to a level of competence which is defined by tasks that a nonprofessional can be trained to do. However, a professional can set a high standard of competence and rise to that level. Physicians realized that others could administer medicines and give injections, thereby freeing physicians to do tasks commensurate with their training. Likewise, we clinical aphasiologists should at least recognize that we perform tasks requiring different levels and types of competency and that our time might be better utilized by concentrating on tasks most appropriate to our training.

An a priori list of specific tasks to be trained to a brain injured communication aide trainee might be determined in a manner suggested by Irwin (1967) who implied that we should identify our clinical activities and rank them with respect to the degree of training required for their successful performance. We do not have such a list but are anxious to develop one as our trainee proceeds through the program. We do disagree with the guidelines approved by ASHA's Legislative Council in 1969 which appeared to leave the specification of tasks solely up to the supervising professional or the employing agency. A set of core tasks could be established, and an employing agency should expect our idealized aphasia aide to enter a job with the ability to carry out these core tasks. Armed with certain basic capabilities identified by the profession, the aide could easily adjust to the particular needs of the employing agency.

Training the Communication Aide

I want to skim quickly over the discussion of training the aphasia aide, primarily because I am anxious to hear from you on this subject. Our pilot training program at Memphis State is not expected, in the spirit of a null hypothesis, to give birth to a large number of training programs as found in occupational therapy. Cromwell (1974) described the development of 51 training programs for occupational therapy assistants, with 35 of those approved and in operation. Our vision is more modest but is not without precedent, since we can benefit from training guidelines developed by NASHA's Committee on Supportive Personnel (1970). Our program is designed to determine the set of core tasks that define the aphasia communication aide and that can be taught by an independent training program.

We anticipate that, in general, our training program must emphasize observation of live and videotaped aphasic behavior and de-emphasize use of reading materials for teaching basics, especially with our brain-injured subjects. Our first trainee will be exposed to the following sequence: (1) an initial period of extensive testing of his own capabilities and limitations with a variety of standard tests, (2) several weeks of controlled observation and informal interaction with patients and graduate students, and (3) direct contact with a gradually increasing variety of patients. Direct contact will involve pre-determined, well-defined tasks. In addition, the trainee will receive some training and will be evaluated as a functioning communication aide at the Memphis VA Hospital.

Let me summarize by referring back to the three questions posed early in this paper. We view the communication aide for aphasics not as a substitute for the professional speech pathologist but as an assistant

to the professional. Therefore, we intend not that the aide take a job from the professional but that a job opportunity be available, for example, to the brain-injured adult. Furthermore, the aide should not impair the quality of services but, as defined here, should expand the professional's ability to provide services and allow the professional greater opportunity to improve the quality of services. Finally, our pilot training program is intended to be a model program that should remove the responsibility for training from the employing agency. I am sure there are many other important considerations to be given the concept of communication aides, which is my reason for appealing to you today for some help.

Discussion

One member of the audience listed several points of concern regarding the use of supportive personnel or communication aides. (1) One California county, which once employed 10 professional speech pathologists, now employs five professionals and five aides. Therefore, the use of aides has had the effect of replacing the professional rather than of being supplemental to the professional. Though this observation suggests that aides will continue to replace professionals, the speaker called for an examination of the conditions that would permit replacement. (2) Graduate students should be utilized where an aide might be considered, in order to provide much-needed experience for the many professional trainees. (3) Sources of third party payment do not pay for the use of aides. Therefore the market for aides must be determined. The speaker suggested that we must determine why certain sources of support do not pay for the use of aides and look for ways of modifying this situation. (4) Graduate student trainees would do a better job than an aide. The speaker suggested this is an empirical question that should be studied.

A later comment was directed to the likelihood that communication aides would desire certification comparable to professional certification, especially if their training involved over 300 hours of therapy. The speaker responded that aides should be given some form of certification. However, this recognition should reflect a qualitatively different kind of training and competence that will have been specified for communication aides. The fact that a professional has attained a Master's degree should mean something that is distinct from the training of technique exclusively.

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