Therefore Be It
Resolved: 25 Years of Delegate Assembly/Representative Assembly Legislation

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In 1965, the power to legislate the affairs of the American Occupational Therapy Association (AOTA) passed from the Board of Management to the newly created Delegate Assembly. AOTA’s progress in the 25-year period from 1965 to 1990 can be traced by studying the resolutions deliberated upon by that Assembly and its successor, the Representative Assembly. Of interest historically are not only the resolutions passed, but those defeated as well, because all indicate concern for the issues of the times in which the resolutions originated. This paper discusses certain trends that became evident, such as health care legislation concerns, strategic planning, the position of the certified occupational therapy assistant in AOTA, standards in practice and research, and advanced education.

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representative Assembly, and it comprised at least one representative and alternate from each state election area. An additional representative and alternate could be elected from those states with larger populations of AOTA voting members. The affiliating groups were to be delimited by state or territorial boundaries. The RA was the current legislative body of AOTA.

Trends

By reviewing the resolutions of the DA/RA since 1965, one is able to discern certain patterns or trends that indicate the directions in which AOTA has moved to represent the profession. The following illustrate this movement.

Movement Toward a Proactive Stance in Interaction With Federal and State Legislation

AOTA has long been aware of the impact that state and federal legislation can have on the practice of occupational therapy. As early as 1966 (AOTA Delegate Assembly, 1967), the DA adopted a resolution that "affiliated associations increase their awareness of and participation in . . . developing Medicare programs." This was followed by action in 1967 (AOTA Delegate Assembly, 1968) that established a budget item for an association lobbyist in Washington as well as a request for funding of occupational therapy consultant positions at the National Office in the areas of physical and psychosocial practice.

Licensure, which had come before the Assembly first in 1968 in an unfavorable light (AOTA Delegate Assembly, 1968a), moved in 1969 from this initial negative reception to reluctant cooperation (AOTA Delegate Assembly, 1969b) with state legislative committees that were planning this action. By early 1974, the Assembly had taken a neutral stand (AOTA Delegate Assembly, 1974). This rapidly shifted in the second Assembly session of that year (AOTA Delegate Assembly, 1975a) to a stance of high priority toward the pursuit of licensure statutes, with a nationwide strategy to be developed to implement them.

In 1977, a definition of occupational therapy for licensure purposes and a further clarification of AOTA's stance on licensure, that is, that AOTA would support those bills in concert with currently established AOTA policies (AOTA Representative Assembly, 1977), were adopted. This complete reversal of position in a matter of a few years is a strong indication of the political awakening of the Assembly members to the effect of state legislation, both positive and negative, on practice. In part, this may have been an indirect result of another resolution (AOTA Delegate Assembly, 1974) adopted in 1974 that established Government Affairs as a standing committee of the DA. This committee, along with its counterparts in state associations, has been effective in keeping the membership abreast of current health care legislation. By 1975 (AOTA Delegate Assembly, 1976a), the DA felt confident enough to vote to advise the state of New York as to the negative effects of reduction in Medicaid funding on the people in that state.

In 1976, the DA supported a resolution to obtain third-party reimbursement for occupational therapy services and another to develop coalitions with professional associations for common interests. That year also saw the DA adopting the formation of the AOTA Political Action Committee (AOTPAC). The Assembly resolved to urge Congress to implement, through the Department of Health, Education and Welfare, the guidelines of the 1973 Rehabilitation Act prohibiting discrimination against handicapped persons (AOTA Delegate Assembly, 1976b). By 1978, the Assembly resolved to vigorously oppose the Council on Medical Services of the American Medical Association in its stance to amend Medicare legislation resulting in reduced occupational therapy coverage under Medicare, a full circle back to the original 1966 issue that had begun AOTA's movement into government affairs (AOTA Representative Assembly, 1978b). In 1979 (AOTA Representative Assembly, 1979), a resolution was adopted requiring that AOTA increase its efforts to expand occupational therapy coverage in state and federal legislation by increasing lobbying and political planning efforts. In 1981, a new definition for licensure, which would be general enough for all states, was adopted (AOTA Representative Assembly, 1981). In 1984, support was resolved for state occupational therapy government affairs efforts (AOTA Representative Assembly, 1984). In 1990, states were supported to achieve and maintain regulation (AOTA Representative Assembly, 1990).

