



Arizona Department of Education
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AZ-TAS

OCCUPATIONAL THERAPY AND PHYSICAL THERAPY

Processes and Procedures for Services in Public Schools

Exceptional Student Services
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I. INTRODUCTION

The first AZ-TAS document entitled Occupational Therapy and Physical Therapy Services, completed in 2000, was the result of hard work, dedication, and commitment from many occupational therapists and physical therapists, educators, parents, and administrators across Arizona. This current document complies with the requirements and definitions of the current Reauthorization of the Individuals with Disabilities Education Act (IDEA), as well as best practices in occupational therapy and physical therapy in the school setting.

This document provides general guidelines to promote consistency in the service delivery of occupational therapy and physical therapy in the public education agencies in the state of Arizona. The guidelines are intended for use by occupational therapists, physical therapists, certified occupational therapy assistants, physical therapy assistants, staff at the institutions of higher education, and school administrators. Since administrative procedures vary from agency to agency, these guidelines are designed to assist the schools in understanding the federal regulations, state rules, and state licensure laws that govern these professions, as well as in implementing the practices that are supported by their professional organizations.

Occupational therapy (OT) and physical therapy (PT) are two of the related services that may be necessary to enable a child with a disability to benefit from special education under the IDEA. In Arizona, school-based therapists provide services to children in special education ages 3–22. Therapists working in the school system should become familiar with the laws governing special education: federal IDEA law (20 USC 1400 et seq.) and the related regulations (34 CFR, Parts 300 and 301); Arizona Revised Statutes, Title 15 (ARS 15-761 through 15-774); and the Arizona Administrative Code, R7-2-401 et seq. Additionally, occupational therapists should become familiar with the rules and regulations of the Arizona Board of Occupational Therapy Examiners, and physical therapists should review the rules and regulations set forth by the Arizona Board of Physical Therapy. (Copies of these rules and regulations can be obtained from the respective state licensure boards.) Finally, occupational therapists and physical therapists should take time to review and understand the policies and procedures set forth by their specific public education agency (PEA).

INTERACTION BETWEEN OCCUPATIONAL THERAPY AND PHYSICAL THERAPY

It is important to point out that although the professionals in occupational therapy and physical therapy may use similar activities, each discipline has its own areas of expertise. The related services of occupational therapy and physical therapy that a student receives should support the student's educational program to ensure an effective educational experience and be indicated in the student's IEP. The two professions are complementary; however, as stated in their individual state licensure laws (ARS, Chapter 32, Physical Therapy and Chapter 34, Occupational Therapy), only a licensed occupational therapist or licensed occupational therapy assistant may provide occupational therapy services and only a licensed physical therapist may provide physical therapy services.

DISCLAIMER

This document is published as a technical assistance document by the Arizona Department of Education to provide guidelines to therapists, parents, administrators, and teachers about procedures, available options, and considerations with regard to occupational therapy (OT) and physical therapy (PT) services. The guidelines, based on federal regulations, state statutes, and Arizona licensure laws, are not meant to interpret the law, nor are they meant to be mandates. They serve as recommendations for best practice for related services in the schools.

II. DEFINITIONS

It is important for all readers to have a common understanding of the terms used in this document. Following are the definitions of terms used in this document.

SPECIAL EDUCATION

Special education means specially designed instruction at no cost to parents, to meet the unique needs of a child with a disability, including instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings; and instruction in physical education (34 CFR 300.39)

INDIVIDUALIZED EDUCATION PROGRAM

The individualized education program (IEP) means a written statement for a child with a disability that is developed, reviewed, and revised in a meeting in accordance with 34 CFR 300.320–324. The IEP serves as a communication vehicle, commitment of resources, management tool, compliance monitoring document, evaluation device, and opportunity for resolving differences.

RELATED SERVICE

According to IDEA, related service means transportation and such developmental, corrective, and other support services as are required to assist a child with a disability to benefit from special education. Related services may include speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation (including therapeutic recreation), early identification and assessment of disabilities in children, counseling services (including rehabilitation counseling), orientation and mobility services, medical services for diagnostic or evaluation purposes, school health services and school nurse services, social work services in schools, and parent counseling and training (34 CFR 300.34 (a)).

LEAST RESTRICTIVE ENVIRONMENT

The least restrictive environment (LRE) is another important provision of the law that affects the practice of occupational therapy and physical therapy in school settings. The least restrictive environment means that to the maximum extent appropriate, children

with disabilities, including children in public or private institutions or other care facilities, are educated with children who are non-disabled. It further means that special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily (34 CFR 300.114).

Occupational and physical therapy services should be provided within the context of the child's educational program for the services to exemplify the spirit of least restrictive environment intended by IDEA. In order to integrate occupational therapy and physical therapy services effectively within the school setting, occupational therapists and physical therapists must understand special education and local school district programs and policies.

III. OCCUPATIONAL THERAPY AS A RELATED SERVICE

DEFINITIONS

Federal IDEA regulations define occupational therapy as services provided by a qualified occupational therapist. The definition includes improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning if functions are impaired or lost; and preventing, through early intervention, initial or further impairment or loss of function (CFR 300.34(c)(6)).

The Arizona Board of Occupational Therapy Examiners defines occupational therapy as the use of occupational therapy services with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, socioeconomic and cultural differences, or the aging process in order to achieve optimum functional performance, maximize independence, prevent disability, and maintain health including evaluation, treatment, and consultation (ARS 32-3401.5).

