Guidelines for

Occupational Therapy in Educational Settings

Working Draft

State of Connecticut Department of Education 1999

Guidelines for Occupational Therapy in Educational Settings

Contents

Foreword

The Connecticut State Department of Education is pleased to provide you with these guidelines in draft publication. They have been designed to:

- promote best practice in occupational therapy in educational settings,
- encourage a continuum of service delivery options, and
- provide an overview of the conceptual framework of occupational therapy as a support in educational settings.

As stated in the *Connecticut Agenda for Improving Education Services to All Students, Particularly Students Eligible for Special Education and Related Services*, service delivery should emphasize a collaborative approach across disciplines in order to accommodate the needs of each learner. This collaborative approach is emphasized throughout this document.

Occupational therapy as an educational support service can be quite different from occupational therapy in a hospital or clinic. School-based therapists focus on assisting students to acquire the functional abilities necessary to access educational materials and adapt to their educational environment. They may help students with daily activities related to educational participation, adapt the performance context, teach alternative methods, or facilitate the use of assistive devices. Occupational therapists in schools work with other educational professionals, members of the community and families to help all students engage in their educational activities. This collaboration is also the foundation for promoting the participation of students with disabilities in the general educational environment. These guidelines suggest service delivery models that increase the capacity of schools to meet the needs of all children.

Many individuals assisted in the development and review of these guidelines, including school therapists, faculty from Connecticut colleges and universities, administrators, other district personnel and families. We invite you to use these guidelines and provide written comments and suggestions for future improvements.

Theodore S. Sergi
Commissioner of Education

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This document should be viewed as an evolving set of guidelines. Changes in laws, regulations and practices regarding occupational therapy in educational settings may impact its content.

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SECTION I

Introduction

1. Historical Perspective

Occupational therapy and the occupational therapist's role in educational settings have evolved along with educational reforms. More recently therapists, school administrators, and teachers are searching for service models relevant to educational environments and curriculum. Parents, students and school personnel seek collaboration, mutual decision-making, and inclusion of students with their peers as much as possible. However, the education and training for occupational therapists covers services in many settings such as hospitals, nursing homes and schools. They are trained to assist people of all ages, using diverse therapy approaches.

Traditional school-based therapy often isolated students with disabilities from their peers. Therapists identified "problems" among students and treated them in a special therapy room. Families and teachers often were not encouraged to participate directly in therapy. Interventions were provided to students who had been pulled out from classroom activities. Sometimes the therapy did not correlate directly with students' everyday environments, or transfer readily to requirements of the school setting. The need for more appropriate education of students, including those with disabilities, spurred legislative changes in the mid 1970s.

Professional research in occupational therapy suggests that a collaborative service model works best. Rather than simply pulling students out of classes for interventions that may not apply in classrooms, key professionals and families together identify, evaluate, plan, provide varied service delivery models, and reevaluate how students can best function in various educational settings. Services and evaluation focus on the whole student and the environment of the students. The entire team involved with the student provides input and strives to offer interventions, which support and promote success in students' educational programs and objectives. Occupational therapy goals support preparation for learning, living and working. Occupational therapy interventions are effective when they improve students' performance in contexts in which students participate.

To increase their effectiveness in school environments, as well as to meet increasingly complex federal requirements, the Connecticut State Department of Education produced initial guidelines for occupational therapists in 1982. Occupational Therapy is one of the "related services" of special education under federal and state laws. The original Connecticut guidelines defined occupational therapist roles, students' physical conditions which might require evaluation, and therapy activities to help students benefit from their special education programs. Since then, federal laws affecting students with disabilities have changed significantly and new laws are in effect. Concurrently, "related services" have developed alternative service delivery models, which offer creative activities to meet specific needs of students with disabilities.

2. Vision Statement

All people in Connecticut are valued and respected as contributing members of their own family and diverse communities. When disabilities compromise or disrupt students' educational performance, occupational therapy practitioners provide essential services. Occupational therapy practitioners offer individualized, contextualized, culturally relevant educational services by building effective partnerships with students, family members, educators, and other providers representing a broad range of educational, medical and social service disciplines.

