The Use of Occupational Therapists in Independent Living Programs

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Key Words: community occupational therapy • research

Objectives. Occupational therapy literature describes various independent living programs developed by occupational therapists and at times documents their effectiveness, yet none of the literature reviewed examined the involvement of occupational therapists in independent living programs.

Method. Directors of independent living programs in the United States were surveyed to ascertain their use of occupational therapists, to discover which disciplines were providing traditional occupational therapy services (e.g., daily living skills, assistive device provision, etc.) in these programs, and to identify which types of independent living programs were more likely to use occupational therapy services.

Results. Less than half of the 96 responding independent living programs (46%) reported using occupational therapy services, and those programs that did provide occupational therapy services did so at a minimal rate. The programs that employed occupational therapists offered traditional occupational therapy services more often than those with no occupational therapists, but frequently, occupational therapists were not the providers of these traditional occupational therapy services. Chi-square analyses indicated that an independent living program's use of occupational therapy services was significantly affected by the type of facility (p = 0.05), the primary funding source (p = 0.04), and the program's practices regarding the hiring of professionals without disabilities (p = 0.04).

Conclusion. Possible reasons why occupational therapists are not employed more by independent living centers are discussed and recommendations for change are provided.

Independence is a concept highly valued by occupational therapists. Indeed, most occupational therapists would agree that a primary goal of their practice is to assist others in living their lives as independently as possible. However, legislation associated with independent living and the independent living movement "does not identify occupational therapy as a primary service or even mandate that independent living centers use occupational therapy in the planning of service delivery" (Baum, 1980, p. 773). Furthermore, the literature and promotional brochures distributed by many independent living programs (ILPs) commonly identify services traditionally provided by occupational therapists, such as daily living skills training and adaptive device provision, as available, but often these centers do not employ occupational therapists.

Independent living has been defined by Frieden and Cole (1985) as "control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities, including managing one's affairs, participating..."
in day-to-day life in the community, fulfilling a range of social roles, and making decisions that lead to self-determination and the minimization of physical and psychological dependence on others” (p. 735).

Occupational therapists have traditionally been trained in the medical model, which focuses primarily on changing the person through intervention and treatment by health care professionals. The independent living model focuses on changing the community (e.g., eliminating architectural and attitudinal barriers) rather than the person, and emphasizes consumer control (allowing consumers to choose the services and the service providers they need).

Iceman and Dunlap (1984) surveyed a sample of programs that provided independent living skills evaluation and training, but that were not necessarily ILPs. As part of their survey, Iceman and Dunlap sought to identify professionals used by these evaluation and training programs. Of the 10 professions identified, occupational therapy ranked sixth, with 42% of the programs reporting that they used occupational therapists on a “full-time, part-time, or consultation basis” (p. 54). Occupational therapists were preceded in order by social workers, rehabilitation counselors, psychologists, mobility instructors, and recreational therapists, and were followed by interpreters, speech therapists, home-based teachers, and physical therapists.

As evidenced by the literature, occupational therapists have developed and used independent living training programs in their practice. Bachelder (1985) reviewed the history of the independent living movement, discussed three types of ILPs, and identified factors associated with the successful transition of a person from a medical to an independent living setting. Frieden and Cole (1985) discussed the independent living movement and the role of occupational therapy in independent living programs, especially as related to the rehabilitation of persons with spinal cord injuries. Pendleton (1989) studied the extent to which occupational therapists who work in physical rehabilitation settings train clients in independent living skills. Kibele (1989) discussed the role of occupational therapy in improving the quality of life with adults who have cerebral palsy and examined both medical and independent living models in relation to the occupational therapist’s role with this population. McCuaig and Frank (1991) used an ethnographic approach to document the independent living skills of a woman with cerebral palsy.

