Use of Aides in Occupational Therapy Practice

Kyle V. Russell, Elizabeth M. Kanny

Key Words: personnel management • practice guidelines • professional practice

Objectives. This study examined the use of aides in occupational therapy practice, the supervision and training of aides, and practitioners' attitudes toward the use of aides.

Method. A questionnaire was mailed to a systematically selected sample of 510 occupational therapists and occupational therapy assistants. The response rate was 74%.

Results. The use of occupational therapy aides is prevalent in a variety of settings. Forty percent of respondents reported that they currently work with aides, whereas 23% reported that they have never worked with aides. Occupational therapy aides perform a variety of tasks and receive various levels and amounts of supervision and training. Of those respondents who delegated specific skilled tasks to aides, 76% reported daily contact for purposes of supervision and training. Nineteen percent who currently work or have worked with aides reported being in a situation where an ethical issue arose related to aide use.

Conclusion. On the basis of the data, it is suggested that occupational therapy practitioners would benefit from taking a proactive role in determining how aides can be used to maximize service delivery while maintaining quality services. There also appear to be ethical concerns related to appropriate delegation of tasks to aides and to their supervision and training.

Developing strategies for providing efficient, high-quality services is a current issue in today's climate of restricted growth and limited funding for health care. The use of aides is one strategy that occupational therapy practitioners can use to increase the efficiency of service delivery. The use of aides to provide services under the direction of occupational therapy practitioners is not a new practice. During World War I, the military employed reconstruction aides who were craftpersons, teachers, and artists (Low, 1992). By the mid-1960s, the tasks performed by occupational therapy aides were formally surveyed (Adamson & Anderson, 1966). The tasks that the researchers identified were similar to those that aides perform today, namely patient treatment, project preparation, clean-up and maintenance, and patient transportation. The survey further revealed that trained assistants were seen as a way to alleviate the growing problem of a shortage of registered occupational therapists (OTRs). The issues of training and supervision, hiring less skilled personnel because of shortages of OTRs, and role delineation between occupational therapy aides and certified occupational therapy assistants (COTAs) that Adamson and Anderson (1966) identified...
persist in the profession today.

By 1991, the American Occupational Therapy Association (AOTA) still lacked an official position on the use of non–occupational therapy personnel, so it established a task force to examine and formalize an Association position statement. Through an extensive review of the literature and feedback from AOTA members, the task force found that occupational therapy aides were being used throughout the entire therapy process, including evaluation, treatment planning, intervention, and documentation. Through a survey of state regulatory boards, the task force found that 28 states of the 49 that responded referred to occupational therapy aides in their practice or title acts most often by a definition of occupational therapy aide and by specifying supervisory requirements (AOTA, 1993).

The task force also surveyed practitioners to obtain their reaction to a White Paper on occupational therapy aides (AOTA, 1994a). The use of a self-selected sample, however, limited the generalizability of findings. The survey found that 57% of the 198 OTR respondents and 46% of the 18 COTA respondents worked with aides and that 80% of all 391 respondents reported that aides are useful (“Task Force Continues Work on OT Aide Issue,” 1994). COTAs had more concerns about the use of aides than did OTRs, and many respondents reported that aides were not provided with site-specific training. On the basis of the work of the task force, the White Paper was adopted with revisions as a Position Paper of the Association in 1995.

The Position Paper: Use of Occupational Therapy Aides in Occupational Therapy Practice (AOTA, 1995b) addresses the role of aides in occupational therapy and provides practitioners with guidelines for the use of aides, including supervision, responsibility and accountability, training, and reimbursement. The paper defines an occupational therapy aide as “an individual assigned by an occupational therapy practitioner to perform delegated, selected, skilled tasks in specific situations under the direction and intense close supervision of an occupational therapy practitioner” (p. 1023), where the term intense close supervision means “daily direct on-site contact” (p. 1023).

The use of aides in occupational therapy practice raises issues of accountability, supervision, and reimbursement as well as legal and ethical considerations, which warrant further study (AOTA, 1995b). Therefore, the present study was designed to examine the attitudes of OTRs and COTAs toward the use of occupational therapy aides, to identify how they are being used in practice, to identify how they are being supervised and trained, and to examine ethical issues. Unlike previous studies, this study intended to examine issues through a random sample of occupational therapy practitioners.