The Connecticut Shared Vision and the Connecticut State Board of Education Position Statement on the Education of Students with Disabilities are cornerstones for services occupational therapy practitioners offer (see appendices).

Occupational therapy practitioners and (where relevant) paraprofessionals under their direction:

- adhere to federal and state laws, regulations, policies, and standards;
- provide essential and unique services to students with disabilities and their families. In a supportive role, occupational therapists help students participate and learn at school, at home and in the community;
- help families obtain valued life outcomes for students with disabilities. These include choices, meaningful relationships, work, safe home and educational environments, and health;
- deliver an array of services, which change as students develop. Programmatic consultation, teaming, collaboration, and/or direct service may be appropriate at different stages and transitions in the students' lives;
- facilitate the inclusion of students in the same natural environments, routines, and activities as their peers through shared responsibility, collaboration, curricular and environmental modifications; and specific skill development;
- promote interagency collaboration, shared responsibility for service implementation, and coordination of the multiple systems that deliver services and offer support to students and their families; and
- promote hiring an adequate supply of properly trained personnel who pursue appropriate continuing education and other professional development activities.

3. Mission and Purpose

The purpose of these guidelines is to provide a concise, comprehensive reference manual which defines the role of occupational therapy as a related service under the Individuals with Disability Education Act (IDEA) and other relevant federal and state regulations.

The mission arising from the purpose is:

- to provide an overview of the conceptual framework of occupational therapy as an educational component, including:
  - requirements,
  - guiding principles,
  - unique role/responsibilities, and
  - relationship to curriculum involvement.

- to promote awareness of assessment and service delivery patterns;
- to promote a continuum of service delivery options, recognizing collaboration as an essential, fundamental strategy for developing students' functional outcomes within the context of their natural environments;
- to promote best practices; and
- to encourage professional development, peer support and mentoring.

4. Occupational Therapy Role in Educational Settings

Occupational therapy as an educational support service can be quite different from occupational therapy in a clinic or hospital. School-based therapists focus on removing barriers from students' ability to learn, helping students develop skills which increase their independence in the school environment, and educating school personnel about the different considerations required for students with disabilities. Everything the therapist does with students in school must be educationally relevant. The therapist evaluates, assesses and accommodates functional abilities of students in school classrooms, hallways and other designated areas.

The therapist works with teachers to help students acquire functional abilities necessary to access educational materials and move about the school. To help students function better in classrooms, the lunchroom, or restrooms, therapists may work with them on adapting or modifying their equipment/materials. Other assistance includes helping students participate in activities outside of the school through mobility on field trips, sports events, on playgrounds and within the community.

Special education students face a demanding environment at school. Presentation methods for educational materials must be modified to meet the challenges of students' disabilities, such as their ability to communicate, view and manipulate educational materials, and move about the school. Therapists work closely with teachers to promote the highest level of function possible for students pursuing educational goals.

The following table illustrates how occupational therapy services in schools have evolved.

Occupational Therapy As An Educational Support Service

Historical Continuum

Formerly	Currently
Focus on Disabilities and Problems	Focus on Student Learning Outcomes and Abilities
Pullout Isolated Service	Support to Student from all School Personnel
Families Given Information, Little Involvement	Families Team with School Personnel as Partners
Students' Segregated from other Students	Students Included with other Students
Therapy-specific Student Goals	Curriculum-based Educational Student Goals
Therapist Provides Service Independently	Many Types of School Personnel Involved
Standardized Tests Used	Also Observe and Assess Student Level of Functioning
Clinic-Based Assistance	School- and Community-Based Assistance

Adapted from: B. Blossom, F. Ford and C. Cruse. Physical Therapy/Occupational Therapy in Public Schools. Vol. II. Rome, GA: Rehabilitation Publications & Therapies, Inc. 1996.