Several occupational therapists have developed programs to teach consumers independent living skills. Neistadt and Marques (1984) described an independent living skills training program for adults with multiple handicaps and reported the independent living status of those persons who participated in the program. Jackson, Rankin, Sieffken, and Clark (1986) discussed an independent skills transition program for adolescents with developmental disabilities. Nochajski and Gordon (1987) used an adaptation of the game Trivial Pursuit to teach community living skills to adults with developmental disabilities. Neistadt (1987) described an independent living skills program for adults with developmental disabilities. A vocational readiness and independent living skills program for adolescents with psychiatric impairments was discussed by Nelson and Condrin (1987). Neistadt and O’Reilly (1988) presented a model in which independent living skills groups were led by Level I fieldwork students who were supervised by faculty and facility staff members. Neistadt and Gohn (1990) reported the effectiveness of their Level I independent living skills fieldwork model. Jackson (1989) described the themes that guided the development of a transition program (from high school to adult life) for adolescents with disabilities. In 1981, the American Occupational Therapy Association (AOTA) published its first position paper on the role of occupational therapy in independent living; in 1993 the Association adopted a second position paper on this issue. AOTA also supported the Project for Independent Living in Occupational Therapy (PILOT) (Powell, 1996).

Most of this literature described various independent living programs and, at times, documented the programs’ effectiveness. It did not, however, examine the involvement of occupational therapists in ILPs. Therefore, the survey in this study was designed to address the following questions:

1. How many ILPs employ, contract with, or refer clients to occupational therapists?
2. Do some types of ILPs more frequently use occupational therapy services than others?
3. In ILPs that do not use occupational therapists, which traditional occupational therapy services are provided and by which disciplines?
4. In ILPs where occupational therapy services are used, are traditional occupational therapy services provided and, if so, by which discipline?

Method

Subjects

The directors of all 386 ILPs identified in the Directory of Independent Living Programs and subsequent updates (Independent Living Research Utilization Project, 1989) served as subjects. To decrease possible confusion, no distinction was made between certified occupational therapy assistants and occupational therapists, though some respondents did identify themselves or their service providers as one or the other.

Instrument

A questionnaire was developed, piloted, and revised. Pilot subjects suggested minor word changes for clarification. Pilot subjects included three regional ILPs and three of my
The first section of the final questionnaire requested demographic characteristics of the ILP (using a multiple-choice format); the second section solicited information in reference to the use of occupational therapy personnel by the ILP; and the final section sought to identify the services provided by the ILP and the service providers. The identified services included daily living skills (grooming, bathing, dressing, feeding and eating, homemaking, driving, etc.); sensorimotor skills (joint mobility, gross and fine motor coordination, sensory awareness, personal exercise, etc.); assistive and adaptive device provision (adapted silverware, reachers, buttonhooks, raised toilet seats, grab bars, etc.); orthotic devices (slings or splints); and mobility (i.e., using a wheelchair, walker, or other ambulation aid).

**Results**

A chi-square analysis using frequencies tested for the significance of differences in the patterns of occupational therapy use by different types of ILPs. A significance level of $p = .05$ was selected. Cells that had inadequate frequencies because of small sample size were deleted.

Responses were received from 224 (58%) of the 386 surveys sent. Of these, 14 surveys were excluded from analysis because the respondents indicated the program was not an ILP or because the returned survey was incomplete. A total of 210 surveys (54%) was analyzed.

**Use of Occupational Therapy Services**

More than half of the respondents ($n = 114$ or 54%) indicated that their programs did not use occupational therapists to provide independent living services to clients. Ninety-six (46%) of the programs did use occupational therapy services. Chi-square analysis indicated no significant difference in the number of ILPs using occupational therapists compared with the number of ILPs not using occupational therapy services. Of those ILPs that did use occupational therapy services, 21 (22%) employed occupational therapists as staff members, 27 (28%) contracted with occupational therapists, 36 (38%) referred consumers for occupational therapy services, and 2 (2%) had occupational therapists who provided services on a volunteer basis. The 10 remaining respondents (10%) said that their programs used a combination of employment methods to procure occupational therapy services, the most common being employing occupational therapists on a contract and referral basis.