The American Occupational Therapy Association (AOTA) defines the practice of occupational therapy as the therapeutic use of purposeful and meaningful occupations (goal-directed activities) to evaluate and treat individuals who have a disease or disorder, impairment, activity limitation, or participation restriction which interferes with their ability to function independently in daily life roles and to promote health and wellness (AOTA, 1999).

The definitions of the Arizona Board of Occupational Therapy Examiners and American Occupational Therapy Association are much broader than the definition under the IDEA. For purposes of the provision of OT/PT in the schools, the definition provided in the IDEA, that of supporting educational goals, will be used.

OCCUPATIONAL THERAPY SERVICES IN EDUCATION

School-based guidelines published by AOTA, “Occupational Therapy Services for Children and Youth under the Individuals with Disabilities Education Act,” state that occupational therapy services are client centered and recognize the client’s needs, wants, and priorities. Within the school environment, the client may represent a single individual, such as the student, the teacher, or the parent. The client may also be a group of people, such as the entire IEP team, the school staff, or the district bus drivers who need training in proper lifting and handling techniques (AOTA, 1997).

In the public education system, the role of the occupational therapist ranges from direct service provider to provider of services such as consulting, program development, and training. By providing these services, occupational therapists are able to indirectly serve students while the students learn in more inclusive settings and thus comply with the least restrictive environment mandate. Additionally, the IDEA requirement that services be delivered within the general education curriculum as much as possible is met. Therefore, occupational therapists in schools often take on a greater role as consultants than when they work in non-educational settings. Occupational therapy services delivered to students, or on behalf of students, must be considered within the therapist’s realm of work. Service delivery involves the therapist and the IEP team in a collaborative process of designing and implementing services in the most appropriate and least restrictive environment.

OCCUPATIONAL THERAPY PERFORMANCE AREAS

The expertise of the occupational therapist (OT) and occupational therapist assistant (COTA) lies in their knowledge of occupations (everyday life activities) and how engaging in occupations (everyday life activities at school) can be beneficial to students in their academic performance at school (Occupational Therapy Practice Framework: Domain and Process, AOTA, 2002). OTs and COTAs often use the terms *occupation* and *activity* interchangeably to describe daily life pursuits. They are used interchangeably in this document as they pertain to school and educational performance.

Within the school setting, the occupational therapist and occupational therapy assistant (under the supervision of an occupational therapist) look at student performance in the following areas of occupation:

1. **Activities of Daily Living**—activities that are oriented toward taking care of one’s own body. They include personal hygiene and grooming, toilet hygiene, dressing (as related to school performance), eating, and feeding.
2. **Instrumental Activities of Daily Living**—activities that are oriented toward interacting with the environment and often involve complex routines. They include use of a communication device, meal/snack preparation and cleanup, safety procedures, and shopping (grocery and other).
3. **Education**—activities that are oriented toward being a student and participating in a learning environment. They include academic (e.g., assisting a student to be

- successful with learning and/or making adaptations for math, reading, writing) and non-academic areas (e.g., recess, lunchroom, hallway), along with participation in extracurricular and prevocational activities.
4. **Play/Leisure**—any spontaneous or organized activity that provides enjoyment, entertainment, amusement, or diversion. This includes play exploration (e.g., exploration play, practice play, pretend play, constructive play, and symbolic play) and play participation (e.g., participating in play, maintaining a balance of play, and obtaining, using, and maintaining toys, equipment, and supplies appropriately).
 5. **Work**—activities needed for engaging in employment or volunteer activities that, for students, may include learning to write out checks or complete job applications, as well as developing work habits.
 6. **Social Participation**—individual and group interactions with peers and friends.



Occupational therapists and occupational therapy assistants also look at the many factors that influence the performance of students within the school environment, including:

1. **Performance Skills**—small units of performance
 - a. *Motor skills* that include skills in moving and interacting with tasks, objects, and the environment (e.g., posture, mobility related to moving the body in space when interacting with tasks or objects, coordination, strength, and effort and energy).
 - b. *Process skills* that include temporal organization to begin and end a task in logical sequence, organization of space and objects to find and use materials, and adaptation, which allows the student to notice cues in the environment and make adjustments as needed (e.g., finding a quiet area to read or write in the classroom when it gets noisy).
 - c. *Interaction/communication skills* that include physicality (using the physical body when communicating, e.g., making physical contact with others, using eye gaze to communicate) and relations (maintaining appropriate relationships by collaborating, conforming to social norms, and learning to establish rapport with others).
2. **Performance Patterns**—behaviors developed over time
 - a. *Habits*—specific, automatic behaviors that can either support or interfere with a student’s performance in the school environment.
 - b. *Routines*—established sequences of activities that provide a structure for daily life at school.
 - c. *Roles*—set of behaviors that have some socially agreed upon function and for which there is an accepted code of norms.
3. **Context**—a variety of interrelated conditions within and surrounding the student that can influence performance within the school setting

