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Q & A : School-based OT and PT (Issue #3)

Question: *I'm still having trouble when I try to differentiate between medical and educational models and figure out when therapy should be provided in schools. What is the difference between school therapy and medical therapy?*

Response: The medical-educational comparison/distinction came about in an effort to differentiate school-based therapy services as distinct within the range of possible services that pediatric therapy professions can offer. The way that the terms are still used doesn't differentiate much more than the *PLACE* where therapy is provided. "Schools offer educational therapy." Services provided in a hospital, clinic, or office are generally viewed as "medical therapy." A focus on "either medical or educational" as a criterion for considering school therapy services misses some important issues related to effective practices for supporting children with disabilities in their roles as students. There's a helpful article in Physical and Occupational Therapy in Pediatrics -issue #2, 1995, written by Irene McEwen and M'Lisa Shelden (both PTs) - "Pediatric therapy in the 1990s: The demise of the educational versus medical dichotomy."

A more accurate differentiation between medical and educational services is associated with the different paradigms upon which each model is built. This perspective is relevant to all therapy services that have a legitimate place in a student's IEP.

In disability studies, medicalized models view the attributes of the person as a central tenet. They assume that limitations or other factors within the child are the cause of disability. Interventions are based on the belief that changing the component deficit(s), or characteristics of the child (to the extent that change is possible), results in improved performance and function. In hand with this, when the components cannot be changed, functional limitations are believed to be inevitable. Traditional pediatric therapy and special education approaches have been criticized for identifying what "building blocks" of typical development are limited or missing - then planning intervention to increase their integrity, with the assumption that improved function is the result.

Newer models of disability and inclusive philosophies reject the view that disability resides solely within the person. They recognize immediate and even far reaching environmental factors as important influences and contributors to disability and function. Environmental variables also offer ways to support persons with disabilities, often providing more intervention options than are available when we look

only to the characteristics of the individual person. Updated frameworks in both occupational and physical therapy professions reflect similar perspectives.

In sum, differentiating educational and medical models doesn't help the IEP team in their related services decision-making. That determination is best made with thorough evaluation procedures and subsequent team-based problem-solving processes that identify in sequence, the student's goals, program/ placement and related services needed in order to achieve individualized goals.

Question: *The IEP team is trying to accurately communicate what therapy services a student needs. The therapist has a great deal of responsibility as the year begins, but requires a lesser degree of involvement as the year goes on.*

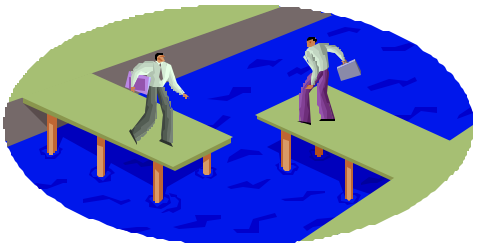
Response: The IEP team's responsibility to individualize programs according to students' needs means that variability in service frequencies and durations is inevitable. An example helps to illustrate how the team may proceed. The needed expertise from an OT includes program development, staff training, finding and providing equipment options for a student to use for eating and other classroom activities that require tool use (written expression, science, art, music and physical education). This requires larger initial (up front) time expenditures by the therapist. Once the interventions are in place and classroom staff are using these supports, the OT's time demands diminish.

One way to reflect this in the IEP is through a variable service level that is clearly documented. It might say "OT for X minutes per week (or month, depending upon your team's preferences) for the first marking period (term or semester), OT for Y minutes per week (or month) for the second marking period (term or semester), OT for z minutes per week (or month) for the third marking period (term or semester)", etc.

Question: *My team is at odds over OT and PT services for one student. The therapists in the community private practice think we should be providing different services than we have been implementing. What can we do?*

Response: If you end up in contentious situations over community-based therapists' opinions versus the school's therapists' opinion, remember that each recommendation is a piece of data the IEP team needs to consider. What's the basis for any therapist's recommendation whether or not to provide service? Do you use anecdotal evidence or measured evidence? Frequently, therapists' justifications for service recommendations are rooted in clinical opinion, experience, "gut feelings", lore and hand-me-down knowledge, or opinions of respected colleagues. For the majority of our interventions, we don't have sound evidence to support our belief that they are "as effective" or "more effective" than other interventions. In some areas, we do have evidence that they are *LESS* effective.

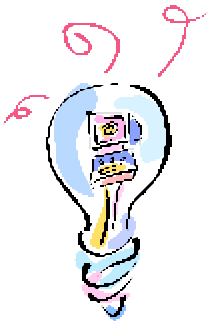
The IEP team's consensus implies general agreement, an opinion or view that's held by all or most. This requires that team members talk about, and listen to the variety of findings. Effective practice standards involve a reasoned process rather than decisions based unknowns or on misunderstanding. In a collaborative approach, the team identifies realistic outcomes for the specific student, then determines what interferes with their achieving these outcomes, and finally selects the program and services that will help the child progress toward goal attainment.



Because of time constraints and other issues, many IEP teams miss important pro-

gram planning steps that would ultimately help greatly in relation to this challenge. For example, in a specific situation the therapist needs to look for equipment, go to PE class, train staff and make equipment on behalf of the student. These strategies are indicated (they are sufficient and only "as special as needed") in order to help the student accomplish the team's targeted outcome(s). When the team understands that these strategies/interventions are part of the related service therapy program they are include in this student's IEP. The team's decision regarding type and amount of service reflects that knowledge.