Forward Movement Through Strategic Planning

One of the most striking aspects of AOTA has been its ability to develop strategic plans. As early as 1968, the DA adopted a resolution for a Long Range Plan (AOTA Delegate Assembly, 1968). This plan included the early directions for many later actions of the Assembly, whether to be carried out by presentation of future resolutions or by policy-making through other motions. It was superseded in 1974 (AOTA Delegate Assembly, 1974) by a new plan, the implementation of which was to be overseen by the Vice-President of AOTA. This was followed by the adoption of Association objectives ranked in priority order and the establishment of a method to review Association priorities related to the Long Range Plan (AOTA Delegate Assembly, 1975a). This in turn necessitated a resolution stating the mission and goals of AOTA. Following this, the DA adopted the three phases of the Advocacy Model, recommended by the Task Force on Association Strategy and Planning, which was to promote membership cohesion regarding the goals and objectives of the Association (AOTA Delegate Assembly, 1975b). Although no further resolutions appear to address this trend directly, the trend set in motion a series of planning and management strategies (i.e., the Strategic Integrated Management Sys-
Although the latter resolution failed, another was adopted to expand eligibility criteria so that COTAs were considered equal to registered occupational therapists. Study possibilities of restricted or limited voting privileges for elected position on the Executive Board was created as were those of registered therapists. Certification fees, while another called for a more meaningful role for COTAs in state and national organizations. Certification initially, therefore, did not have the same effect of providing a standard for them. This began to change in the early years of the DA. Although by 1965 they were considered to be graduates of training programs endorsed by AOTA, certified occupational therapy assistants (COTAs) were not considered full-fledged members of the Association, nor could they hold positions in the Association equal to registered occupational therapists (OTRs). Forward movements were being made on their behalf, however. An early resolution in 1965 standardized certification fees, while another called for a more meaningful role for COTAs in state and national organizations. Although the latter resolution failed, another was adopted to study potential ways in which COTAs could participate in these organizations (AOTA Delegate Assembly, 1966). In 1967, a resolution to allow COTAs to vote for offices in the Association was referred, but was followed by one to study possibilities of restricted or limited voting privileges (AOTA Delegate Assembly, 1968). By 1972, the DA resolved to expand eligibility criteria so that COTAs were included in awards recognition for outstanding occupational therapy personnel (AOTA Delegate Assembly, 1972). A resolution to enable COTAs to vote in all Association affairs was referred in that year, but in 1973 a COTA-elected position on the Executive Board was created (AOTA Delegate Assembly, 1975)—a form of progress, if not of equality. In 1975, the Certified Occupational Therapy Assistant Award of Excellence was created, although another resolution to add COTAs to the eligibility list for the AOTA Roster of Fellows failed (AOTA Delegate Assembly, 1975b). Also in this year, COTAs were granted the receipt of the American Journal of Occupational Therapy (AJOT), a regular membership benefit for OTRs that had previously been denied them (AOTA Delegate Assembly, 1975b).

Until 1975, a major difference between COTAs and OTRs had been the use of a national certification examination as the means of entry into the profession; there was no such unified examination for COTAs. In the second Assembly of that year, a resolution requiring a certification examination for COTAs was adopted (AOTA Delegate Assembly, 1976a), and in the following year the specifics of this examination were delineated. These included the initial administration date in 1977 (AOTA Delegate Assembly, 1976b). This removed a major difference in credentialing status between OTRs and COTAs and was further strengthened in the second Assembly of that year by a resolution that created a policy for the terms for entry of individuals to become COTAs in the same language as that used for OTRs (AOTA Representative Assembly, 1977). That COTAs now have a much stronger position in the Association can be seen in the current work of the COTA representative to the RA, an extension of these resolutions, and in other active COTA participation at both state and national levels.