Method
Sample
The sample consisted of 510 systematically selected active AOTA members, which represented slightly more than 1% of the total membership. Systematic selection is a probability sampling method generally considered equivalent to random sampling in which following a random start every nth name (sampling interval) on a given list is selected (Portney & Watkins, 1993).

Instrument
A 72-item questionnaire was developed specifically for this study on the basis of a literature review and the AOTA (1995b) Position Paper on occupational therapy aides. Face and content validity were addressed through a table of specifications and review by a member of AOTA’s Non-OT Practitioner Task Force. A pretest of the questionnaire that focused on clarity and ease of administration was conducted with staff members of a local occupational therapy department, and this feedback was used to refine the questionnaire.

The questionnaire was designed to gather data on attitudes toward the use of occupational therapy aides (20 items), the current level of use of aides (27 items), the level of supervision and training that aides are receiving (9 items), demographic information (14 items), and ethical situations regarding the use of aides (2 items). Lists of items to mark as applicable and one open-ended question were also included. The questions on attitudes used a five-point Likert scale on which 1 represented strongly agree, and 5 represented strongly disagree. The open-ended question on ethics asked: “Have you ever been in a situation with an OT aide where an ethical issue arose?” and “If yes, please describe the situation, how it was dealt with, and how you felt after it was resolved or left unresolved.”

Procedure and Data Analysis
The questionnaire was printed in booklets, which were mailed to the sample. Two follow-up surveys were mailed to nonrespondents at 3 weeks and 7 weeks after the initial mailing to facilitate a high response rate (Dillman, 1978). Quantitative data analysis consisted of tabulating frequencies and correlations and formulating an index to determine the attitudes of practitioners toward the use of aides. Qualitative analysis was used to identify themes and patterns in response to the question relating to ethical issues.

Results
Response Rate and Demographics
Of the 510 surveys mailed, 382 were returned. Of this
group, 16 respondents did not fill out the survey because they were retired or no longer working. The final sample consisted of 366 respondents (296 OTRs, 70 COTAs). Using Dillman's (1978) method, the response rate was calculated by dividing the number of questionnaires returned and usable (366) by the total number mailed (510) minus those deemed nonusable (16). This quantity was then multiplied by 100, yielding a response rate of 74%.

Respondents were distributed across the following employment settings: 23% in skilled nursing facilities, 17% in general hospitals, 16% in school-based facilities, 11% in outpatient clinics, 8% in private practice, 7% in home health agencies, 6% in community-based facilities, 4% in rehabilitation facilities, 2% in university or college settings, and 6% in other settings. Respondents were working in the following positions: 80% as staff therapists, 15% in administration and management, 2% as educators, and 3% in other positions. Their work experience with occupational therapy aides was as follows: 40% were currently working with aides, 37% had worked with aides in the past, and 23% had never worked with aides. Table 1 shows the distribution of occupational therapy aides across respondent practice areas.

**Extent of Use of Aides**

The demographics section of the survey asked how many OTRs, COTAs, and occupational therapy aides worked in the respondent's department and facility, and ratios of practitioners to aides were calculated from these data. According to the responses of the 296 OTRs, there was an average 1 aide for every 5 OTRs and 1 aide for every COTA. This indicates that aides made up approximately 14% of the workforce of occupational therapy personnel as reported by respondents.

**Supervision and Training**

For every 40 hr an occupational therapy aide works, respondents (n = 202) reported spending a median of 5 hr supervising and training the aide (M = 6.5 hr, mode = 5 hr, range = 0–40 hr). The median was used as the most reliable measure of central tendency because the data were markedly skewed.

In addition to the hours per week spent supervising and training occupational therapy aides, respondents were queried as to the frequency of contact for supervision and training. Of the respondents who currently worked with aides who perform delegated skilled tasks (n = 111), 76% reported contact for supervision and training at least once daily, 9% reported contact almost every day, 10% reported weekly contact, and 2% reported contact less than weekly. The largest number of respondents (41%) reported daily contact. When asked whether occupational therapy aides were trained with each specific patient for each specific task, respondents working with aides (n = 114) reported as follows: 32% always, 30% usually, 25% sometimes, 11% seldom, and 3% never.