SECTION II

Laws and Regulations

1. Occupational Therapy under IDEA

The Individuals with Disabilities Education Act (IDEA) **Part B** and the Connecticut General Statutes sections 10-76a to 10-76dd inclusive provide for the provision of special education for children with disabilities ages 3 through 21 "who, by reason thereof, need special education and related services." Included are students with disabilities who have been suspended or expelled from school. Related services are "such developmental, corrective, and other supportive services . . . as required to assist a child with a disability to benefit from special education, and includes...occupational therapy" (34 C.F.R 300.16). Special education means "specially designed instruction" that meets the unique needs of students with disabilities. In addition to instruction in the classroom, special education includes instruction at home, in a hospital, and in other institutions; physical education; speech pathology (if considered special education instruction); and vocational education.

Special education and related services are part of students' individualized education programs (IEP), which detail the educational program tailored to meet students' specific educational needs. According to case law, the individualized education program (IEP) does not mean the **best** or **maximum** education possible (Osborne, 1995; Hanft, 1995), but should confer an educational benefit "likely to produce progress, not trivial education advancement" (Osborne, 1995, p.3).

In 1997 Congress reauthorized amendments to IDEA which cover numerous areas, such as: state and local educational agency role and responsibilities, eligibility criteria, student disciplinary situations, private/parochial/charter schools, parental involvement, IEP provisions, data collection, records, and grant funding (see appendices). The full text of IDEA, amendments and other legislation summarized in these *Guidelines* should be referred to whenever needed for decision-making and fuller understanding.

A. Occupational Therapy (OT) is a related service for eligible students ages 3 through 21 who require "...such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education" (34 CFR 300.16(a)).

This includes:

- improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- improving ability to perform tasks for independent functioning when functions are impaired or lost;
- preventing, through early intervention, initial or further impairment or loss of function (300.16(5)(i)(ii)(iii)).

In order for students to receive OT services under IDEA Part B, federal law requires that the students be eligible for special education and that the related service (occupational therapy) be necessary to assist the students with disabilities to benefit from special education. In this manner, OTs serve in a supportive role, helping students participate in and benefit from special education.

Occupational therapy is defined as service provided by a qualified occupational therapist. (34CFR 300.16 (a)(7))

B. Eligibility covers children with disabilities in any of the following federal classifications who may have a need for occupational therapy as a related service:

- mental retardation;
- hearing impairments, including deafness;
- speech or language impairments;
- visual impairments, including blindness;
- serious emotional disturbance; orthopedic impairments;
- autism;
- traumatic brain injury;
- other health impairments;
- specific learning disabilities;
- deaf-blindness/multiple disabilities;
- neurological impairment;
- developmental delays (3-5 years).
  (see United States Code 20USC)

C. Required Services for students with disabilities include a free appropriate public education (FAPE). This means special education and related services provided at public expense, under public supervision and direction, and without charge, which meet the state standards. Preschool, elementary or secondary school education is provided in conformity with students' IEPs.

Services include:

- special education;
- related services needed by students to benefit from special education means transportation and such developmental, corrective, and other related/supportive services including:
  - speech pathology and audiology,
  - psychological services,
  - physical and occupational therapy,
  - recreation, including therapeutic recreation,
  - social work services,
  - counseling services,
  - medical services (diagnostic or evaluation only),
  - parent training and counseling,
  - assistive technology devices and services,
  - rehabilitation counseling, and
  - school health services.

D. Team models described in IDEA are implemented with multidisciplinary service delivery (see glossary) and focus on students' educational/learning needs. Families are

specifically included as members of the team that makes eligibility, placement and program decisions. The regular education teacher participates in the IEP, when appropriate, to help determine the extent and nature of the students' participation in the general curriculum. In Connecticut such teams are defined as Planning and Placement Teams (PPT).

E. LRE (Least Restrictive Environment) (requirement of service delivery) states that, "to the maximum extent appropriate, children with disabilities are to be educated with children who are not disabled, and that...removal of these children 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."

F. Continuum of Alternative Placements requires that each public agency ensure a continuum of alternative placements is available to meet special education and related services needs of students with disabilities. The IEP team must determine which of the alternative placements listed in the definition of special education best meets the needs of the students. Alternative placements include instruction in regular classes, special classes, special schools, home instruction, instruction in hospitals and institutions, and services to supplement regular class placement such as resource room or itinerant instruction [34CFR, 300.551 and RCSA, Sec. 10-76d-14].