- a. *Cultural*—customs, beliefs, activity patterns, behavior standard, and expectations accepted by the society of which the student is a member.
 - b. *Physical*—accessibility to and performance within buildings and environment, objects, tools, devices, sensory qualities of environment.
 - c. *Social*—availability and expectations of significant others including parents, teachers, caregivers.
 - d. *Personal*—consideration of age, gender, socioeconomic status.
 - e. *Spiritual*—that which inspires and motivates the student.
 - f. *Temporal*—year in school, time of school year.
 - g. *Virtual*—environment in which communication occurs by means of airways or computers and absence of physical contact.
4. **Activity Demands**—aspects of an activity needed for the student to carry out the activity
- a. *Objects* and their properties (pencils, scissors, crayons, utensils).
 - b. *Space* demands (e.g., size, room arrangement, surface, lighting, temperature, noise).
 - c. *Social* demands (e.g., rules of games, expectations of peers).
 - d. *Sequence and timing* for activities (e.g., steps to making a sandwich for lunch).
 - e. *Required actions* (usual skills required by student to carry out activity).
 - f. *Required body functions* and body structures (e.g., use of two hands, crossing midline, joint mobility).
5. **Client Factors**—factors that reside within the student that may affect performance in areas of occupation at school
- a. *Mental functions* including level of alertness and arousal, memory and perceptual abilities, orientation to person-place-time, energy and drive, body image, self-concept, self-esteem, regulation of emotions.
 - b. *Sensory functions* including seeing and related functions (visual acuity, visual fields), hearing and vestibular sense, taste, smell, proprioception, touch and sensations related to temperature and pressure, pain.
 - c. *Neuromusculoskeletal* and movement-related functions including range of motion, control of muscle tone, and integration of developmentally appropriate reflexes and reactions as the basis for more normal movement, muscle strength, endurance and postural control, gross coordination, motor planning, fine coordination and dexterity, oral motor control.
 - d. *Body systems function* including cardiovascular, immunological, respiratory, digestive, metabolic, and endocrine.
 - e. *Body structure categories* including the structure of the nervous system, structures related to movement.

The occupational therapist, as a member of the IEP team, participates in the development of and decision-making process relating to IEP goals (and, if appropriate, short-term

objectives), frequency and duration of services, as well as monitoring of the IEP and progress toward IEP goals.

In the educational setting, the occupational therapist provides evaluation and therapy services based upon educational referrals, not physician referrals. Should the school receive a referral from a physician, the IEP team must consider the referral and base any subsequent recommendations on educational need. If a student has an identifiable occupational therapy need that does not affect the student's ability to learn and benefit from the educational experience, that therapy is not the responsibility of the public education agency.

OCCUPATIONAL THERAPIST RECOMMENDED COMPETENCIES

Occupational therapists working in Arizona must be licensed by the Arizona Board of Occupational Therapy Examiners. The license must be current and valid for the therapist to be considered a qualified provider under the IDEA.

The following are recommended competencies adapted from AOTA, 1990, which meet (and in some cases exceed) requirements set forth by the Arizona Board of Occupational Therapy Examiners in ARS 32-3401.6. Best practice would suggest that advanced competencies such as the supervision of COTAs or occupational therapy students, comprehensive evaluations of assistive technology needs, and using specialized techniques for severe feeding/swallowing disorders would require further training, education, and experience.

1. Knowledge of disabling conditions that occur before and after birth and their effects on students with special needs related to educational performance.
2. Knowledge of the educational system and its critical components, including federal and state regulations and ethical/legal responsibilities that apply to occupational therapists in the educational setting.
3. Knowledge of major theories, treatment procedures, and research relevant to providing occupational therapy services for children (infants through age 22) with disabilities.
4. Ability to assess the functional performance of students with disabilities within the school environment.
5. Ability to interpret assessment results appropriately and use the results to develop therapeutic intervention plans and classroom strategies appropriate to the educational goals for the student.
6. Ability to communicate effectively (both orally and in writing) with educational personnel, parents, local and state agencies, and the community at large.
7. Ability to engage in consensus decision-making as part of the IEP process in order to write appropriate IEP goals and objectives.
8. Ability to plan and implement intervention strategies using a continuum of service delivery approaches, in accordance with student needs.

9. Ability to evaluate, modify, and document the effectiveness of occupational therapy intervention, as it relates to the student's education program.
10. Ability to facilitate transition between agencies, programs, and professionals as service provision changes (early intervention to preschool, preschool to school age, and school to work).

OCCUPATIONAL THERAPY ASSISTANT RECOMMENDED COMPETENCIES

Occupational therapy assistants working in Arizona must be licensed by the Arizona Board of Occupational Therapy Examiners. The license must be current and valid for the therapist to be considered a qualified provider under the IDEA.

The following are recommended competencies adapted from AOTA, 1990, which meet (and in some cases exceed) requirements set forth by the Arizona Board of Occupational Therapy Examiners in ARS 32-3401.6.

1. Knowledge of disabling conditions that occur before and after birth and their effects on students with special needs related to educational performance.
2. Knowledge of the educational system and its critical components, including federal and state regulations and ethical/legal responsibilities that apply to occupational therapists in the educational setting.
3. Knowledge of occupational therapy treatment procedures and therapeutic activities relevant to providing occupational therapy services for children, ages 3 to 22, who have disabilities.
4. Ability to relate observations of student performance to performance components of learning activities, in order to effectively grade activities and positively impact the educational program of students with disabilities within the school environment.
5. Ability to collaborate with occupational therapy personnel in the collection of data for the occupational therapy comprehensive assessment, including reviews of student files, interviews with referring sources, and observations of student performance.
6. Ability to communicate effectively with educational team members in implementing appropriate therapeutic intervention plans and classroom strategies as developed by the supervising occupational therapist.
7. Ability to participate in consensus decision-making as part of the IEP process in collaboration with the supervising occupational therapist to develop appropriate IEP goals and objectives.
8. Ability to document service contacts and maintain student therapy files, according to district and/or therapy department procedures.
9. Ability to facilitate transition between agencies, programs, and professionals as service provision changes (early intervention to preschool, preschool to school age, and school to work).