**Attitudes Toward the Use of Aides**

**OTR versus COTA attitudes.** The means presented in Table 2 were calculated on the basis of all respondents (n = 366), those who had experience working with occupational therapy aides, and those who had no experience working with aides. Both OTR and COTA respondents tended to disagree with the statement that occupational therapy aides should replace some positions where COTAs currently work; however, COTAs disagreed more strongly (M = 4.00 for OTRs, M = 4.33 for COTAs, p = .003). COTA respondents were more likely than OTR respondents to agree with the statement that aides will replace some positions where occupational therapy practitioners currently work (M = 3.62 for OTRs, M = 3.23 for COTAs, p = .008). Thus, COTA respondents reported being more concerned about aides replacing occupational therapy practitioners. Both OTR and COTA respondents tended to agree that COTAs can appropriately supervise aides; however, COTAs were more likely than OTRs to agree that aides may be appropriately supervised by a COTA (M = 2.67 for OTRs, M = 2.11 for COTAs, p = .00006). COTA respondents also reported that more time was spent supervising and training occupational therapy aides than that reported by OTRs (M = 5.96/40 hr for OTRs, M = 8.71/40 hr for COTAs, p = .03).

**Staff therapist versus manager attitudes.** Staff therapists were more likely to report being uncomfortable because of not understanding AOTA's position on occupational therapy aides than were administrators and managers (M = 2.93 for staff therapists, M = 3.44 for managers, p = .0003) and because of not understanding state guidelines (M = 3.09 for staff therapists, M = 3.65 for managers, p = .0002). Respondents as a whole reported more discomfort with not understanding AOTA's Position Paper than with not understanding state guidelines (M = 3.19 for

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>n</th>
<th>Respondents Working With Aides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand therapy</td>
<td>12</td>
<td>9 (75%)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>59</td>
<td>33 (56%)</td>
</tr>
<tr>
<td>Developmental</td>
<td>19</td>
<td>9 (47%)</td>
</tr>
<tr>
<td>Physical disabilities</td>
<td>70</td>
<td>32 (46%)</td>
</tr>
<tr>
<td>Gerontology</td>
<td>78</td>
<td>35 (45%)</td>
</tr>
<tr>
<td>Work programs</td>
<td>6</td>
<td>2 (33%)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>58</td>
<td>15 (26%)</td>
</tr>
<tr>
<td>Mental health</td>
<td>10</td>
<td>1 (10%)</td>
</tr>
<tr>
<td>Higher education</td>
<td>6</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

*Note: n = 143 for respondents currently working with occupational therapy aides.*

Table 1

**Practice Areas of Respondents Currently Working With**
### Table 2
Attitudes of Respondents Toward the Use of Occupational Therapy Aides