G. Individualized Educational Program (IEP) is developed for each student receiving special education and related services. A written plan must be in effect at the beginning of each school year and before any special education and related services are provided.

The IEP must include:

- a statement of measurable annual goals and short-term instructional objectives or benchmarks with the relevance to the general curriculum for the student;

- the specific special education and related services to be provided which will advance students' goals, including assistive technology services or devices, if appropriate, and occupational therapy services only if the team includes an occupational therapist who recommends it;

- a statement of the specific educational services needed by the student, including a description of special education and related services and the supplementary aids and services to be provided to the student, or on behalf of the student, and a statement of the program modifications or supports for school personnel that will be provided for the student: (a) to advance appropriately toward attaining the annual goals; (b) to be involved and progress in the general curriculum and to participate in extracurricular and other nonacademic activities; and (c) to be educated and participate in the regular class and in extracurricular and other nonacademic activities;

- a statement of the student's present level of educational performance, including how the student's disability affects involvement and progress in the general curriculum; or for preschool students, as appropriate, how the disability affects the

student's participation in appropriate activities;

- an explanation of the extent, if any, to which the student will not be able to participate with non-disabled students in the regular class and in the extracurricular and other non-academic activities;

- transition planning, as applicable, that includes: (a) beginning at age 14 and updated annually, a statement of the transition service needs of the student under applicable components of the student's IEP that focuses on the student's courses of study (such as participation in advanced-placement courses or a vocational education program); (b) beginning at age 16 (or younger, if determined appropriate by the PPT), a statement of needed transition services for the student, including, when appropriate, a statement of the interagency responsibilities or any needed linkages; and (c) beginning at least one year before the student reaches the age of eighteen, a statement that the student has been informed of his or her rights that will transfer to the student on reaching the age of eighteen;

- the projected date for the beginning of the services and modifications, and anticipated frequency, location, and duration of those services and modifications, including the length of the school day and school year and criteria to determine when services will no longer be needed;

- a statement of how the student's progress toward the annual goals will be measured which is to include objective criteria and evaluation procedures;

- a statement of any individual modifications in the administration of state or district wide assessment of student achievement that are needed in order for the student to participate in a particular State or district wide assessment of student achievement (or part of such assessment) a statement of why that assessment is not appropriate for the student; and how the student will be assessed;

- a statement of how the student's parent will be regularly informed at least as often as parents are informed of their nondisabled student's progress toward the annual goals and the extent to which that progress is sufficient to enable the student to achieve the goals by the end of the year;

- a list of individuals who shall implement the IEP; and

- in the case of a residential placement, whether such placement is being recommended because of the need for services other than educational services.

The IEP team is a group of individuals composed of:

- the student, when appropriate;
- at least one special education teacher or where appropriate, at least one special education provider of the student;
- at least one regular education teacher of the student if the student is, or might be, participating in a regular educational environment;
- a representative of the local education agency (LEA) who is qualified to provide or supervise the provision of specially designed instruction; is knowledgeable about the general curriculum and about the availability of resources of the school district;
- the parents or guardians of the student;
- an individual who can interpret the instructional implications of the evaluation results, who may otherwise be a member of the team; and
- (at the discretion of parents or LEA) other individuals who have knowledge or special expertise regarding the student, including related services personnel; and
- (when evaluating a student suspected of having a specific learning disability) the student's regular teacher, or, if the student does not have a regular classroom teacher qualified to teach a student of his or her age, at least one qualified person to conduct individual diagnostic examinations of students, such as a school psychologist, speech/language pathologist or remedial reading teacher.

If the purpose of the PPT is consideration of transition services for a student, the LEA shall invite; (1) the student; and (2) a representative of any other agency that is likely to be responsible for providing or paying for transition services. If the student does not attend, the LEA shall take other steps to ensure that the student's preferences and interests are considered. If an agency invited to send a representative to the PPT does not do so, the district shall take other steps to obtain the participation of the other agency in the planning of any transition services.