10. Ability to problem-solve and create solutions for student programs coupled with the ability to seek supervision from occupational therapy supervisor when appropriate.
11. Ability to use a variety of adaptive equipment and positional devices and/or to modify classroom supplies for student educational programs.

IV. PHYSICAL THERAPY AS A RELATED SERVICE

DEFINITIONS

Federal IDEA regulations define physical therapy as services provided by a qualified physical therapist. (CFR 300.34 (c) (9)).

The Arizona Board of Physical Therapy defines physical therapy as:

1. The examining, evaluating, and testing of persons who have mechanical, physiological, and developmental impairment, functional limitations, and disabilities or other health and movement-related conditions in order to determine a diagnosis, a prognosis, and a plan of therapeutic intervention and to assess the ongoing effects of intervention;
2. Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic intervention including:
 - a. Therapeutic exercise
 - b. Functional training in self-care and in home, community, or work reintegration
 - c. Manual therapy techniques
 - d. Therapeutic massage
 - e. Assistive and adaptive orthotic, prosthetic, protective, and supportive devices and equipment
 - f. Pulmonary hygiene
 - g. Debridement and wound care
 - h. Physical agents or modalities
 - i. Mechanical and electrotherapy modalities
 - j. Patient-related instruction
3. Reducing the risk of injury, impairments, functional limitations, and disabilities by means that include promoting and maintaining a person's fitness, health, and quality of life; and
4. Engaging in administration, consultation, education, and research.



The Arizona Board of Physical Therapy definition of physical therapy, which encompasses therapy in medical facilities for medical as well as educational purposes, is much broader than the definition under the IDEA. For purposes of defining physical therapy services provided in the schools, the IDEA definition, that of supporting educational goals, is used.

PHYSICAL THERAPY SERVICES IN EDUCATION

Physical therapists working in Arizona must be licensed by the Arizona Board of Physical Therapy. The license must be current and valid for the therapist to be considered a qualified provider under the IDEA.

Within the educational model, physical therapists assist special education students with the development and practice of motor and postural control, safety and mobility in the educational environment, sensory processing, or other underlying performance components that significantly impact the student's educational experience. Physical therapists may also assist with equipment needs and communicate with community agencies on behalf of the student. A student may require either physical therapy as a related service to benefit from special education or physical therapy as an ancillary service to be maintained in the least restrictive environment.

Although certain disabling conditions cause motor dysfunction, the student may receive physical therapy through the school system only if the condition and movement problem interferes with the student's educational performance and ability to meet IEP goals. This interference must be identified and documented by the IEP/multidisciplinary evaluation team. Educational physical therapy services may include screening, assessment, program planning, intervention, communication, consultation, education, and documentation.

PHYSICAL THERAPY PERFORMANCE AREAS

The physical therapist uses educational expertise to support students in their:

1. Physical access to educational activities.
2. Movement requirements for daily living and self-care.
3. Prevocational physical requirements.
4. Access to school play and recreation activities and equipment.
5. Physical management components related to psycho-social development, functional communication, and transportation to and from school.

Specific student performance areas that may be addressed by physical therapy when it is required for a student to participate in school activities and remain in the least restrictive environment include:

1. **Neuromuscular and musculoskeletal systems**—range of motion, control of muscle tone, muscle strength, endurance, gross motor coordination, and motor planning.
2. **Sensory processing**—equilibrium and protective reactions, proprioceptive and kinesthetic input, and bilateral coordination).
3. **Functional communication**—classroom positioning, recommendations for adaptive devices or equipment.
4. **Environmental adaptations**—evaluations and recommendations for modifications of architectural barriers and children's equipment.
5. **Posture and positioning**—symmetry of positions, handling and transfer

methods.

6. **Adaptive equipment**—skin care, recommendations for splints, bracing, and positioning devices.
7. **Functional mobility**—transfer skills, gait evaluation and recommendations, wheelchair mobility.
8. **Mobility and transfer skills**—adaptive equipment, wheelchair and equipment care, and use for self-help.
9. **Physiological function**—functional muscle strengthening, cardiorespiratory function and fitness, body mechanics, energy conservation techniques.
10. **Prevocational and vocational skills**—generally strengthening, sitting and standing tolerance, motor coordination, adaptive equipment.
11. **Education/communication**—information on disability and educational impact, staff training and development, liaison between medical and education staff (Martin, 1992).

As with the occupational therapist, the physical therapist participates in the development and decision-making process relating to IEP goals and services and the monitoring of progress toward IEP goals.

In the educational setting, the physical therapist provides evaluation and therapy services based upon educational referrals, not physician referrals. Should the school receive a referral from a physician, the referral must be considered by the IEP team and any subsequent recommendations based on educational need. If a student has an identifiable physical therapy need that does not affect the student's ability to learn and benefit from the educational experience, that therapy is not the responsibility of the public education agency (e.g., a child with a sports injury/cast continues to learn although he or she may be uncomfortable in the school environment).

PHYSICAL THERAPIST RECOMMENDED COMPETENCIES

Physical therapists working in Arizona must be licensed by the Arizona Board of Physical Therapy. The license must be current and valid for the therapist to be considered a qualified provider under the IDEA.

