This article provides a historical review of certified occupational therapy assistant (COTA) education, professional roles, career mobility, and professional development. The evolution of COTA education from 2 hospital-based, 12-week training programs to the current 162 accredited 2-year college degree or professional certificate programs is examined. The expansion of the COTA role from well-delineated direct service provider to advanced practitioner able to assume leadership roles within the profession is explored. Historic and current programs and methods supportive of COTA career mobility and professional development goals, including the Career Mobility Program, continuing education, career laddering, and the Advanced Practitioner program are described.


In 1960, the first two classes of certified occupational therapy assistants (COTAs) completed their 12-week training program at Westboro State Hospital, Westboro, Massachusetts, and Marcy State Hospital, Marcy, New York, and began their practice in well-delineated, circumscribed roles at these hospitals. These early COTAs were credentialed only for psychiatric practice and were not considered full members of the American Occupational Therapy Association (AOTA) (Hirama, 1986). Today, there are more than 12,000 COTAs who are graduates of 2-year college degree or professional certificate programs and who are practicing in a diversity of settings and assuming a wide variety of practitioner and leadership roles within our profession. Outside of COTA textbooks, little has been written about the changes in COTA education and the growth in COTA professional roles over the past 39 years. This article reviews these changes and the expanded professional roles COTAs can assume in today’s practice environment. A heightened awareness of COTA history may enhance practitioners’, supervisors’, and employers’ recognition of COTA career mobility needs and professional development goals.

COTA Education

The need for an assistant-level practitioner in the occupational therapy profession was first recognized in 1949 when a plan to establish education programs for occupational therapy assistants was proposed at the March AOTA Board of Management meeting (Brittell, 1989; Hirama, 1986). The proposal recommended that assistant education programs be based in psychiatric hospitals because of the occupational
therapy manpower shortage in psychiatry. However, it was not until 1956 that the AOTA Board of Management approved a plan that recognized a second level of occupational therapy personnel. A committee was formed to implement this plan and develop guidelines for assistant education and certification (Hirama, 1986). On October 20, 1957, the AOTA Board of Management accepted the committee’s final document, which provided a curriculum guide and outlined minimum requirements for an acceptable occupational therapy assistant training program.

These programs were to be designed to cover only one specific disability area, that of psychiatry, and to result in certification in that specialty area. The term certified occupational therapy assistant and COTA insignia were formally adopted at this time. One year later, AOTA distributed official notifications to state and federal agencies, the American Psychiatric Association, The National Association for Mental Health, and other agencies and individuals deemed appropriate, informing them of the new COTA personnel level (AOTA, 1958).

After these actions, education programs were established in psychiatric facilities that needed COTA personnel because of the ongoing registered occupational therapist (OTR) manpower shortage (Cromwell, 1968). The first program, developed in 1958, was a 12 weeks long and combined didactic course work and specialty skills with supervised clinical experience (AOTA, 1958; Brittell, 1989; Crampton, 1967). Graduates of these programs were eligible to use the COTA designation and wear the COTA insignia. Simultaneously, in 1958, persons who had worked as occupational therapy aides for 2 years in a specific practice area before AOTA established standards for COTA education were “grandfathered” into the COTA level, if three qualified persons (including their current OTR supervisor) provided AOTA with satisfactory recommendations (AOTA, 1958; Cromwell, 1968). This grandfather clause ended 3 years after the commencement of the first formal COTA education programs.

Interest in developing COTA education beyond psychiatry grew as the need for more direct service providers expanded because OTRs began to assume indirect service roles and responsibilities in practice areas other than psychiatry (Crampton, 1967). In October 1960, the AOTA Board of Management developed a 12-week curriculum to train COTAs for general practice. In 1961, a 3-month training program for nursing home practice was established in Montgomery County, Maryland, on the basis of this proposed curriculum (Caskey, 1961; Cromwell, 1968). In 1964 and 1965, the first two COTA programs in junior colleges were begun at Mount Aloysius Junior College in Pennsylvania and St. Mary Junior College in Minnesota, respectively (Brittell, 1989; Crampton, 1967). All these programs certified COTAs for either general practice or psychiatric practice. A pilot occupational therapy assistant education program, which AOTA began in 1965, combined general practice and psychiatry training, enabling COTAs to obtain dual certification in these practice areas (Schwagmeyer, 1969). By 1966, AOTA mandated that all new occupational therapy assistant education programs provide this dual training (Hirama, 1986).