<table>
<thead>
<tr>
<th>Attitude Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The challenge of learning to work with occupational therapy aides excites me.</td>
<td>6</td>
<td>28</td>
<td>52</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>2. I feel it is appropriate to delegate some specific skilled tasks to aides.</td>
<td>11</td>
<td>40</td>
<td>15</td>
<td>22</td>
<td>12</td>
</tr>
<tr>
<td>3. Occupational therapy aides can eliminate a good part of the repetitive work of OTRs and COTAs.</td>
<td>21</td>
<td>50</td>
<td>16</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>4. I am confident that I can learn to use occupational therapy aides in the OT practice area where I am currently employed.</td>
<td>21</td>
<td>42</td>
<td>18</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>5. Almost any OTR or COTA who is patient and motivated can learn to work with occupational therapy aides.</td>
<td>24</td>
<td>55</td>
<td>13</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>6. Occupational therapy aides should replace some positions where COTAs work currently.</td>
<td>1</td>
<td>6</td>
<td>17</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>7. I feel occupational therapy aides are necessary given the current trends in health care.</td>
<td>12</td>
<td>38</td>
<td>30</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>8. I would be able to train and supervise occupational therapy aides effectively.</td>
<td>22</td>
<td>56</td>
<td>14</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>9. I believe that generally occupational therapy aides are adequately trained and supervised for the tasks they perform.</td>
<td>4</td>
<td>20</td>
<td>40</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>10. Occupational therapy aides should replace some positions where OTRs work currently.</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>23</td>
<td>67</td>
</tr>
<tr>
<td>11. Using occupational therapy aides makes me uncomfortable because I don’t understand my state’s (or district’s) guidelines.</td>
<td>3</td>
<td>29</td>
<td>23</td>
<td>34</td>
<td>11</td>
</tr>
<tr>
<td>12. Occupational therapy aides could potentially decrease the costs of service provision in my setting without compromising quality.</td>
<td>4</td>
<td>34</td>
<td>26</td>
<td>26</td>
<td>10</td>
</tr>
<tr>
<td>13. I am uncomfortable with the ethical aspects related to using occupational therapy aides.</td>
<td>8</td>
<td>27</td>
<td>33</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>14. Using occupational therapy aides may increase the availability of OT in underserved areas, thus benefiting the field of occupational therapy.</td>
<td>5</td>
<td>33</td>
<td>28</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>15. Occupational therapy aides will replace some positions where OT practitioners work currently.</td>
<td>4</td>
<td>20</td>
<td>16</td>
<td>36</td>
<td>23</td>
</tr>
<tr>
<td>16. I feel apprehensive about using occupational therapy aides to provide OT treatment because of liability issues.</td>
<td>14</td>
<td>43</td>
<td>20</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>17. Occupational therapy aides may be appropriately supervised by a COTA.</td>
<td>12</td>
<td>47</td>
<td>20</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>18. Using occupational therapy aides makes me uncomfortable because I don’t understand AOTA’s position on their use.</td>
<td>4</td>
<td>30</td>
<td>28</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>19. Clients benefit from the decreased costs associated with using occupational therapy aides.</td>
<td>4</td>
<td>28</td>
<td>33</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>20. The use of occupational therapy aides to provide delegated skilled tasks makes the therapist less accessible to the client, thus threatening the quality of service.</td>
<td>19</td>
<td>31</td>
<td>21</td>
<td>25</td>
<td>4</td>
</tr>
</tbody>
</table>

Note. N = 366. AOTA = American Occupational Therapy Association; COTA = certified occupational therapy assistant; OT = occupational therapy; OTR = registered occupational therapist.

state guidelines, $M = 3.04$ for AOTA’s position, $p = .03$)

**Attitudes Based on Level of Experience Working With Aides**

Respondents currently working with occupational therapy aides were more likely than those who have never worked with aides to agree that aides can eliminate a good part of occupational therapy practitioners’ repetitive work ($M = 2.58$ for never worked with aides, $M = 1.96$ for currently working with aides, $p = .000003$). Respondents currently working with aides were more likely to report that aides are necessary, given the current trends in health care ($M = 3.04$ for never worked with aides, $M = 2.30$ for currently working with aides, $p = .0000009$). Respondents who had never worked with aides were more likely to agree that aides should fill some positions that COTAs currently fill ($M = 3.89$ for never worked with aides, $M = 4.19$ for currently working with aides, $p = .01$).

**Attitudes Based on Tasks Aides Perform**

Respondents who worked in settings that used occupational therapy aides to provide delegated skilled tasks were more likely to report that it is appropriate to delegate some specific skilled tasks to aides ($M = 2.49$ for skilled, $M = 3.40$ for unskilled, $p = .0000002$). Respondents who delegated skilled tasks to aides were more likely to agree that aides are necessary, given the current trends in health care ($M = 2.31$ for skilled, $M = 2.67$ for unskilled, $p = .0000002$).
were more likely to agree that aides could potentially decrease the costs of service delivery in their settings without compromising quality ($M = 2.77$ for skilled, $M = 3.16$ for unskilled, $p = .009$).

**General Attitudes Toward Aides**

An index was developed from 8 of the 20 questions relating to attitudes toward occupational therapy aides. Items were selected for the index if agreement seemed to indicate support toward the use of aides and if each item had a moderate level of correlation with other items in the index. Items included in the index were 1, 2, 3, 4, 5, 14, 17, and 19 (see Table 2). No significant difference was found between OTR and COTA respondents' general attitude toward occupational therapy aides. Staff therapists reported being generally more positive toward the use of aides than did managers ($p = .04$). Respondents who currently worked with aides reported being generally more positive toward the use of aides than those who had never worked with aides ($p < .0001$). Respondents who used occupational therapy aides for skilled tasks reported being generally more positive toward the use of aides than those who did not use aides for skilled tasks ($p < .0001$).