In addressing the composition of the PPT, as noted above, the LEA shall include certified and/or licensed professionals, who represent each of the teaching, administrative, and pupil personnel staffs and who participate equally in the decision making process. These persons shall be knowledgeable in the areas necessary to determine and review the appropriate education program for the student. The administrative representative shall be a person, other than the student's teacher, who is qualified to provide or supervise the provision of special education.

The regular education teacher of the student, as a member of the PPT, shall, to the extent appropriate, participate in the development, review and revision of the IEP of the

student, including the determination of appropriate positive behavioral interventions and strategies and determination of supplementary aids and services, program modifications, and support for school personnel.

Meetings must be held at least once a year to review each student's IEP and, if appropriate, revise its provisions. **Schools must report to families on the progress of their children with disabilities at least as frequently as the school reports progress of non-disabled students**. If a purpose of the IEP meeting includes transition services, the student must be invited. The IEP commits in writing any resources necessary for students with disabilities to receive special education and related services.

H. Transition Services are "a coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school to post-school activities including post-secondary education, vocational training, integrated employment, continuing and adult education, adult services, independent living, or community participation" (34 CFR 300.18).

Services must be based on the students' needs taking into account the student's interests and preferences and include instruction, community experiences, employment and other post-school adult living objectives development, and if appropriate, acquisition of daily living skills and functional vocational evaluation. Planning for transition services must begin at age 14 with a statement of transition needs in the IEP, such as a prevocational course.

I. Services must be at no cost to parents. The state may use any available federal, state, local, and private sources. Part B of IDEA does not relieve an insurer or other third party from an otherwise valid obligation to provide or pay for services.

J. Parental Rights focus primarily on families being involved and informed. Key provisions are that parents:

- receive written prior notice whenever the school district proposes or refuses to initiate or change the: identification, evaluation, educational placement, or provision of FAPE;

- receive full information in the native language or other mode of communication unless clearly not feasible;

- give informed consent for the: initial evaluation, reevaluation, initial placement in special education, and placement in private school. Consent for evaluation cannot be construed as consent for placement. If parents refuse, the school district may pursue evaluation or placement through mediation and hearing procedures. In the case of private placements, LEAs must initiate due process if parents refuse consent;

- must have an opportunity to participate in meetings concerning identification, evaluation, placement and provision of FAPE; however, LEAs may meet without the parents present if the parent has been provided with proper notice;

- may withdraw consent at any time;

- provide consent for release of information under certain circumstances;

- may inspect and review their child's records and request amendments to the record, (FERPA and confidentiality requirements established in Part B apply) and request amendments to the record, with limitations, which includes a hearing process if the local educational agency (LEA) disagrees with the amendment request;

- must be given a copy of procedural safeguards in easily understandable language. Information about procedural safeguards must include:

    - independent educational evaluation,
    - written prior notice,
    - parental consent,
    - access to educational records,
    - opportunity to present or file complaints, and request a hearing,
    - student's placement while awaiting outcome of due process proceedings,
    - procedures for interim alternative education settings,
    - requirements for unilateral placements of their children in private schools at public expense,
    - mediation,
    - due process hearings,
    - state-level appeals (if applicable),
    - civil actions, and
    - possible attorneys' fees.

- may initiate an impartial due process hearing when the LEA proposes or refuses to initiate or change: identification, evaluation, or educational placement of the child or the provision of a free appropriate public education to all students.

Procedures are in place to protect the rights of students whenever parents/guardian are unknown or students are wards of the state.

K. Evaluation Requirements include an **initial evaluation** to determine whether a student is a student with a disability and to determine educational needs and modifications. Evaluation includes administering tests, non-diagnostic tests, and other evaluation materials, which should be in the student's native language or other mode of communication unless not feasible. Tests cannot be discriminatory. When standardized tests are used, trained personnel must administer them in conformance with the producer's instructions. Instruments must be validated for the specific purpose for which they are being used, and assess the specific areas of educational need. No one procedure shall be the sole criterion for determining an appropriate educational program. Evaluations must be made by a multidisciplinary team, including at least one teacher or specialist with knowledge about the suspected disability. In Connecticut, the planning and placement team designs the evaluation.