In 1968, 10 years after the first COTAs were formally educated through an AOTA-approved program, there were more than 1,200 COTAs practicing and 20 occupational therapy assistant education programs (Hirama, 1986). Following this decade milestone, the number of occupational therapy assistant education programs increased, and more of them (16 of 26) were located in academic institutions rather than in hospitals or other health care facilities.

In 1970, an additional avenue to becoming a COTA opened. Occupational therapy technicians in military service who had worked in occupational therapy for at least 12 months and were recommended by an OTR for COTA certification became eligible (Hirama, 1986).

By 1972, a concern about the lack of consistency in occupational therapy assistant education programs, which ranged from 9-month and 11-month institution-based programs to 2-year college degree programs, was growing. The depth and breadth of study among these programs obviously varied, yet graduates of these programs were equally eligible to become COTAs (Cantwell, 1970). Therefore, in 1975, AOTA adopted the revised Essentials and Guidelines for an Approved Educational Program for the Occupational Therapy Assistant, which strengthened and expanded the original occupational therapy assistant education guidelines and required by 1977 that all graduates of AOTA-approved COTA programs pass a written certification examination (AOTA, 1976). Since that time, the standards for occupational therapy assistant education have been revised three times to strengthen the quality and ensure the consistency of these programs (AOTA, 1999). Furthermore, all occupational therapy assistant programs must be initially accredited, and then periodically reaccredited, by the Accreditation Council for Occupational Therapy Education (AOTA, 1999).

Over the past 20 years, occupational therapy assistant education programs have continued to develop, with recent market demands for COTAs resulting in a proliferation of these programs. As of July 1999, there were 162 accredited occupational therapy assistant programs, with all but 4 resulting in an associate’s degree; 23 developing programs; and 13 programs with applicant status (A. Harris, personal communication, July 21, 1999). The expanded curricula of current programs bear little resemblance to the 12-week training programs begun more than 30 years ago. Programs today must educate COTAs to assume expanded roles and increased responsibilities in a diverse and challenging health care system (Stancliff, 1996).

**COTA Professional Roles**

During the more than 30 years of COTA development, there has been an ongoing dialogue (and at times heated
debate) over the role of the COTA within the occupational therapy profession (Ad Hoc Committee on COTA Issues, 1996; Black, 1997; Brooks, 1982; Forte, 1988; Holmes, 1997). As stated previously, early COTAs trained in institution-based programs or grandfathered from occupational therapy aide to COTA provided well-defined, direct service in either psychiatry or general practice, but they were not allowed to serve as AOTA representatives, vote in AOTA elections, vote on AOTA proposals, or receive *The American Journal of Occupational Therapy (AJOT)* as an AOTA member benefit. A resolution to give COTAs voting rights and provide for COTA representation on AOTA boards was defeated by AOTA’s Delegate Assembly in 1965. This resolution also proposed the development of a division within AOTA to deal with COTA concerns, interests, and issues (AOTA, 1962).

The defeat of this resolution reflected the abrasive relationship that had developed between many OTRs and COTAs since the inception of the assistant-level position within our profession (Brunyate, 1967). Although many OTRs supported the idea of different levels of occupational therapy personnel (Madigan, 1985), others did not perhaps because they believed that their position was threatened (Brooks, 1982; Brunyate, 1967; Forte, 1988; Holmes, 1997). In response to OTRs’ lack of support, COTAs became “defensive and soon both sides block[ed] the desired natural melding into a working unit” (Brunyate, 1967, p. 263).

The development of mutual respect and collaborative relationships between COTAs and OTRs required major changes about how individuals viewed their professional role. OTRs had to assume new responsibilities (e.g., supervision, consultation, administration, in-service training) with little educational preparation for these responsibilities (Black, 1997; Forte, 1988; Madigan, 1985). Questions about role differentiation were raised, and several attempts were made to identify the respective responsibilities of the COTA and OTR (AOTA, 1973; Black, 1997; Forte, 1988; Holmes, 1997).

Increased education for COTAs and OTRs to clarify their role responsibilities and for OTRs to develop needed supervisory skills was advocated (Crampton, 1967). In 1972, AOTA funded a workshop that focused on COTA-OTR relationships, and a liaison between COTAs and AOTA’s Council of Development was established to assist COTAs in taking a more active role in the Association (Hirama, 1986). These efforts to support COTA role enhancement were not well received by all members of AOTA (Hirama, 1986), but eventually “the actual experience of working with COTAs quieted the early fears of OTRs” (Joe, 1994, pp. 18–19). However, this level of comfort has not been universally developed or exhibited throughout the profession, and the need to develop awareness and mutual respect for the diverse roles and contributions of COTAs and OTRs is still evident (Ad Hoc Committee on COTA Issues, 1996; Holmes, 1997).