The following are recommended competencies that meet (and in some cases exceed) requirements set forth by the Arizona Board of Physical Therapy:

1. Knowledge of the educational system and its critical components, including the federal and state regulations and the ethical/legal responsibilities that apply to physical therapists in the educational setting.
2. Knowledge of disabling conditions that occur before and after birth, as well as the effects on students as related to educational performance.
3. Knowledge of major theories, treatment procedures, and research relevant to providing physical therapy services for children (infants through age 22) with disabilities.
4. Ability to assess the functional performance of students with disabilities within

- the school environment. This would include identifying, comparing, selecting, and administering appropriate evaluations.
5. Ability to interpret assessment results appropriately and use the results to develop therapeutic intervention plans and classroom strategies appropriate to the educational goals for the student. This could include adaptive equipment, assistive technology devices, and outside professional consultation.
 6. Ability to communicate effectively (both orally and in writing) with educational personnel, parents, local and state agencies, and the community at large.
 7. Ability to engage in consensus decision-making as part of the IEP process in order to write IEP goals and, if appropriate, objectives or benchmarks.
 8. Ability to plan and implement intervention strategies using a continuum of service delivery approaches in accordance with student needs in the least restrictive educational environment.
 9. Ability to evaluate, modify, and document the effectiveness of physical therapy intervention as it relates to the student's educational program.
 10. Ability to facilitate transition between agencies, programs, and professionals as service provision changes (early intervention to preschool, preschool to school age, and school to work).
 11. Evidence of continuing educational efforts to enhance skills, expertise, and professional knowledge as it relates to job performance. This could include such areas as adaptive and assistive technology, training and supervision of other staff, administration, and time management.

V. SERVICES UNDER IDEA AND STATE STATUTES

PRESCHOOL TRANSITION

Transition from early intervention services to preschool programs is significant for many families. Changing from a system in which children may receive services in the context of the family and community to a school-based model in which related services (i.e., OT and/or PT) may be provided in groups in the classroom setting is often difficult to understand and accept. Transition requirements ensure that a team (teachers, early intervention providers, school district representatives, related service providers) works collaboratively with families to plan and provide for a smooth transition to the public school setting. Advance planning for a transition should begin as soon as appropriate (starting when the child is between 2.6–2.9 months of age). This advance planning often relieves much of the anxiety for the parents and helps to start the preschool experience on a positive note.

PRESCHOOL THROUGH AGE 22 SERVICES

Preschool through age 22 educational services from occupational and/or physical therapy are considered related services, and are required to assist a child with a disability to benefit from special education (34 CFR 300.34(a)). The least restrictive environment is addressed in the delivery of related services to preschool and school age children in

special education. Often these services are provided within the context of the classroom or playground environment (in naturally occurring settings) with groups of children, rather than the one-to-one service model. Decisions relating to service delivery are always determined by the IEP team to best meet the educational needs of the individual child.

SECONDARY TRANSITION SERVICES

Secondary transition services, according to IDEA '04, are planned for special education students beginning at age 16, or earlier if so determined by the IEP team. "Transition services" means a coordinated set of activities for a student with a disability that is designed to be within a results-oriented process. The services should focus on improving the academic and functional achievement of the child to facilitate movement from school to post-school activities and may include post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The activities should be based on the individual child's needs, taking into account the child's strengths, preferences, and interests and may include the areas of instruction, related services, community experiences, the development of employment and other post-school adult living objectives and if appropriate, acquisition of daily living skills and provision of a functional vocational evaluation (34 CFR 300.43(a)).



The occupational therapist and physical therapist may play a role as team members in transition planning for these students, and may find themselves part of the student's community experience, assisting in the acquisition of daily living skills and functional vocational evaluations, or they may need to assist in adaptations and access to employment and other post-school living opportunities.

INCLUSION SERVICES

The IEP team determines the least restrictive environment for placement of a child with preference given to placement with nondisabled peers, whenever appropriate. Inclusion is a term reflecting the current educational position that all children with disabilities should have the opportunity to learn from nondisabled peers and to be a part of the regular school environment. Services are provided during naturally occurring activities, giving relevance and support to a student's educational goal. Inclusion addresses the benefits of peer modeling from typical peers, especially for social, behavioral, and communication gains.

Within the school setting, inclusion is seen when a student with significant disabilities is placed in a general education classroom with support services to assist the student in meeting the IEP goals. In situations such as this, occupational and/or physical therapists can provide adaptive and compensatory strategies to increase the student's performance in mobility, access to curriculum/environments, activities of daily living, work, play, and leisure. The interventions they use include the use of activities designed to improve

performance, as well as identify adaptive equipment, environmental modifications, and alternative methods necessary to support improved function. In working with students in inclusionary placements, occupational therapists and physical therapists with professional background and training in neurological conditions can become key members of the team. When collaborating with other educational professionals and parents, they assist with interventions and services to support the student in the general educational setting.

ASSISTIVE TECHNOLOGY SERVICES

Assistive technology (AT) may assist a student in special education in accessing a free appropriate public education (FAPE). Occupational therapists and physical therapists may play a major role in the schools in determining assistive technology needs for students. The term assistive technology device can mean any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability.

The term does not include a medical device that is surgically implanted, or the replacement of such device (34 CFR 300.5). Assistive technology services mean any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. This term includes the evaluation of the needs of such a child, including a functional evaluation of the child in the child's natural environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing AT devices (34 CFR 300.6). Assistive technology devices may include augmentative devices, environmental controls, computers, and modifications to buildings. However, the assistive technology does not always have to be expensive or elaborate. It can be as simple as adaptive eating utensils, inclined planes, adapted pencils, modified books and stories, or Velcro picture boards. Assistive technology services encompass technical assistance and training for children with disabilities and their families, as well as coordination of such services. For technical assistance and resource information, contact the Arizona Department of Education, Exceptional Student Services.