Students should be assessed in all areas related to the suspected disabilities. Local

school districts shall ensure reevaluation if conditions warrant, or if parents or the students' teachers request it, at least once every 3 years (triennial evaluation). The purpose of the re-evaluation is to determine the child's continuing eligibility for services. Parents must provide consent for reevaluation. However, if the district can show that it had taken reasonable measures to obtain consent and the parent fails to respond, consent is not needed. If parents disagree with the local school district's evaluation, they have the right to an independent educational evaluation at public expense, which the LEA can contest through a hearing. If a hearing officer orders an independent evaluation, such evaluation is at public expense.

L. Placement should be based on information from a variety of sources, documenting and considering all data sources. Placement must be reviewed annually. A group of persons including persons knowledgeable about the student, the meaning of the evaluation data, and the placement options should make placement decisions. In Connecticut the PPT makes this decision.

M. Assistive Technology Services and Devices as defined by IDEA is selecting, acquiring and training in use of "any item, piece of equipment or product system, whether acquired commercially or off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with disabilities." Specific activities can include:

- evaluation of needs including functional evaluations in the students' customary environment;
- purchasing, leasing, or otherwise acquiring assistive technology devices;
- selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- coordinating and using other services with assistive devices;
- training or technical assistance for students or, when appropriate, families; and
- training or technical assistance for professionals.

2. Other Federal Laws That Effect the Delivery of Occupational Therapy in School Settings

A. Section 504 of The Rehabilitation Act of 1973, Title V (Public Laws 93-112), and **Title II of the Americans with Disabilities Act (ADA)**, Public Law 101-336, both can have major implications for occupational therapists in school systems. Section 504 of the Rehabilitation Act is a broad civil rights law, which protects the rights of individuals with disabilities in programs, and activities that receive federal financial assistance from the U.S. Department of Education.

Section 504 requires an accommodation plan for all students who meet the definition of disabled. General education is responsible for providing equal access to all programs operated by the public school to students with disabilities under the requirements of Section 504. Sometimes students with disabilities are not eligible for special education services yet have difficulty participating in and benefiting from educational programs.

The occupational therapist can have varying roles in meeting the needs of students who qualify for services under section 504 or the ADA including:

- providing assistance in environmental adaptations;
- acquiring or modifying equipment or devices;
- helping develop the written educational accommodation plan;
- participating in the determination of 504 eligibility.

Any school that receives federal funds must modify or make substitutions in meals for students whose disabilities restrict their diet, such as providing blended foods, special diets, cafeteria modifications, or utensils, at no extra cost.

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law with a clear and comprehensive national mandate to eliminate discrimination against individuals with disabilities. Under Section 504 of the Rehabilitation Act and Title II of the ADA, students might be eligible for occupational therapy services as a reasonable accommodation to help them learn, care for themselves, perform manual tasks, walk, speak and breathe. Under Section 504, students who are currently disabled cannot be denied, or excluded from, educational services. The definition of disability in Section 504 and the ADA is much broader than the disability categories specified in IDEA. Section 504 identifies individuals with disabilities if they have a physical or mental impairment which substantially limits a major life activity, have a record of the impairment, or are regarded as having such an impairment. Students with disabilities defined under 504/ADA must have equal access to educational services as non-disabled students.

B. Head Start Act of 1964 provides comprehensive health, education, dental and social services to infants, toddlers, and preschoolers whose families meet economic guidelines. At least 10 percent of enrollment in Head Start can be used for preschoolers with disabilities, including those with developmental delays (latter if the state so chooses). The OT role in a least restrictive environment (LRE) is providing services to students with identified disabilities using an IEP model. (Public Law 103-252)

C. Goals 2000: Educate America Act is an educational reform law, which lists eight national education goals. Schools must strive to help *all* students, including those with

disabilities, to reach challenging academic and occupational standards. The Act includes goals, which refer to OTs contribution to student and family learning, and the OT practitioner's professional development (Public Law 103-227).

D. School-To-Work Opportunities Act of 1994 is a joint effort of the U.S. Department of Education and Department of Labor to establish a national framework for states to create "transition" systems. It intends to integrate academic and occupational learning so that students find productive and rewarding roles in the workplace. The OT may be asked to help students make transitions to adult/worker roles (Public Law 103-239).