**Tasks Occupational Therapy Aides Perform**

Respondents currently working with occupational therapy aides ($n = 143$) marked yes or no for a list of nine tasks sometimes performed by aides (see Table 3). In addition, they were given the opportunity to write in tasks that were not listed. Some of the tasks included transporting patients; assisting with patient transfers; cleaning the department, including the linen and dishes; fabricating simple adaptive equipment; adapting clothing; making straps for splints; assisting with treatment; maintaining patient education brochures; scheduling; answering phones; taking referrals; setting up evaluations; and leading exercise, homemaking, and community groups.

**Documentation**

Of the 143 respondents currently working with occupational therapy aides, 20% reported that aides document in patients' charts. When asked to describe the documentation of aides, respondents reported that aides document clerical information, such as attendance (43%), objective clinical information (34%), and therapeutic evaluation or treatment planning information (9%). The remaining 14% offered no description of documentation by aides. Aides who document therapeutic evaluation or treatment planning information represent 2% of all occupational therapy aides. When asked whether the patient's record reflected that an aide was involved with treatment, 114 respondents who work with aides who perform delegated skilled tasks reported as follows: 31% never, 24% seldom, 12% sometimes, 19% usually, and 14% always.

**Benefits of and Concerns With Using Aides**

The benefit of occupational therapy aides that respondents most often endorsed was "frees time of practitioners for higher level tasks" (85%). Other benefits reported were "increases efficiency" (54%), "decreases cost" (46%), "expands availability of services" (42%), "provides care in underserved areas" (26%), and "increases quality of service" (17%). Three percent added the following comments about benefits: "provides for increased visibility of OT services"; "allows more time for quality care by OTR/COTA"; "lets them observe OTs for interest in the field as a profession"; and "in areas where COTAs are not available, the aide can help with some unskilled tasks that take up OTR's time."

The concern that respondents most often endorsed was "liability for malpractice" (70%). Other concerns were "overuse" (65%), "inappropriate billing" (52%), "increases distance between client and practitioner" (51%), "decreases quality of service" (50%), and "increases managerial role of OTR and COTA" (35%). Nine percent added the following concerns: "misuse"; "they get carried away at times and give inappropriate cognitive tasks, provide too much cuing, must be closely monitored"; "may not be properly trained/supervised"; "used to replace COTAs or OTRs instead of complement existing services"; "diminished skill level of front-line clinician"; "lack of knowledge base if they are being asked to do skilled tasks"; "administration and others, insurance may feel OT services can be performed by aides"; "may decrease need for OT and endanger profession or push toward 'super therapist' and general aides to do OT and PT [physical therapy]"; "improper use as more of a clinician";
representation of what OT can do for patients”; and “we must take the leadership—develop the policies and procedures, OT must be proactive—learn from nursing.”

**Ethical Issues**

In response to the open-ended question regarding ethical issues, 78% of the 269 respondents who reported working or having worked with occupational therapy aides indicated that they had not been in a situation where an ethical issue arose; 19% reported that they had been in such a situation; and 3% did not respond to the item. The responses of the 19% who reported ethical issues were analyzed qualitatively to identify themes. Themes included lack of or inappropriate supervision or training, overuse or pressure from management to overuse aides, aide makes error or oversteps scope of responsibility, and billing issues. Reported examples of lack of or inappropriate supervision or training included an aide seeing patients independently, changing treatment plans, or using specialized techniques with no specific training. Reported examples relating to overuse of aides included administrators pressuring for the use of aides without supervision, non-occupational therapy personnel encouraging aides to plan and run groups, and aides covering an OTR patient load until a hospital employed sufficient OTRs. Reported examples relating to errors made by aides or their overstepping responsibility included not following instructions and breaching confidentiality. Respondents also reported concerns about billing for occupational therapy services inaccurately or inappropriately when an aide was used.

**Discussion**

Results show that the majority of respondents had a positive attitude toward the use of occupational therapy aides, that aides were being used in a variety of practice settings for a variety of tasks, and that aides were provided with a level of supervision and training that met or exceeded AOTA’s (1995b) guideline for daily, direct contact. The finding that occupational therapy practitioners who had not worked with aides were more likely to agree that occupational therapy aides should replace some positions where COTAs currently work is a key point because it appears to indicate that once a practitioner has experience working with aides, the delineation between COTAs and aides becomes clearer. This distinction between those who have worked and those who have never worked with occupational therapy aides is notable because those who work with aides reported being more supportive of the use of aides in general.