EDUCATIONAL MODEL

The educational model differs significantly from the medical model. In the schools, the focus and purpose of occupational and physical therapy services is to enable the child to benefit from special education, i.e., to enable a child to reach academic and functional skills goals. The child's educational needs are specified in the IEP, placing the medical needs in the domain of parent responsibility for private providers. In the educational setting, the OT and/or PT provide evaluation and therapy services based upon educational referrals, not physician referrals. Should the school receive a referral from a physician, the IEP team must consider the referral and base any subsequent recommendations on educational need.

The occupational therapist, occupational therapy assistant, and physical therapist have distinct roles in providing services in the school setting. The occupational therapist and

physical therapist provide the following services within their respective area of expertise:

1. Screening and interpretation of screening results.
2. Evaluation and interpretation of evaluation results.
3. Program planning and implementation of intervention.
4. Documentation of services.
5. Clinical supervision of therapy assistants in conformance with statutory, regulatory, and professional rules.
6. Supervision and training of therapy aides who provide supportive services assigned by the occupational or physical therapist.

The occupational therapy assistant provides the following services:

1. Screening without interpretation of results.
2. Assistance with data collection and evaluation.
3. Implementation of intervention.
4. Documentation of services.
5. Communication with supervising occupational therapist with respect to professional needs and student performance.

DETERMINING THE NEED FOR OCCUPATIONAL OR PHYSICAL THERAPY

If the need for OT and/or PT services is suspected at the time of an initial or reevaluation, the appropriate therapist must participate in the evaluation process in order to ensure that the evaluation covers all areas related to the suspected disability. If the potential need for related services emerges during an interim period, the IEP team, including the appropriate therapist, must review all current information and decide what additional information, if any, is necessary to determine the need for and the scope of any related service. If no additional information is needed, the justification for the related service should be included in the IEP. If additional data that require parental consent are needed, the school should conduct a reevaluation. Once the additional information is available, the team must make a determination about the need for and scope of services.

The IEP team determines if OT or PT services are required in order for the child to benefit from special education. It is often difficult for parents and others to understand that, while a child may indeed benefit from therapy, it may not be a required service within the context of special education. Examples of instances when therapy *may not* be indicated are:

1. Staff is aware of and understands implications of the student's medical and/or physical condition and is managing the student's environment appropriately without therapy.
2. Deficits do not interfere with the student's ability to function adequately within an educational setting.
3. Student has learned appropriate strategies to compensate for deficits.
4. Functional living skills are not goals of student's special educational program.

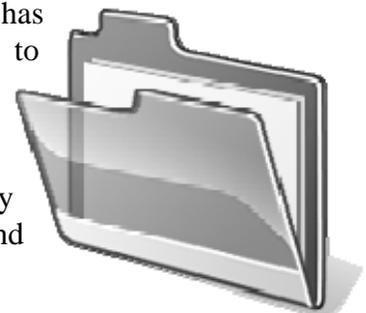
5. Modifications to the school environment have been made and are effective for the student.
6. Current level of achievement is consistent with other areas of development.
7. Assistive technology is available, in working order, and effective, and staff has been trained on the care and use.
8. Therapy is no longer effecting positive change in the student's level of function or rate of skill acquisition.
9. Needed strategies can be implemented effectively by current educational team, and continued occupational therapy and/or physical therapy intervention is not required.
10. Demands for written communication are within the capabilities of the student in the current placement.
11. Modifications to testing procedures or written communication formats have been made and are effective.
12. The student has adequate motor development to control and coordinate movements.
13. The student is demonstrating progress toward IEP goals and objectives or benchmarks without support of related services.

If therapy is deemed necessary, the therapist helps the team determine frequency, amount, and duration of the therapy, as well as the location for delivery of services (e.g., general education classroom, pull-out therapy room, special education classroom, playground, cafeteria) with emphasis on using naturally occurring environments. The therapist will also guide decisions on how therapy services will be delivered, e.g., individually or in groups, direct (hands-on) or indirect (consultation); how therapy may be reinforced by teachers, paraeducators, parents, and other staff; equipment management; and what training may be necessary to enable others (e.g., staff, parents, peers) to implement and support the therapy goals.

MAINTAINING DOCUMENTATION

Documentation is essential for good communication and accountability of the occupational therapist's and the physical therapist's actions. Documentation should conform to federal, state, and public education agency requirements. Educational relevance for all therapy services should be clearly documented. Documentation provides physical evidence for the service delivery to students. Documentation includes: assessment; present level of academic achievement and functional performance; annual goals; any benchmarks or short term objectives, if appropriate; and level of service, duration, and frequency. Generally, each local educational agency has procedures and forms that document the process from referral to placement for students identified as needing special education and related services.

Documentation should include referral for occupational therapy and/or physical therapy; parental permission for any evaluation and



prior written notice for initial and reevaluation (including procedural safeguards); evaluation report; determination of eligibility for special education services by the IEP team; the individualized education program (IEP); progress reports; IEP review/revision; documentation of classroom adaptations and modifications; and parent contact log. It is also wise to keep notes of any training provided to others in conformance with the IEP.