As the years progressed, the COTAs professional roles expanded, and opportunities for professional recognition grew. In 1975, the COTA Award of Excellence was established to recognize the significant professional contributions of a COTA through clinical practice, education, administrative education, publication, or presentation; eligibility for the AOTA Award of Merit and Eleanor Clarke Slagle Lectureship was extended to COTAs, and COTAs were given *AJOT* as an AOTA member benefit (Hirama, 1986). In 1976, COTAs received full AOTA voting rights, and a COTA was elected to AOTA’s Executive Board. In 1978, the COTA Roster of Honor was established to recognize COTAs who made major scholarly contributions in practice, research, and education (Joe, 1994). In 1983, a COTA representative to the Representative Assembly was elected, and in 1986, the Representative Assembly established the COTA Advisory Committee to AOTA’s Executive Board. The Terry Brittell COTA/OTR Partnership Award was also established at that time to recognize a professional team exemplifying partnership and promoting occupational therapy through collaboration (Forte, 1988). Starting in 1988, the COTA forum became a permanent feature at the AOTA Annual Conference, and in 1991, AOTA established a COTA network steering committee. COTA representatives now serve on the Commission on Practice, the Commission on Standards and Ethics, the Commission on Education, and the Representative Assembly (Walker, 1994).

The expansion of COTA roles beyond direct service provider has increased the awareness of the vital contributions COTAs make to our profession (Black, 1997; Strickland, 1988). In 1997, AOTA established the Advanced Practitioner program for COTAs, a self-initiated process that acknowledges achievement of an advanced level of practice within an area of occupational therapy (AOTA, 1997). Health care trends, such as managed care, decreased lengths of stay, and increased home and community-based practice have required the OTR to become more focused on evaluation and treatment planning, resulting in the COTA assuming more responsibility for treatment implementation. These trends support COTAs’ expanded position within the health care arena, with a projected increase in demand for COTAs and a guaranteed (and potentially exponential) growth in their professional roles (Black, 1997; Joe, 1996; Silvergleit, 1994; Stanciff, 1996; Strickland, 1988).

**Professional Development and Career Mobility**

Several issues and concerns about COTA professional development and career mobility are reflected in the literature. Early on, AOTA recognized the desire for COTAs to advance professionally. Its Delegate Assembly passed a resolution in 1971 to determine procedures that would facilitate COTA career advancement without the requirement
of an additional academic degree (Adams, 1981; Colman, 1992). The Career Mobility Program (CMP), instituted in 1973 in response to this resolution, gave COTAs who met the criterion of 2 years of COTA experience the right to take the certification examination. Because of concerns that this criterion was not sufficient, the program was amended in 1975 and 1976 to include the additional criteria of a minimum of 4 years of COTA practice with satisfactory delivery of direct services to clients under the supervision of an OTR, successful completion of approved therapist-level clinical fieldwork for at least 6 months, and payment of annual certification fees. CMP participants engaged in independent study and self-assessment and received feedback from OTR supervisors (Adams, 1981).

The CMP generated intense debate until its demise in 1982. Proponents cited the need for an increased number of qualified professionals within the health care system and advocated flexible entry into the profession as a way to increase personnel, viewing practical experience to be as viable as academic preparation (Colman, 1992). In contrast, CMP opponents cautioned that sidestepping the traditional educational route to become an OTR would undervalue the OTR credential and may not result in the acquisition of adequate skills and knowledge to provide the desired quality of care (Colman, 1992). Johnson (1988) noted that being credentialed without fulfilling academic and clinical requirements negated the value of the educational process and its contributions to the profession (p. 4) while depriving the recipient of such credentialing of valuable resources that contribute to professional growth and success (p. 4). Concerns were also voiced that the CMP might diminish the status of COTAs who chose not to participate (Nelson, 1975).

Although the AOTA Representative Assembly voted in 1981 to recommend the CMP be continued, the program was revoked in 1982 because of pervasive concerns about the impact of lowering the educational requirements for entry into the profession (Colman, 1992). The implied message of the CMP was that it does not require a college degree to be an occupational therapist, registered...despite our statements to the world [that] we are professionals [with educations befitting a professional]” (Hightower-Vandamm, 1981, pp. 771–772). In addition, several state licensure boards did not recognize OTRs who had attained their status through the CMP or allow them to work in public schools. Questions were also raised about reimbursement for services performed by these OTRs (Hirama, 1986).

