# OT Services Under IDEA 97

## Decision-Making Challenges

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Occupational therapy is one of a number of specialized services and supports available for children with disabilities under the Individuals With Disabilities Education Act Amendments of 1997 (IDEA 97).[1] An individualized education program (IEP) team is responsible for determining if and when a student needs any of these services or supports. The IEP team includes *at least* the child's parents, a regular education teacher, a special education teacher, a representative of the school district who is qualified to provide or supervise special education, an individual who is knowledgeable about the child's evaluation results, and, if appropriate, the child. Parents and the school district may invite other persons to participate in the process (Part 300 §300.344).[2]

Both IDEA 97 provisions and best practice decision-making approaches[3,4] recognize the benefit of collaborative efforts that bring different perspectives together when planning for students with special educational needs. Therefore, the IEP team collects and reviews information about the student's strengths and needs from a variety of sources, including parents, therapists, educators, and others involved with the student to identify the child's educational outcomes and annual goals, and then determine an educational program. These sources will have different perspectives on what is best for the student. For example, parents may present different expectations, preferences, and concerns about a child's education program than educators.[5,6] Even within the same discipline, novice and experienced therapists will often make different recommendations for the same child.[7] Because most professionals have limited training in methods of collaborative planning,[8] it is not surprising that at times occupational therapists and other IEP team members are challenged by the process of agreeing on the most appropriate school-based services. However, IDEA 97 requires a team decision to determine which specific services are required to support an individual student's education.

### LEGAL DEFINITIONS AND REQUIREMENTS

IDEA 97 defines a *child with a disability*, and thus his or her eligibility for special education, the following way:

> (a) General. (1) As used in this part, the term child with a disability means a child evaluated in accordance with §300.530–300.536 as having mental retardation, a hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, serious emotional disturbance (hereafter referred to as emotional disturbance), an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services (Part 300 §300.7).[2]

State laws may include additional provisions for identifying a child with a disability within their jurisdictions, based on individualized procedures for evaluating, reviewing, and synthesizing information to identify the content of the child's education program.

*Special education* is defined by IDEA 97 as specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability (Part 300 §300.26).[2] As soon as the IEP team determines that a student requires special education, that student becomes eligible for any of the related services identified in IDEA 97 using the following definition:

> As used in this part, the term related services means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology 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, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training (Part 300, §300.24).[2]

It is important to understand that after a child becomes eligible for special education, the school district is not required to provide *any and all* occupational therapy services. The district is responsible only for *related services*, which IDEA defines as those services *necessary* for the student to benefit from his or her special education program. Under IDEA 97, a related service is validated by its relationship to the student's team-generated annual IEP and its necessity as a support to help the child benefit from a program of specially designed instruction. This relationship, which characterizes all related services, is assuredly absent from any therapy program that does not support a child's special education.

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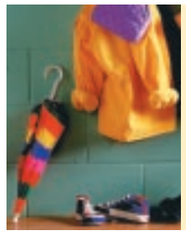
School-based occupational therapy evaluations may be requested for students either before or after their special education eligibility is determined. In the former situation, the therapist's evaluation should help the IEP team identify whether the child has a disability that requires special education. In both cases, the therapy evaluation is a source of program planning information. It does not determine whether occupational therapy in the schools will be recommended. Part B of IDEA's implementing regulations stipulates that at a minimum, evaluators must "ensure that tools and strategies that directly assist the team in determining the child's educational needs are used," and that evaluators must "use a variety of tools and strategies to gather relevant functional and developmental information related to enabling the child to be involved in and progress in the general curriculum" (Part 300, §300.532).[2]

### DECISION-MAKING GUIDELINES

Sets of criteria and guidelines for school-based therapy have been published,[9,10,11] followed by support for as well as criticism of their development and use.[12,13] The favorable views generally cite efficient use of the practitioner's time as well as increased objectivity and consistency of recommendations. Objections have been raised over these models' lack of research support; their preference for decisions based on objectivity rather than on individualization (which is required by IDEA 97); and their reliance on unidisciplinary perspectives, rather than on the collaborative decision-making approach that underlies the IEP process.

When making related services decisions, some teams inject specific practitioner procedures such as test administration, or traditional discipline-specific roles ("a fine-motor performance problem warrants OT"). This approach generally leads to isolated and fragmented services that are not unified by common IEP goals, a practice that interferes with related services provision.[14]

Using standardized test results (whose administration is not required by IDEA 97) to help make related services decisions appears to add an objective element when team members are unsure about what to do. Families may be told, "The test results show…therefore, Johnny is eligible for…." However, the



The IEP process must determine a student's *need for OT as a related service* rather than *OT eligibility.*

tests used are not designed for this purpose, and they are not validated to correlate with related services justification. Also, many measures are discriminative, rather than evaluative,[15] so they are not designed to show change upon retest. Therefore, concerns should be raised when these tests are readministered and their results are interpreted and reported to reflect progress, status quo, or even regression.