Of the 96 ILPs that employed or contracted with occupational therapists to provide services, most employed only one occupational therapist ($n = 33, 35$%). One ILP had occupational therapists employed as staff members full-time; five had part-time occupational therapy staff members. The remaining ILPs did not provide

this information. When asked approximately how many hours per month the ILP contracted with occupational therapists, answers ranged from “varies” to “less than one” hr per month to “over 100 hr per month” with a mean of 16.88 hr per month (the mean being calculated only from those ILPs reporting contract hours in integers).

The 36 respondents who referred clients to occupational therapists indicated that they used these services from ½ hr per month to 86 hr per month with a mean of 6.94 hr per month. Seven respondents did not directly answer this question, five of these indicated that they did not know the answer, and two reported that the number varies.

When the 96 respondents who used occupational therapy services were asked about the service provision models used by their occupational therapists, 61 (64%) stated that the occupational therapists provided both direct services to clients and consultation to other staff members. Twenty-eight (29%) reported that the occupational therapists provided only direct services to clients, five (5%) indicated that occupational therapists provided only consultation to other staff members, and two respondents (2%) did not answer this question.

Several of the respondents indicated that, although their programs did not currently use occupational therapists, there were plans to do so in the future. Several respondents indicated that occupational therapy services were available to their consumers through “specific disability service groups, i.e., local chapters of the MS [multiple sclerosis] society, Head Injury Foundation, etc.” One respondent added, “We do occasionally need the services/advice of an occupational therapist. Fortunately for us, one of our staff members is married to an occupational therapist, and he has volunteered his skill and expertise.” Another respondent stated, “[Occupational therapy] students are used as job coaches.”

**Comparison of Programs**

Chi-square analyses indicated that an ILP’s use of occupational therapy services was significantly affected by the type of facility (residential, nonresidential, or combined), ($p = 0.05$), the primary funding source (donations, grants, etc.), ($p = 0.04$), and the ILP’s practices regarding the hiring of professionals who do not have disabilities ($p = 0.04$). Use was not affected by the service provision patterns (direct, indirect, or both), the geographic setting (urban, rural, or both), the consumer population served (one vs. several types of disabilities), or the emphasis on consumer operation (the extent to which consumers are involved in the operation of the program).

Whether or not an ILP used occupational therapists, most were nonresidential. Some programs had both residential and nonresidential components, the majority of which used occupational therapy services. Even fewer
ILPs that did not use occupational therapy services was a combination of sources. The primary funding source for occupational therapy (see Table 1), The Frequency of Occupational Therapy Use According to Primary Funding Source

<table>
<thead>
<tr>
<th>Source</th>
<th>Programs With Occupational Therapy Services</th>
<th>Programs Without Occupational Therapy Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for service</td>
<td>7 3</td>
<td>5 2</td>
<td>12 6</td>
</tr>
<tr>
<td>Donation</td>
<td>0 0</td>
<td>1 0.5</td>
<td>1 0.5</td>
</tr>
<tr>
<td>Federal grant</td>
<td>21 10</td>
<td>40 19</td>
<td>61 29</td>
</tr>
<tr>
<td>Other grant Rehabilitation agency</td>
<td>7 3</td>
<td>17 8</td>
<td>24 11</td>
</tr>
<tr>
<td>Other</td>
<td>13 6</td>
<td>17 8</td>
<td>30 14</td>
</tr>
<tr>
<td>Combination</td>
<td>11 5</td>
<td>4 2</td>
<td>15 7</td>
</tr>
<tr>
<td>No answer</td>
<td>36 17</td>
<td>29 14</td>
<td>65 51</td>
</tr>
<tr>
<td></td>
<td>1 0.5</td>
<td>1 0.5</td>
<td>2 1</td>
</tr>
</tbody>
</table>

ILPs were solely residential, and only half of these used occupational therapy (see Table 1).

Approximately a third of all ILPs were funded by a combination of sources. The primary funding source for ILPs that did not use occupational therapy services was a federal grant. ILPs with occupational therapists were most frequently funded by a combination of sources. Also, when the primary funding source was a rehabilitation agency, the number of ILPs that did not use occupational therapists was greater than those that did use occupational therapy services (see Table 2).

