Role Release Benefits Everyone

As occupational therapists, we are typically members of treatment teams hired to address the needs of clients. It is assumed that we and the other team members (e.g., physical therapists, speech-language pathologists, nurses, teachers) possess the skills to effectively meet the client’s (and employer’s) needs. Giangreco, Cloninger, and Iverson (1993) define the characteristics of effective teams:

1. Have two or more members who possess various skills that may serve different functions, therefore allowing the body of theory and skills to be enlarged.
2. Develop a shared framework and purposefully pursue a unified set of goals.
3. Engage in problem-solving and collaborative activities to reach shared goals.
4. Share and allocate resources to help the learner (the client) attain his or her goals.
5. Have participatory interactions designed to complement each other and improve effectiveness.
6. Serve a collective evaluation function and offer each other feedback.
7. Judge success or failure by group performance toward the unified set of goals rather than by the individual member’s performance.

Teams are differentiated from working groups in which performance is the collective sum of what members do as individuals. Teams require both individual and mutual accountability; hence, potential performance levels are greater than the sum of all the team members’ individual bests: “Team accountability is about the sincere promises we make to ourselves and others, promises that underpin two critical aspects of effective teams: commitment and trust” (Katzenbach & Smith, 1993, p. 116).

In school-based occupational therapy, therapists frequently function as members of individualized education program teams to meet the needs of students with severe and profound disabilities in inclusive settings. It is essential that the team collaborates to establish achievable, meaningful educational goals that all members will collectively work toward. When team members collaborate, knowledge is shared. Additionally, the student is subjected to less fragmentation because expectations of each professional on the team are stable across environments. For example, if the goal is that the student will increase functional independence at the wheelchair level, it would be expected in the regular classroom, in the cafeteria, in physical education, on the playground, and everywhere else the student traveled during the school day. All team members develop problem-solving skills as they collectively work through problems regarding the student. Members provide support for one another, learn together how to best help the student, and thereby develop increased confidence in their professional abilities.

Whatever setting a person works in as a clinical occupational therapist, effectiveness as a collaborative team member will be enhanced with the use of role release. In role release, information and skills that are traditionally associated with one discipline are released to team members of other disciplines (Lyon & Lyon, 1980). In school-based practice, after a team has established collective goals, the members decide what competencies can be carried out by core team members who interact with the student daily. Positioning, range of motion, feeding techniques, and brushing (for treatment of sensory defensiveness) are examples of occupational therapy skills that may be considered for role release.

To implement role release of an occupational therapy skill, systematic
instruction is provided by the occupational therapist to the team member(s) who will be carrying over the skill to ensure safety of the student and team members. The team determines what skills need to be taught as well as minimal competency criteria for implementation. The therapist models the skill in the student’s natural setting and observes other team member(s) for competency. Therapists who release skills to other team members without observing for competency potentially risk the student’s well-being and their occupational therapy professional license. Written instructions should be provided, along with pictures or drawings to illustrate correct positioning. Follow-up can then be provided via phone calls, review of data collected, scheduled as well as impromptu observations, and updated written instructions as the need arises.

When family members and other team members are given this intense level of training in implementation of occupational therapy skills, they are able to provide the student with needed support during practice opportunities throughout the week, not just while the therapist is present. This supported practice is especially important for students with severe and profound disabilities who require consistent repetition of a new skill to make changes. Consider the following example: A therapist develops a specialized feeding program for a junior high student with multiple disabilities and implements the program in therapy sessions twice a week in the school cafeteria. The student is likely to make slow progress because of the lack of consistency and low frequency of the specialized treatment. In contrast, if the therapist provides systematic instruction in the specialized feeding program to the student’s family and school staff sufficient to establish their competency, it can be carried out during 21 meals per week, rather than limiting it to just 2 therapy sessions. With more frequent opportunities to practice the new feeding program, the student is likely to achieve a higher level of function in a shorter period, and all team members can share in the success.

Many therapists are hesitant to practice role release. They may believe that advanced levels of knowledge are required to implement the occupational therapy skills and, therefore, that teaching these skills to non-occupational therapists is risky and possibly unethical. In fact, when we teach others to implement a technique, we are not imparting to them all our occupational therapy knowledge of the area but are focusing on the specific methods. Explanations of the rationale for the technique or theoretical foundation are minimized or avoided.

The team teaching, observations, documentation, and follow-up required when a role release approach is used require a great deal of the therapist’s time. Time is also needed for team meetings, group goal setting, and other case-load responsibilities. Therefore, administrative support, planning, and flexibility regarding use of role release are important to its success (Giangreco, 1986). Another reason for resisting role release is the concern regarding blending of professional roles (Benson, 1993). Therapists may believe that they will lose their professional identity and value if they “release” their knowledge to others.

However, as Foto (1996) reminded us: “our focus and the basis of our decisions must always be directed toward the preservation of the quality of patient care, not the protection of our profession” (p. 9).

References