Many schools participate in Medicaid claiming. In this case, therapy has been determined to be both an educational need as well as a medical need. Evaluation documentation and therapy logs (that include the student's name, dates of service, service provided, amount of service, and therapist's signature and provider number) must be maintained. Consult with your school's Medicaid coordinator for more detailed information and any required use forms.

VI. INTERVENTION

COLLABORATIVE TEAMING

Occupational therapists and physical therapists must always strive to think in terms of collaborative teaming. In the public school system, this teamwork gets accomplished when the work of the group centers around planning for a student. Collaboration is most easily achieved when all members on the team are committed to teaching, learning, and working together across traditional disciplinary boundaries. The team should always include the parent, the child (if appropriate), and the student's teachers. Additional professionals on the team may include the psychologist, social worker, educational consultant, nurse, principal, and other related providers (e.g., speech therapist). They often share information with each other through role release so the skills the student needs to learn and practice throughout the day/week/year are taught by the people who spend the most time with the student. Building a team takes time and requires a willingness to communicate and interact openly. Members respect the unique expertise of each individual on the team and value the sharing of information for the benefit of the student. Everyone on a team should have an equal voice, but not necessarily the same perspective.

As part of the team, the OT and PT share responsibility for identifying priorities, strengths and needs, planning strategies and goals for educational performance, and anticipating outcomes for the future. In order for this to happen, it is imperative that the related service providers become familiar with the general education curriculum and convey to teachers how services can assist the student to participate more fully.

The determination about the need for related services should be a team decision, based on the needs of the student and the areas of expertise of the staff. Decisions are made by consensus. Plans formulated by the team are carried out until the team revises the plan. Realistically, because of varying opportunities for in-service training, background experience in teaming, and philosophical differences, not all members of a team are at the same level of sophistication, understanding, and commitment to a collaborative team model. Logistical problems relating to time and resources may also present barriers to

collaboration. In spite of these realities, a team approach with a comprehensive plan for delivery of services is in the best interest of the student.

ADAPTATIONS, MODIFICATIONS, AND ACCOMMODATIONS

Through a collaborative process, team members identify a child's present level of educational performance and determine how a child's disability affects his or her involvement and progress in the general education curriculum. This process leads to the development of adaptations. Adaptations include accommodations and modifications and are based on an individual student's strengths and needs. Accommodations are provisions made in how a student accesses and demonstrates learning. These do not substantially change the instructional level, the content, or the performance criteria. The changes are made in order to provide a student equal access to learning and equal opportunity to demonstrate what is known.

Modifications are substantial changes in what a student is expected to learn and to demonstrate. Changes may be made in the instructional level, the content, or the performance criteria. Such changes are made to provide a student with meaningful and productive learning experiences, environments, and assessments based on individual needs and abilities.

SERVICE DELIVERY

It is critical that the service delivery model chosen by the IEP team reflects the student's educational needs as outlined in the IEP. All services that an occupational therapist or physical therapist provides to a student or on behalf of a student must be indicated in the IEP and should be considered interventions. Therapists provide the following continuum of services to students:

Direct Services are hands-on services provided to the student when specialized therapy by a skilled service provider is determined to be the most appropriate model of service. These services can be delivered through individual, small group, and/or whole class activities. Individual contacts may require an isolated setting for a short period of time; however, the focus of any pull-out service is to return the student to the naturally occurring setting as soon as possible. Integrating therapy into the classroom routine provides opportunities for the student to learn functional motor, communication, and other skills as part of the natural routines in integrated school and community environments.

School-based therapists work in the natural environments of individual students. These may include the classroom, cafeteria, library, bathroom, playground, hallways, and/or other specialty areas on the school grounds and in the community. Direct services should include some level of indirect/consultative services with other team members to ensure that the therapist's specialized appraisal and suggested treatment are incorporated into daily activities and routines. The direct service option must be considered, discussed, and used when appropriate to meet the individual needs of the student. However, it is considered the most intrusive service option. The decision not to use this model cannot

be made based upon personnel shortages or uncertainty regarding the availability of staff.

Indirect or Consultation Services are used in general training, observation of student performance, monitoring of performance data, and development of materials to adapt the curriculum. These types of indirect services are no less important to a student's success than hands-on service. Consultation service refers to the reciprocal exchange of information where the primary recipients of the service are other team members. It involves the exchange of ideas and skills between team members (including parents) that are related to the educational program for a specific student. It can include spending time on behalf of the student with student-related activities such as fabrication of materials, adaptation of classroom materials, and/or home/hospital/clinic visits with the student, as long as it is clearly documented in the IEP.

STAFF DEVELOPMENT AND TECHNICAL ASSISTANCE

At times, staff training and other supports are needed for personnel to fully implement the IEP and provide FAPE to the child. Educational staff must often implement strategies and interventions devised by the therapist that allow the student to practice the skills several times within natural environments and contexts. Techniques and strategies that are incorporated into a classroom program are not considered part of the therapy as delineated in the IEP, but are a part of the educational programming for the student. Parents/families and school staff may need specialized training to allow them to use certain equipment, materials, techniques, transfers, programs, etc. This is usually included in the IEP as "Supports for School Personnel."

Three components of staff development/technical assistance are conferring with school personnel, making periodic student checks, and providing equipment modification or repair on an as-need basis, whether the student is placed in special education or not.