An overwhelming majority of the ILPs employed professionals who were not disabled. Almost half of these ILPs did not use occupational therapy services, whereas the rest did use occupational therapy services (see Table 2). A number of the respondents who did hire professionals without disabilities added qualifying statements to their answers, commonly indicating that staff members without a disability were a minority, or that they hired them "reluctantly."

Regardless of whether the ILPs used occupational therapy, they were most likely to provide services directly. Few respondents offered services solely indirectly. The remainder of the respondents used both service provision patterns (see Table 4). More than half of the ILPs served only urban areas; nearly one third served only rural areas. One respondent indicated that the ILP was a "state wide program" and several others indicated that their catchment areas encompassed several counties. Those ILPs using occupational therapy services were twice as likely to serve an urban setting than a rural setting (see Table 5).

Whether or not an ILP used occupational therapists, it was most likely to serve several different consumer populations. Of the 114 ILPs that did not use occupational therapists, 37% (n = 78) reported serving varied consumer populations. The three most common populations served were, in order, persons with spinal cord injuries, persons with hearing impairments, and persons with visual impairments. Of the 36 ILPs that did not offer occupational therapy and serve only one population, only two served persons with mental retardation and only three

Table 2
The Frequency of Occupational Therapy Use According to Primary Funding Source (N = 210)

Table 3
Employment of Professionals Without Disabilities (N = 210)

Table 4
The Frequency of Occupational Therapy Use According to Service Delivery Pattern (N = 210)

Table 5
The Frequency of Occupational Therapy Use According to Geographic Setting (N = 210)
Table 6
The Frequency of Occupational Therapy Use According to Consumer Population (N = 210)

<table>
<thead>
<tr>
<th>Number of Populations</th>
<th>Programs With Occupational Therapy Services</th>
<th>Programs Without Occupational Therapy Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>One population</td>
<td>24</td>
<td>11</td>
<td>56</td>
</tr>
<tr>
<td>Several populations</td>
<td>73</td>
<td>35</td>
<td>78</td>
</tr>
<tr>
<td>No answer</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

provided services to persons with psychiatric disabilities.

Of the respondents, 73% said their programs use occupational therapy and provide services to varied consumer populations. The three most commonly served populations were, in order, persons who are hearing impaired, persons with spinal cord injuries, and persons with head injuries. Of those 23 (11%) ILPs that used occupational therapy and serve one consumer population, only three reported working with persons who had psychiatric disabilities. Four served persons with mental retardation (see Table 6).

Finally, 72% of the respondents reported that consumers were involved in their operations. Consumer involvement was not a variable associated with the use or nonuse of occupational therapists by the respondents (see Table 7).

Table 7
The Frequency of Occupational Therapy Use According to Consumer Operation (N = 210)

<table>
<thead>
<tr>
<th></th>
<th>Programs With Occupational Therapy Services</th>
<th>Programs Without Occupational Therapy Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Is consumer operated</td>
<td>65</td>
<td>31</td>
<td>87</td>
</tr>
<tr>
<td>Not consumer operated</td>
<td>29</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>No answer</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

identified service areas. Many respondents indicated that their services were provided by several different disciplines and listed more than one service provider per service area. Therefore, only the top five responses are reported, resulting sometimes in totals of less than 100% and at other times (because of multiple responses by ILPs) in totals of more than 100% (see Table 8).

Of the ILPs that did not use occupational therapy services, 100 (88%) provide information or training to consumers in the area of daily living skills. In 34 of these programs (34%), the person most likely to provide these services was an independent living specialist (or independent living coordinator, independent living trainer, or independent living counselor, all of these responses being combined throughout the study). In 29 (29%) of the ILPs, these services were provided by a peer; a staff member provided these services at 8 ILPs (8%); and rehabilitation teachers and rehabilitation counselors provided daily living skills services for 6 (6%) and 4 (4%) respondents, respectively.

Most of these 114 ILPs did not offer information or training to consumers in the area of sensorimotor skills. One respondent stated that sensorimotor skills training was "not typical or appropriate" for ILPs in that state. In those 35 ILPs (31%) providing information or training in sensorimotor skills, the most likely person to be the provider was a peer (n = 11, 31%), followed by an independent living specialist (n = 10, 29%), a staff member (n = 7, 20%), a rehabilitation counselor (n = 5, 14%), and a rehabilitation teacher or orientation and mobility instructor (n = 4 or 11%).