Some IEP teams focus on reviewing a child's performance component deficits. Occupational therapists have many readily available tools that help them to collect, analyze, and report on performance component information. Programming and service decisions that rely on this information assume that factors within the child are the cause of disability. Another assumption is that improving the child's performance depends on changing the component deficit(s), to the extent that change is possible. However, relying on performance component information does not reflect contemporary disability views[16] or therapeutic and developmental approaches that embrace person and environment interaction as the basis of function.[17,18,19] Decisions made from a performance component deficit orientation can lead the IEP team to ineffective and inefficient plans. A student's IEP may include services that improve performance component deficits but do not result in functional outcomes. For example, intervention that increased Jose's hand strength did not resolve the handwriting troubles he experiences. Further, teams may deny or overlook relevant service options because their evaluation data focus on characteristics of the child and not on limiting factors in the environment that adversely affect the child's school performance.

Therapists evaluating the functional performances of children with disabilities are aware of the complexity and uniqueness of each child's experience within a given context and across environments. Attempts to capture the essence of these multiple, changing dimensions and "fitting" the student into a predefined category that is equated with a particular type and level of service, or even within a range of several options, are seen in many service guides. Resembling "one-size-fits-all" offers, these methods do not encourage a process in which programming decisions reflect an appreciation of the student's unique strengths, needs, and circumstances.

A child's intelligence is also considered during the IEP process, although a relationship between cognitive level and a child's ability to benefit from therapy has not been supported in the literature.[20] Anticipating intervention responsiveness according to a child's cognition is not recommended. However, information about the student's cognitive abilities helps the team understand how the child learns and is useful for identifying how instructional activities and materials may be designed and presented for successful participation.

## OT'S CONTRIBUTION TO IEP DECISION MAKING

The IEP process must determine a student's *need for OT as a related service* rather than *OT eligibility*. There are no single procedures, checklists, or collections of identifying characteristics that reveal this need. Trying to reach a conclusion with specific eligibility models or decision guides based on standard test scores, therapy history, chronological age, and performance discrepancies, or other criteria that are not supported by research or based on sound clinical reasoning is a questionable practice. Further, this approach is counter to IDEA's intent and processes regarding team practices and individualized decision making. Plainly and simply, determining a student's need for occupational therapy as a related service requires good teamwork. Unfortunately, a lack of good teamwork may be the biggest barrier to effective decision making for many students.

Occupational therapists contribute to the collaborative team process with a valid and relevant evaluation that generates information that is useful for program planning. As a result, classroom-based observations and informal assessments of student performance across environments and activities may be preferred over tools that describe developmental milestones the student has achieved and quantify skill levels. Therapists may need to introduce new assessments and procedures that reflect the purpose of a school-based therapy evaluation rather than use tools that are familiar or readily available. Assessment strategies that consider the child's school performance in context and over time include both formal and informal tools (e.g., the School Function Assessment,[21] therapist observation during student routines, interviews with teachers). Knowledge about demands, intervention resources, and opportunities in the general education curriculum is essential. School-based therapists also need to be clear about the roles and capabilities of other persons available to provide educational services and support for the child.

The therapist who completes an evaluation does not have the independent authority to determine the student's need for occupational therapy as a related service. The collective expertise of the IEP team is required to determine the child's educational needs, establish individualized goals, and then identify the necessary supports and services to meet these needs.

## CASE EXAMPLE

Peter is a 5-year-old boy with Down syndrome in general education kindergarten. His IEP team has determined that he has a disability under the classification of mental retardation. They have identified a need for specially designed instruction around art activities and all written and drawn expression because Peter requires accommodations to participate in the curriculum requirements of coloring, drawing, and manual activity. They have determined that an occupational therapist's expertise is needed to help devise some of the accommodations that support Peter's participation in these classroom activities and assignments. The provision of OT as a related service for Peter is linked to this annual IEP goal generated by the team:

> Peter will express legible written/drawn responses for art, math, and reading activities and assignments in the kindergarten curriculum.

A priority concern for Diana, the school-based OT, as she begins working with Peter, is to devise alternate means of expression and participation in prewriting activities and assignments for the short term. He needs a reliable method for labeling his pictures and papers with his name, such as letter or word stamps with ink pads, stickers, a name stencil or individual letter stencils that he sequences and colors, or other means. Diana helps the team incorporate regular activities and approaches that develop Peter's work and task behaviors and increase his ability to hold and use hand tools for a variety of classroom manual activities. Diana pays close attention to the classroom curriculum. She modifies tasks and adapts strategies so that Peter contributes his own product in both group and individual assignments. At regular intervals, Diana identifies realistic expectations for Peter to write and draw independently in various classroom activities and outlines this information for classroom staff. It is important to note that Peter's goal of writing independently is not an end to itself, but supports Peter's ability to participate in the curriculum.

## CONCLUSION

Therapists who are developing or using existing service guidelines or criteria to determine related services, need to reconsider their application. In view of what the education system legally requires and guarantees to all children, therapists and their colleagues in the schools need to balance the data from these evaluation models with the goals of the IEP process.

There are several important features to look for in quality approaches to determining related services needs. Standards and practices for school-based therapy services support effective programming when they facilitate team collaboration during the evaluation and decision-making phases. Evaluation procedures for related services therapy require classroom-based assessment across environments and team consensus regarding the true constraints that interfere with a child's performance. Team members need to define the actual and potential roles and contributions of personnel and resources when identifying a child's IEP and needed supports. Occupational therapists need to advocate for related services decisions that are individualized and support child-focused outcomes that are relevant in the context of the student's educational experience. ■

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