Question: *How much flexibility do I have in combining weekly services over the course of the school year (for example, if the IEP reads 30 minutes per week, can I provide two one-hour periods during a month)?*



The IEP process guarantees families and students that services, supports and accommodations described in the individualized plan will be provided. Whatever service types and frequencies the IEP states, the school district implementing the IEP is responsible to adhere to that plan. If a service is written in the IEP as weekly, it needs to be provided weekly. If it's doubled up and delivered every other week, that student's IEP is not implemented correctly.

If the plan of the IEP is not adequate as written, or a listed service is not necessary in order for the student to accomplish his/her objectives, one needs to refer back to the IEP team and request a review. If the OT's opinion is that it doesn't matter whether or not the service is given regularly and in consistent time periods (such as 30 minutes per week) - or if it's not efficient/effective that way, this can be considered in the IEP planning phase and the team may agree to write something more flexible (OT 120 minutes per month, or variable service level described above).

Question: *A child has just moved into our district and we're unsure of whether or not he should have an IEP and receive either OT or PT at school. He has Erb's Palsy.*

Are there any performance problems related to the Erb's Palsy that are adversely affecting this child's ability to function in school, and do they require specially designed instruction? If so, then the team needs to develop annual goals in the curricular areas requiring special instruction and then determine whether or not OT and/or PT are required in order for the student to achieve these goals. School districts are not bound to provide any and all therapy that might benefit a child, only that which the team determines is necessary in order to meet the child's individualized educational goals. The point for therapy as a related service is that it must relate to the team's educational goals in order to be justified for inclusion in the IEP.

Question: *How much detail should the IEP document include to define the specific therapy approaches and activities that will be implemented as part of the therapy service?*

Therapy approaches, techniques, strategies and activities are the equivalent of "methodologies" in education language. IDEA '97 does not intend that the IEP define methodologies, even though they may be discussed in the planning phases. Court cases have addressed intervention methodologies, without the courts agreeing to stipulate methods in the IEP.

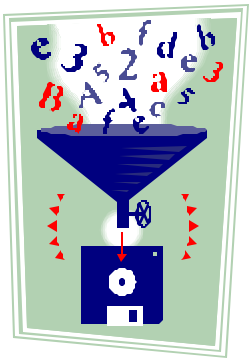
Communication about therapy methods is useful information and something that is discussed and understood in teams that work together to design and implement programs. A balance needs to be made between discussing potential methodologies with the team and spelling them out in the IEP. In the latter case, depending upon how the team wrote the IEP, they would need to reconvene and agree to change the listed methodology if the therapist wanted to try something else. That can be very restricting and not allow for efficient program

planning to promote a student's performance.

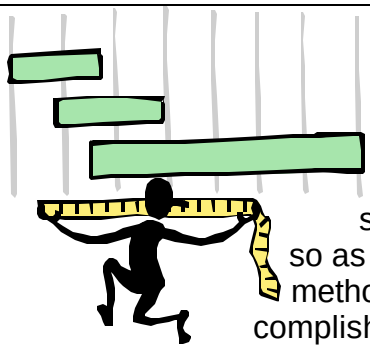
The methodology/model of intervention is not what distinguishes a related service. The unique and necessary contribution of the specific therapy in relation to the student's needs is the primary concern and the feature that teams need to address when making decisions about whether or not to include OT or PT in a student's IEP. Once providing a related service, the OT may choose from a number of different methodologies - some which are more aligned with medical model views than others, in order to help the student achieve his/her IEP objectives. The choice of specific intervention strategies should consider the child's interests and motivations, the efficacy and efficiency of the methods, their fit within the context, and skills of the provider, to name a few.

Question: *I've heard about a new test that may be helpful in determining school therapy needs. Can you tell me more about the School Function Assessment?*

The School Function Assessment (SFA) was developed by a team of researchers with occupational and physical therapy and psychology backgrounds. It's a criterion-referenced measure, designed to help guide program planning for children with disabilities, that was standardized on children in Grades K-6 throughout the United States.



The SFA measures a student's performance of school-based functional tasks that enable/support participation in academics and social aspects of school life. It's a judgment-based questionnaire, completed by one or more team members who know the student well across school routines and environments. Test items represent essential activities and



do not require inferences about underlying skills in order to be scored. Activities are specified in scales in such a way so as to allow a variety of methods to be used to accomplish the criterion. Individual sections can be scored by different persons and then compiled to yield a complete assessment. Items are measurable and written in behavioral terms so they are useful in developing IEP objectives.

The SFA considers task supports, the assistance (adult help) and adaptations (modifications to environment or program) that are currently provided when the student performs school-related functional tasks that are required for participation in his or her education program. The performance of specific functional school activities (moving around school, using materials, interacting with others, following school rules, communication) is also measured. Other features of the SFA include its' ability to highlight areas of strength which may help to overcome challenges a student faces. It also supports effective communication and collaborative program planning among team members.

Research is looking at how various SFA score patterns may be useful predictors of a student's participation in school routines and activities. The SFA is published by The Psychological Corporation and you can learn more about it at www.psychcorp.com

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