The provision of or training in the use of assistive and adaptive equipment was reported to be an available service at nearly three quarters of these ILPs that did not use occupational therapy services. Several respondents stated that they had loan closets or rented equipment, others supplied information on where to obtain equipment, and some indicated that they did not provide the equipment, but did offer training in the use of the devices. At the 84 ILPs providing this service, independent living specialists were the most frequently cited service providers (n = 25 or 30%), followed by peers (n = 18 or 21%), staff members (n = 12 or 14%), rehabilitation teachers (n = 7 or 8%), and other rehabilitation counsel-

Table 8
The Frequency of Provision of Occupational Therapy Services in ILPs Not Employing Occupational Therapists (N = 114)

<table>
<thead>
<tr>
<th>Provide</th>
<th>Do Not Provide</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>(%)</td>
</tr>
<tr>
<td>Daily living skills</td>
<td>100</td>
<td>88</td>
</tr>
<tr>
<td>Sensorimotor skills</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>Adaptive devices</td>
<td>84</td>
<td>74</td>
</tr>
<tr>
<td>Orthotics</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Mobility</td>
<td>65</td>
<td>57</td>
</tr>
</tbody>
</table>

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ors or nurses (n = 4% to 5% for each).

Orthotic devices (such as slings or splints) were not provided by 75% of the ILPs that did not employ occupational therapists (73%). Two ILPs that did offer this service indicated that provision was by "referral." In the 24 ILPs that did provide orthotic devices (21%), the persons most likely to provide this service were either independent living specialists, staff members, or peers (n = 5 or 21% for each), followed by either rehabilitation counselors or nurses (n = 2 or 8% for each).

More than half of the respondents at these ILPs (n = 65, 57%) stated that they did provide information or training in the area of mobility. Several stated that they would refer a client who needed information regarding mobility or mobility training to another source, and a few indicated that they only provided information on mobility aids. At the 65 ILPs providing this service, peers were the most frequently cited service providers (n = 20, 31%), followed by independent living specialists (n = 17, 26%), rehabilitation teachers or orientation and mobility instructors (n = 9, 14%), staff members (n = 7, 11%), and rehabilitation counselors (n = 2, 3%).

Services Provided and the Service Providers at ILPs That Do Employ Occupational Therapists

The 96 ILPs that reported using the services of occupational therapists were also asked to provide information regarding the provision of services or training of consumers in the identified service areas and to identify the person most likely to provide information or training in each of the service areas. As before, many respondents indicated that their services were provided by several different disciplines. A diverse group of service providers was also reported; therefore, only the top five responses are included here. Often, the totals do not equal 100% (see Table 9).

Eighty-eight (92%) of the ILPs that used occupational therapy services provided information or training in the area of daily living skills. Two respondents (2%) stated that this section was not applicable; both indicated times that this service was "by referral only." In those 88, the most likely service providers for daily living skills were peers (n = 28 or 32%), followed by occupational therapists (n = 23 or 26%), independent living specialists (n = 18 or 20%), staff members (n = 8 or 9%), and rehabilitation counselors (n = 6 or 7%).

Sensorimotor skills training was offered by more than half of these ILPs, and occupational therapists were the most commonly cited provider of this service (n = 16 or 33%). Other providers of this service were peers (n = 10, 20%), independent living specialists (n = 8 or 16%), staff members (n = 7 or 14%), and physical therapists (n = 5 or 10%).

Eighty-two (85%) of the respondents indicated that they either provided or offered information regarding assistive and adaptive equipment to consumers, and again, occupational therapists were the most commonly cited providers of this service (n = 26, 30%). Peers were the second most frequently cited providers at 18% (n = 16), followed by independent living specialists (n = 9 or 10%), and rehabilitation counselors and staff members, (n = 5 or 6% for each). One respondent stated that "the adaptive equipment service for over 10 years consisted of 1, 2 or 3 occupational therapists and for the past two years was managed by a COTA, with a staff members of an information specialist and designer-fabricator. As of March the staff members consist of an information specialist, designer-fabricator and [the] same COTA used as [a] consult primarily to staff members, during [this] period of transition, but also for direct client services."