1. *Case/Colleague Collaboration:* The result of this collaboration may include curriculum adaptations and classroom or environmental modifications, or it may generate a referral for an occupational therapy and/or physical therapy assessment.
2. *Periodic Student Check:* The therapist may follow up on a student who previously received related services or who is considered at high risk but is not currently receiving related service.
3. *Equipment Consultation:* Some students require periodic adjustments or repair of adapted equipment or supplies used in their educational setting. Therapists may be consulted on an as-need basis for students whose equipment needs repairs and who may not be receiving related services.

TERMINATION OF SERVICES

Prior to discontinuing services, the IEP team must have sufficient data to determine that services are no longer required. In some instances, the information may be obtained from informal sources such as classroom observations, therapy notes, and parent interviews. In other circumstances, more formal assessment strategies may be necessary. In either case, documentation of the reasons for the decision should be documented in a reevaluation

report or in the IEP. The IEP team reviews the evaluation results and makes the final determination.

Questions which may be used to determine whether a child continues to need occupational and/or physical therapy services include:

1. Has the student developed the performance components needed to progress toward the educational goals established in the IEP?
2. Have the environmental or curricular adaptations been established to allow for achievement of educational goals?
3. Are the student's needs being met by others at this time and no longer require the skilled services of a therapist?
4. Has the educational setting changed and is the student functional within this setting?
5. Has the student learned appropriate strategies to compensate for deficits?
6. Is therapy no longer effecting change in the student's level of function or rate of skill acquisition, or no longer required for the child to benefit from special education?

Prior written notice to parents must accompany the decision to discontinue services. The evaluation/reevaluation report or the present levels of academic achievement and functional performance should include information summarizing student's progress, current levels of functioning, and how that level of performance affects involvement and progress in the general education curriculum.

VII. ADDITIONAL CONSIDERATIONS

WORKLOADS VERSUS CASELOADS

According to the American Occupational Therapy Association, in their "Practice Tips for Occupational Therapists and Occupational Therapy Assistants" (AOTA, 2006), the concept of *workload* encompasses all of the work activities a therapist performs that benefits students directly and indirectly. The term *caseload* refers only to the number of children seen by an OT or PT as part of the individualized education program. This traditional caseload "counting" approach does not fully appreciate the complexity of the OT's or PT's role in current best-practice scenarios. Pull-out services built around a clinical model of predictable, routine "appointments" have limited support in the educational literature and do not necessarily promote the generalization of skills to the classroom or other appropriate settings.

To meet the needs of children, teachers, parents, and school programs, a workload approach for OTs and PTs helps in the development of work patterns that optimize effectiveness and impact. Practitioners must redesign their work patterns so they are able to serve students in their least restrictive environment and at the same time support their performance need (e.g., in language arts, during the restroom break, during lunch, on the playground or during PE, getting on or off the bus). Practitioners also must have time in

their workday for collaborative teamwork and data collection. A workload approach allows practitioners the flexibility to be wherever children need them whether they are needed for applying strategies and techniques to the classroom or for school activities and tasks.

Activities to be included in an OT's or PT's workload are: intervention, documentation, evaluation, screening, team meetings, consultation with other staff, travel between sites, corollary duties, child-specific data collection, IEP development, case management, transition services, parent and staff training or in-service, research and research review, advocacy, and participation in school-wide activities.

SCHEDULING

Team members need to be flexible when scheduling in order to meet a student's needs. Integrated programming can support student's success. Intervention may need to be provided in a variety of settings: academics, lunch, recess, and specials (art, PE, music, computers, etc).

Therapists may help the student accomplish goals more effectively by using a variable time rather than the traditional hands-on, 30 minutes per week. To accomplish the flexibility, it is often helpful to indicate the frequency as: minutes per week, minutes per month, or minutes per semester. It may be appropriate to specify in the IEP more intense therapy services early in the school year, fading to less intense services as the year passes and routines are established across programs and activities of the school day. Whatever the frequency of the service, it is important that this is made clear to the entire team, including the parent, and the frequency is clearly documented in the IEP.

Block scheduling is a current trend in service delivery that provides a variable time schedule. Using this model, the therapist can vary types of intervention and the duration and intensity of services.

In a variable time schedule, there can be flexibility from month to month, which would be reflected in the IEP. For example, on an IEP which calls for one hour of occupational therapy per month, one month may include: 20 minutes of hands-on intervention during handwriting in the classroom (week one); 10 minutes of intervention in the classroom and consultation with the teacher (week two); 15 minutes intervention during art (week three); 10 minutes intervention during PE and 5 minutes intervention during transitions in the hallway, going from the bus to the classroom. Month two may include: 30 minutes intervention in the classroom (week one) and 15 minutes intervention in art (week two) and another 15 minutes intervention in the classroom (week four).

Block scheduling does not indicate a range of service time (e.g., 30–90 minutes per month) as ranges of time are not acceptable on the IEP.

VIII. SUMMARY

The occupational and physical therapies are vital additions to the educational setting. They can make a tremendous difference in the amount and speed of progress a student may make. However, they are also related services, meant to allow the student with a disability to benefit from their special education programs and services. Students may make sufficient progress and no longer require such services, even though they may still have disabilities.

School administrators must ensure that needed therapy services are secured for students requiring such services, and then evaluate the quality and performance of the service providers, just as they evaluate other staff under their supervision. Parents should provide continuity in the home setting, requesting any training needed to implement therapy strategies appropriate for the home setting. Classroom personnel must be aware of how therapy can impact the child's ability to learn and perform, and the importance of implementing strategies and interventions, whenever possible, in appropriate classroom contexts. The concept of "team" must always be remembered in providing services to students with disabilities.