**The Strengthening of the COTA Position Within AOTA**

Occupational therapy assistants appear to have followed roughly the same developmental patterns as occupational therapists in that they were initially not certified. They were different in that the educational programs that were instrumental in their training were not governed by a set of essentials as were those of registered therapists. Certification fees, while another called for a more meaningful role for COTAs in state and national organizations. Certification initially, therefore, did not have the same effect of providing a standard for them. This began to change in the early years of the DA. Although by 1965 they were considered to be graduates of training programs endorsed by AOTA, certified occupational therapy assistants (COTAs) were not considered full-fledged members of the Association, nor could they hold positions in the Association equal to registered occupational therapists (OTRs). Forward movements were being made on their behalf, however. An early resolution in 1965 standardized certification fees, while another called for a more meaningful role for COTAs in state and national organizations. Although the latter resolution failed, another was adopted to study potential ways in which COTAs could participate in these organizations (AOTA Delegate Assembly, 1966). In 1967, a resolution to allow COTAs to vote for offices in the Association was referred, but was followed by one to study possibilities of restricted or limited voting privileges (AOTA Delegate Assembly, 1968). By 1972, the DA resolved to expand eligibility criteria so that COTAs were included in awards recognition for outstanding occupational therapy personnel (AOTA Delegate Assembly, 1972). A resolution to enable COTAs to vote in all Association affairs was referred in that year, but in 1973 a COTA-elected position on the Executive Board was created (AOTA Delegate Assembly, 1975)—a form of progress, if not of equality. In 1975, the Certified Occupational Therapy Assistant Award of Excellence was created, although another resolution to add COTAs to the eligibility list for the AOTA Roster of Fellows failed (AOTA Delegate Assembly, 1975b). Also in this year, COTAs were granted the receipt of the American Journal of Occupational Therapy (AJOT), a regular membership benefit for OTRs that had previously been denied them (AOTA Delegate Assembly, 1975b).

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**Standards of Practice**

Standards of practice in occupational therapy have been a concern of the Association since its early days, with attempts at different stages to formalize them. The first Assembly resolution on this subject was adopted in 1968. The standards set forth were general and sought to cover all areas without specific delineation in treatment populations (AOTA Delegate Assembly, 1969a). By 1977, it was believed that more specific standards of practice should be developed, specifically in the areas of mental health, developmental and physical disabilities, and home health care (AOTA Representative Assembly, 1977). These were adopted by resolution in 1978 (AOTA Representative Assembly, 1978b). In 1980, the Standards for OT in Schools were adopted (AOTA Representative Assembly, 1980). This movement has continued in the form of adoption by motion of practice and position papers for roles and functions of occupational therapy personnel in various areas of practice. A few standards continue to be presented as resolutions.

**Movement to Strengthen Research and Advanced-Degree Education**

Although a resolution that surfaced early in 1966 that would have provided an annual scholarship for prospective authors (AOTA Delegate Assembly, 1967) was referred, funding was allocated by resolution to the existing American Occupational Therapy Foundation (AOTF) for charitable and educational purposes, indicating an early concern for education and research by the Assembly. By 1969, a resolution had been passed placing 2% of annual membership dues in AOTA at AOTF’s disposal (AOTA Delegate Assembly, 1969b). This provided a steady means of funding for later scholarship and research efforts. In 1974 (AOTA Delegate Assembly, 1975a), the DA resolved that the Council on Practice would guide occupational therapy endeavors for experienced therapists to practice in such specialty areas as research, education, and administration. Research consultant services and graduate education services were called for, with a position to be established in the National Office of Coordinator of Education Services; this effort was tabled. Elements of the Long Range Plan of 1974 were related to education and re-
Movement in the Assembly Becomes More Complex to Track

As strategies like the Long Range Plan have been implemented, their various components have been moved into task forces and ad hoc committees whose actions and reports have become part of Assembly action but do not necessarily result in the formulation of new resolutions. Thus, it will become increasingly necessary to review not only action on resolutions but also other business of the Assembly to have a complete picture of RA functioning in the future. This may be part of the reason for the decline in numbers of resolutions in the late 1980s and into 1990. Additionally, in the last 3 years, potential resolutions have been reviewed to prevent cyclical repetition of certain topics or to provide historic precedent that might negate the presentation of a resolution. Another factor that may make it more difficult to abstract information about Assembly action is that the minutes, which were once printed in their entirety in AJOT, are now published as brief summaries, often including only the name of a resolution and its passage. Those that were tabled, referred, or failed are not indicated. (Note. A copy of the complete minutes is available from AOTA upon request.)