A majority of these 96 respondents did not offer orthotic devices or related training to clients, but of those 36 programs that did (38%), the most likely service provider was an occupational therapist (n = 21, 58%). Six respondents (17%) stated that orthoses were provided by a referral source outside of the facility. A peer provided this service 14% of the time (n = 5), a physical therapist 11% of the time (n = 4), and a nurse 8% of the time (n = 3).

Seventy percent of the 96 ILPs (n = 67) provided mobility devices or training. The most frequently cited service provider was an occupational therapist (n = 19, 28%), followed, in order, by a peer (n = 15 or 22%), an independent living specialist (n = 10 or 15%), a physical therapist, (n = 8 or 12%) and orientation and mobility instructors (n = 8 or 12%). One respondent stated "extensive hands on training [is done] by referral; practical tips [come] from [a] peer counselor and/or [an] Independent Living Skills Instructor."

Discussion

More than half (54%) of the 210 ILPs responding to this survey did not use occupational therapy services, and those ILPs that did use occupational therapy services did so at a minimal rate (an average of 16.88 hr per month when contracting with an occupational therapy and an average of 6.94 hr per month when referring clients for occupational therapy services). There are several possible explanations for this finding. One explanation could

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Table 9
The Frequency of Provision of Occupational Therapy Services in ILPs Employing Occupational Therapists (N = 96)

<table>
<thead>
<tr>
<th>Service</th>
<th>Provide</th>
<th>Do Not Provide</th>
<th>Not Applicable</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily living skills</td>
<td>88</td>
<td>92</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Sensorimotor skills</td>
<td>49</td>
<td>51</td>
<td>44</td>
<td>2</td>
</tr>
<tr>
<td>Orthotics</td>
<td>82</td>
<td>85</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Mobility</td>
<td>36</td>
<td>58</td>
<td>56</td>
<td>4</td>
</tr>
</tbody>
</table>
be that because ILPs are not mandated to provide occupational therapy services, an ILP may opt for an employee who commands a lower salary than does an occupational therapist. Or, ILPs may not employ occupational therapists because an occupational therapist is not available in the program's locale. It is also possible that because ILPs were founded on the premise of consumer helping consumer, ILP administrators may resist hiring occupational therapists whose education and practice are grounded on the medical model. Finally, the ILP's administrator may believe that the program does not need the services of an occupational therapist. For example, the administrator may wonder why the program needs the services of an occupational therapist for assistive device provision when a consumer or an independent living specialist can order equipment from a self-help catalog or a medical supply company.

The term independent living specialist and other associated titles (i.e., independent living skills instructor, independent living skills trainer, etc.) are used broadly in the independent living model. Some programs give the title of independent living specialists to consumers with on-the-job training, whereas some graduates of specialized college training programs use the same title. One respondent stated, "Peer counselors are paid staff who have a personal disability, and demonstrated qualifications in counseling. Independent living skills instructors may be paid staff members or contract employees who are qualified to teach on the topic which they are assigned. Frequently instructors are qualified persons with a disability." None of the respondents indicated how persons were judged to be qualified. This lack of uniformity in training could contribute to a variation in the quality of services provided by independent living specialists.

One key concern is that although consumers serving as independent living specialists may be knowledgeable about their own disabilities, they may be less informed about other disabilities. Kibele (1989) found that two of the five adults with cerebral palsy who were participants in her study "acknowledged that staff and peers at independent living skills agencies lack an understanding of the functional limitations imposed by cerebral palsy, which are not necessarily experienced by persons with other disabilities" (p. 374). Although I believe that a person with a disability is often more qualified to address many independent living issues than a health care professional who is not disabled, I am concerned that areas such as orthotic device provision, sensorimotor skills training, and in some cases, the recommending of certain assistive and adaptive equipment, would be better served by an occupational therapist.