Most notable about the CMP’s demise was that it did not draw many participants. During its first 5 1/2 years, only 47 of the 4,105 eligible COTAs completed the program (Adams, 1981), and by the program’s end, a mere 64 COTAs had become OTRs through CMP. A follow-up of the first 47 COTAs who became OTRs through the CMP indicated that they appreciated “the opportunity to participate, but would have preferred the traditional academic route to certification if it had been feasible” (Adams, 1981, p. 331).

It is important to emphasize that not all COTAs practicing today who seek to develop professionally or advance their careers choose to do so by becoming OTRs (Black, 1994; Holmes, 1997; Holmes & Black, 1995; Johnson, 1988; Stancliff, 1999). In fact, pressuring COTAs to become OTRs can devalue the role of the COTA. Instead, these COTAs should be encouraged to verbalize their pride and satisfaction in being an OTA (Shannon, 1988).

There are other viable and valid ways for COTAs to grow professionally, and the profession supports and needs both COTAs and OTRs (Holmes, 1997; Sladyk, 1997). They can seek self-enhancement activities and continuing education to broaden their perspectives; gain new insights; and learn new skills, theories, and techniques (Blechert & Christiansen, 1993). Such involvement in lifelong learning facilitates expansion of COTA roles as specialists and educators. Holmes (1997) found that COTAs benefit from remaining COTAs while developing professional growth plans to “facilitate the role of the COTA to its fullest potential” (p. 46). Grimpe (1994) discussed the merit of using self-evaluation to increase competence via experience, education, supervision, and strengthening of the COTA role on the COTA–OTR team.

Career laddering is a means of advancing within the profession through mechanisms other than formal education (Koehn, Winistorfer, & Zemke, 1993; Strickland, 1988). Programs for career ladder are usually based in institutions or companies with large staffing patterns to facilitate experienced COTAs’ development of skills and knowledge in a particular clinical program area (Strickland, 1988). The COTA who advances via career laddering has a high level of professional competence and initiative, leading to an enhanced COTA–OTR partnership and opportunities for the COTA to engage in consultation, education, management, and supervision (Swedberg, 1993). Creation of job enrichment programs enables not only the development of the COTA, but also that of “the OT program, institution and ultimately the profession” (Strickland, 1988, p. 12).

However, there are still COTAs who seek to develop professionally by becoming OTRs. Motivators for the pursuit of a professional occupational therapy degree have been identified as increased job skills, enhanced job security; greater financial rewards, and the need to relieve occupational stress and staff shortages (Anderson, 1989; Cipriani, McPhee, & Swartwood, 1995). Because these COTAs can become OTRs only through formal education programs, Bruhn (1991) recommended that articulation agreements be established between occupational therapy assistant and occupational therapist education programs to facilitate COTA professional growth and to encourage their retention in the field. These articulation agreements would enable “educational laddering,” that is, the transference of occupational therapy assistant courses to a 4-year baccalaure-
reate degree. Most occupational therapy professional educational programs permit this credit transfer, enabling COTAs to advance to OTR without losing credit for education already completed (G. Gaidelis, personal communication, October 30, 1996; Sladyk, 1997).

Because traditional day-session occupational therapy schools make it difficult to continue with full-time weekday employment, many COTAs find it costly to attend these programs (Anderson, 1989; Cipriani et al., 1995). For this group, nontraditional class schedules (i.e., evening and weekend programs), which were identified as crucial to COTA career mobility by the 1981 COTA Task Force (Hirama, 1986), are available in nine professional education programs (A. Harris, personal communication, June 21, 1998). COTAs who decide to pursue these alternative educational delivery systems and special programs are most often nontraditional students who continue to work in the field, bringing to their professional education programs unique strengths, issues, and concerns.

Conclusion
The professional education of COTAs has progressed to a level that enables these practitioners to assume a variety of professional roles in a diversity of practice settings. Opportunities for career advancement and professional development have become increasingly available to COTAs, as supervisors and administrators recognize the contributions COTAs can make in today’s changing health care system.

COTAs can choose to advance professionally through the COTA–OTR partnership, continuing education, career laddering programs, development of specialty skills, or the pursuit of a professional-level degree in occupational therapy. Support of their professional development on multiple levels not only enables them to reach their fullest potential and receive professional recognition, but also enhances the profession in general. ▲

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References


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