Issues

Issues have also surfaced over the 25-year period that, although they have not shown a specific trendlike pattern, are important enough to merit comment because of the amount of time and effort that the Assembly has spent on them.

Membership Fees

The issue of membership fees was the topic of numerous resolutions, 37 in the 1970 Assembly meeting alone (AOTA Delegate Assembly, 1971). Most of these were directed toward securing a reduction in fees for nonpracticing therapists, although a few were directed toward overall reductions with related budget-cost reductions. Association membership dues were at issue because continuing certification was linked to it. Payment of membership dues maintained certification. If certification lapsed, the therapist might be required to retake the certification exam, state licensure exam, or both. These requests for fee reductions for various categories of nonworking therapists continued sporadically over the next decade. The issue was only put to rest in 1986, when the Assembly resolved to separate AOTA from certification policies and programs by creating the separate American Occupational Therapy Certification Board (AOTCB) (AOTA Representative Assembly, 1986). Following the creation of the AOTCB, certification was awarded for the therapist’s lifetime with initial certification, while membership in AOTA with its concomitant fee became voluntary, allowing nonpracticing therapists to retain certification without paying an annual fee if they chose to do so.

Continuing Education and Continuing Competency

In 1971 (AOTA Delegate Assembly, 1971), the Assembly passed a three-phase plan with an emphasis on development of plans for continuing education related to the implementation of standards for continuing certification and regulation. It also created holding accounts for continuing education workshops. In 1974, a resolution was referred that would have created an additional position in the National Office for continuing education, along with a resolution requesting objectives for the position of Coordinator of Educational Services (tabled) (AOTA Delegate Assembly, 1975a). By 1976, an Office of Continuing Education was established as a 2-year pilot project to develop continuing education programs (AOTA Delegate Assembly, 1976b). This continues as part of the National Office as a result of action in 1979 requesting that the responsibilities of the office be continued and adding additional duties. In this way, several aspects of continuing competence and education were brought to the Assembly’s attention, and actions were set in motion (AOTA Representative Assembly, 1979). In 1979, after much debate, resolutions were adopted that called for a mandatory recertification process defined by a variety of options, including continuing education, which must be submitted to the voting membership of AOTA before ratification. It was resolved that the Continuing Education Program...
continue with duties outlined in the 1974 resolution and that further responsibilities be added to those previously set forth. A later resolution was adopted that stated the responsibility of individuals in identifying their own educational needs and goals. During the 1980 Assembly, a move to make recertification a voluntary process was defeated (AOTA Representative Assembly, 1980). In 1982 (AOTA Representative Assembly, 1982), a resolution was adopted that called for a comprehensive plan for continuing education that would address the needs of the COTA as well as those of the OTR. At present, all recertification efforts have been discontinued, because certification is granted for life. The continuing education comprehensive plan was never fully realized, although major continuing education projects continue to be developed at the national level. Continuing education requirements for therapists are increasingly being dictated by state licensure laws, which include continuing education requirements for licensure renewal. Because these differ from state to state, continuing education remains fragmented.

Recruitment and Personnel

As part of the Long Range Plan adopted in 1967 (AOTA Delegate Assembly, 1968), an AOTA position was created in 1969 for a recruitment consultant to develop and maintain career information, among other duties (AOTA Delegate Assembly, 1969b). In 1970, it was directed that recruitment was to be deemphasized in favor of increasing focus on public information (AOTA Delegate Assembly, 1970). This changed as a result of the Manpower Study funded in 1974 (AOTA Delegate Assembly, 1975a) and was again addressed in 1981 with a charge to identify realistic personnel goals for the profession and to create an ad hoc commission for a 10-year period (AOTA Representative Assembly, 1981). Further information on recruitment and personnel would then be obtained through Manpower Commission reports.