Consistently, the ILPs in this study that employed occupational therapists offered traditional occupational therapy services at a higher percentage rate than those that did not employ occupational therapists. But even in those ILPs with occupational therapists, the occupational therapists were not always the provider of those traditional occupational therapy services. Common providers of these services were independent living specialists, who typically command lower salaries than an occupational therapist. One must consider whether an occupational therapist's expertise justifies additional salary costs.

In this survey, the use of occupational therapy services was found to be affected by three factors: the type of facility, the primary funding source, and whether the ILP hired professionals who did not have disabilities. There are several possible explanations for these findings. First, most of the 210 ILPs surveyed were nonresidential (81%). However, when those ILPs that do and do not use occupational therapy services were compared, it was found that 93% of the 107 programs with no occupational therapy services were in nonresidential settings, but only 74% of the 96 programs with occupational therapy services were in nonresidential settings. The 25 ILPs that offered services in both residential and nonresidential settings were more than twice as likely to offer occupational therapy services.

Second, those ILPs that did not use occupational therapists were funded by a federal grant nearly twice as often as those ILPs that did use occupational therapists. Why aren't occupational therapy positions written into these federal grant proposals? As discussed before, this may be due to the shortage of occupational therapy personnel, the higher costs of occupational therapy services as compared with other service providers in ILPs, or to the anticipated differences in philosophies of those working in the medical model and independent living model. Furthermore, it was disturbing to find that those ILPs whose primary funding source was a rehabilitation agency were less likely to use occupational therapy services. Perhaps it is assumed that a consumer has obtained maximal benefit from occupational therapy services once he or she is "discharged" from the medical model. Or, ILP administrators may not be aware of the breadth of occupational therapy services and how these services can benefit the consumer.

Finally, the 96 ILPs that used occupational therapy services employed nondisabled professionals more frequently. This appears logical considering that most occupational therapists do not have disabilities.

Study Limitations

Because this study had only a 58% response rate, the results are not a complete representation of all ILPs in the United States. The questionnaire instrument also had some limitations. Respondents were asked to place a mark next to the item that best described their ILP, which limited the possibility of other, perhaps more accurate, responses. Also, respondents were asked to identify the person most likely to provide information and training in a certain service area by indicating the person's title. A
wide range of responses resulted, which required the subjective grouping of responses in some cases. Finally, I did not ask about all areas of occupational therapy practice, only those more commonly provided by both ILPs and occupational therapists.

Conclusion and Recommendations

This study provided insight regarding the use of occupational therapists in ILPs and identified those persons who provide traditional occupational therapy services in these settings. However, it also raises issues that warrant further investigation, such as why occupational therapists are not used more by ILPs, what the roles are of occupational therapy practitioners who are currently employed by ILPs, and what the ILPs’ requirements are for independent living specialists. Until more research has been conducted, we can only make assumptions as to why more occupational therapists are not employed by ILPs. Several possible explanations have been discussed and will be reiterated along with recommendations.

As it did with the school-based model of intervention, the occupational therapy profession needs to ensure that occupational therapy students are, at a minimum, introduced to the independent living philosophy, the independent living model, and the appropriate roles for occupational therapists employed by ILPs. Once a pool of therapists knowledgeable about the independent living philosophy and model is developed, occupational therapists can better market their skills to ILP administrators, making them aware that occupational therapy can complement and expand the services they offer consumers.

If the cost of occupational therapy services is prohibitive to an ILP, or if too few occupational therapists are available to provide services in the ILP’s locale, it might be more cost effective and personnel efficient to provide occupational therapy services on a consultation basis to ILPs when possible. Given recent concerns over the rising costs of services and the need for cost containment, I believe occupational therapists have a responsibility to provide services in the most cost effective manner.

As occupational therapists, we need to focus our energies on functional and purposeful activities that will enable the consumer to reach his or her goals. We need to routinely expand services beyond the basic areas of feeding, grooming, dressing, bathing, and toileting, and consider how best to integrate each consumer fully into his or her home and community. It is my belief that the inconsistency of occupational therapists in providing these more comprehensive services in the past contributed in part to the need for the independent living movement.

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