**Use of Aides**

As trends in health care require that the most appropriate person perform tasks in order to optimize efficiency, occupational therapy practitioners must find a balance in the ratio of OTR or COTA to aide. When managers hire new occupational therapy personnel, a careful task analysis of the position needs to be done in order to determine who can best perform the job (i.e., OTR, COTA, aide).

**Supervision and Training**

Although the results indicate that the majority of aides are supervised within the guidelines of daily, direct contact, 21% of the respondents reported less than daily contact. We suggest that occupational therapy practitioners who are providing supervision on a less-than-daily basis are risking a decreased quality of service and potential unethical activities. The AOTA (1995b) stated that aides should receive close supervision, which is defined as “daily, direct contact at the site of work” (AOTA, 1995a, p. 1027), and that aides may be supervised by all levels of occupational therapy practitioners from entry-level COTAs through advanced-level OTRs (AOTA, 1995a). Additionally, the Position Paper (AOTA, 1995b) states that the OTR has the overall responsibility for work performed by the aide. A guide to assist practitioners in the processes of initial training for occupational therapy aides and for ongoing training and supervision would be useful for further delineating information in the Position Paper, especially in relation to supervision and training.

**Ethical Issues Around the Use of Aides**

Nineteen percent of the respondents who worked with or had worked with occupational therapy aides reported having encountered ethical dilemmas related to lack of supervision or training, pressure by management to overuse aides, errors made by aides, and documentation and billing problems. The *Occupational Therapy Code of Ethics* (AOTA, 1994b) provides guidance for dealing with such ethical dilemmas. With respect to supervision, the code states that appropriate supervision must be provided for personnel for whom the occupational therapy practitioner has supervisory responsibility. In the case of aides, this means that daily, direct supervision is needed and that training should ensure that the aides’ techniques are performed safely and effectively. Practitioners also need to guard against pressure to overuse aides on the sole basis of cost-containment measures and not use aides for skilled tasks that require professional judgment for evaluating or grading treatments. Regardless of the circumstances, the practitioner is ultimately responsible for appropriately using aides and following third-party payer, state, and federal guidelines for proper and accurate billing.

**Limitations**

As with all surveys, the general validity may be affected by nonresponse, sampling error, and accuracy of responses.
However, the 74% response rate is high, thereby strengthening the generalizability of results and diminishing the possibility of bias due to large numbers of nonrespondents. Phrasing or terminology used in questions may also affect responses because respondents may interpret questions differently than intended; however, pretesting was used to decrease this occurrence. In retrospect, this study would have been strengthened by querying aides themselves regarding their attitudes and perceptions about their activities in occupational therapy.

Summary and Directions for Further Research
This study examined the current use of aides in occupational therapy practice, supervision and training practices, and attitudes toward the use of aides. Results revealed a fairly widespread use of aides and that most occupational therapy practitioners followed guidelines for direct, daily supervision of aides. Major benefits of using aides related to freeing the practitioner's time, increasing efficiency, and expanding service availability. Concerns about using aides related to lack of adequate training and supervision, pressure for overuse, inappropriate billing, and a potential decrease in quality of services. Given the current market-based health care environment, which is focused on cost-effective services, occupational therapy practitioners will inevitably be dealing with the use of aides in practice. To maintain quality of services and practice ethically, practitioners will need to carefully examine the issues involved and determine appropriate use of aides.

Research directed toward the effective use of aides in specific large practice areas, such as physical rehabilitation, geriatrics, and pediatrics, would help to identify how aides can assist occupational therapy practitioners and enhance intervention. Quality assurance measures would also serve to either support or refute the use of aides as a cost-effective way to deliver occupational therapy services.

Acknowledgments
This research was supported by the American Occupational Therapy Foundation and is based on the first author's independent study conducted in partial fulfillment of the bachelor of science degree, Division of Occupational Therapy, Department of Rehabilitation, University of Washington, Seattle.

References
American Occupational Therapy Association (1993). Commission on Practice task force report: Use of personnel other than OTRs and COTAs to provide occupational therapy services. Rockville, MD: Author.
Task force continues work on OT aide issue. (1994, October 20), OT Week, 8(42), 8-9.