Specialization

Among the first resolutions adopted by the new Delegate Assembly in 1965 was one that charged the AOTA with publishing a quarterly bulletin on practice to enable the membership to keep current in their fields of specialization, it being said that “the AJOT: as a professional journal, is not a vehicle for current news” (AOTA Delegate Assembly, 1966, p. 51). This bulletin was to be continued, by resolution in 1967 (AOTA Delegate Assembly, 1968), for “as long as need was demonstrated.” In 1976, a resolution was adopted providing for the development of specialty sections during the 1977 transition year (from DA to RA) to meet member and consumer needs, and a steering committee was appointed. These original sections were mental health, developmental disabilities, physical disabilities, gerontology, and sensory integration (AOTA Representative Assembly, 1977). This was followed in 1977 by a request for a time frame for completion of directives related to the development of the specialty sections (AOTA Representative Assembly, 1977) and procedural guidelines so that, among other considerations, the importance of the generalist in occupational therapy practice should not be overlooked. The Assembly funded these resolutions. Guidelines were also adopted so that enrichment rather than fragmentation of practice should be emphasized. These guidelines were created in such a way as to allow the establishment of additional specialty sections. Additional funding as a percentage of member dues was adopted in the second RA session for that year (AOTA Representative Assembly, 1978a). In 1979, the RA created by resolution an ad hoc committee to study the basic issues of specialization in practice (AOTA Representative Assembly, 1979) with a possible view toward specialty certification. In that year also, specialty sections became Special Interest Sections as a way of distinguishing interest from specialization competencies. In 1984, voluntary advanced-level certification was presented in resolution form but was referred back to the Executive Board (AOTA Representative Assembly, 1984). It has not resurfaced in resolution form, although efforts to develop methods of evaluating advanced competencies have been studied.

Interaction with the International Community

The United States was already a member of the World Federation of Occupational Therapists (WFOT) when the first DA met. Therapists from foreign countries were requesting to practice in the United States, a privilege denied them at that time because of the established criteria that had to be met before they could sit for the certification examination. In 1966, it was resolved to find an easier method to allow foreign therapists to practice in the United States (at that time, the therapist must have worked for 9 months in the United States). Two resolutions were adopted that would finance the expenses of the AOTA delegate to the WFOT Council business meetings and the WFOT Congress (AOTA Delegate Assembly, 1967). In 1967, restrictions were eased for foreign therapists with a revision of eligibility rules for sitting for the exam (AOTA Delegate Assembly, 1968). The DA supported a sliding scale of membership dues in WFOT and, apparently tardily, from the wording of the resolution, sent AOTA's By-laws and the Essentials of the Accredited Curriculum of Occupational Therapy to the World Federation. In 1970, as a member organization of WFOT, the DA ratified the WFOT amended constitution (AOTA Delegate Assembly, 1970). In 1971, the DA adopted yet another resolution related to qualifications of foreign therapists sitting for the certification examination (AOTA Delegate Assembly, 1971). In 1972, the issue of the role and privileges of the WFOT delegate in regard to AOTA was referred to the
Council on Development for consideration (AOTA Delegate Assembly, 1972). There have been no further resolutions concerning WFOT or foreign therapists to date.

Summary

An article of this length provides only a beginning toward understanding the workings of a legislative body such as the RA. Because it represents the membership, the vote of the RA provides the leadership and direction for the profession. By tracing the path and direction of certain issues over the years, we can gain at least a partial picture of the growth and development of AOTA as well as of the increased sophistication of Assembly leadership. In addition, the availability of the minutes of the Assembly meetings published in their entirety in AJOT through the early 1980s allowed the membership to be in touch with the actions of the Assembly. This is no longer the case, because Assembly minutes have been reduced to two-page to three-page summaries that merely list the actions passed with no discussion (a copy of the complete minutes, however, is available upon request). The basic effect of this is to emphasize the need for individual state delegates to keep their constituents informed and for individual therapists to be responsible for obtaining information at the national level.

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References


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