E. Title XIX of the Social Security Act of 1965 (Medicaid) provides state funding for medical, social, psychological and health services to individuals and families meeting income-based criteria. Services include early and periodic screening, diagnosis, and treatment for students under age 21. The OT may become involved in billing Medicaid. However its focus on medically oriented therapy goals, rather than educational goals, could create confusion in completing Medicaid forms for reimbursement of OT services. Seeking Medicaid coverage for OT services should not cause school based occupational therapy to become a medically based model.

F. Confidentiality Laws, which protect personal information on education records (including health records) include: IDEA, the Family Educational Rights and Privacy Act (FERPA) and state statutes. Parents have the right (including, but not limited) to:

- inspect and review the contents of all records concerning identification, evaluation, placement and FAPE provision;
- request that the school district amend the record's information if the parent believes that the information is inaccurate, misleading, or violates the privacy rights of their children;
- know who besides the parents and authorized school personnel has access to information in the records.

Further information on confidentiality regulations for student records is in Section VI, Part 3 documentation of these *Guidelines*.

3. Connecticut Professional Licensing

Regulations, professional standards and practice acts for related service personnel are covered in Section VII Administration of these Guidelines (also see appendices).

In summary, laws regarding occupational therapy in educational settings assure students' ability to participate in the educational program. Laws do not include provisions to reduce underlying medical impairments, unless it is feasible and clearly improves access and participation in education. Typically, adaptations and modifications in the educational environment are made.

SECTION III

Collaboration

1. Collaborative Systems

Collaboration systems exhibit practices for interaction between at least two co-equal parties voluntarily engaged in shared information, expertise and decision-making as they work toward a common goal.

The *Position Statement on Educating Students with Disabilities*, adopted by the Connecticut Department of Education in June 1996, states that "good practice requires … a collaborative approach to service delivery that includes parental involvement, use of community-based resources, learning experiences that are both school-based and work-based, and pupil services and supports (psychology, guidance, counseling, social work, speech and language and health services)." (See Appendix)

For occupational therapists (OTs) to be effective in the school setting, they should develop and use collaboration skills to promote inclusion of students with disabilities into the general educational environment with their peers. Working as a team heightens awareness and knowledge of individual team members. Conditions conducive to collaboration include:

- mutual goals;
- parity among participants, all input equally valued;
- shared accountability for students' progress;
- shared resources;
- voluntary participation.

Under the right conditions, a collaborative style can exist in any school decision-making process or activity. OTs, parents and other professionals plan together and make decisions, which help students and families to successfully participate in the school and community. Bringing their expertise into the collaborative environment, OTs and other professionals assume that all perspectives are valid and valued, thereby fostering creative problem solving.

Successful collaboration of OTs working in schools necessitates administrative support and understanding of the:

- time OTs need for collaboration with general and special education teachers, other related service providers, and families;
- strategies to promote collaboration and deal with resistance;
- ways to alleviate barriers to collaboration between OTs, educators, other professionals, and parents.

2. Collaborative Teams in the Educational Environment

Collaborative teams use the unique viewpoints of each team member to produce integrated plans for students and families. Plans may include implementation strategies, modifications to classroom activities or curriculum, or decisions on appropriate assessments. Team members communicate via formal and informal systems such as: regular team meetings, communication notebooks, and action plans designating persons responsible for specified actions by specified dates. Structuring and recording collaboration meetings reinforces the concept's importance. (See sample meeting documentation form at the end of this section.)

Team approaches can be transdisciplinary, multidisciplinary or interdisciplinary; all involve a group of individuals from various professions working together on behalf of students.

- Multidisciplinary teams require minimal collaboration. Team members are responsible for common students or purposes, but use their skills and knowledge independently, periodically informing other team members.
- Interdisciplinary teams require significant collaboration. Members use their skills and knowledge to work together on common purposes. They plan, coordinate, and deliver services collaboratively.
- Transdisciplinary teams require maximum collaboration. Members share expertise, skills and knowledge with each other, and share roles when working together on common students or purposes. They plan collaboratively, train one another, and deliver services by sharing roles and responsibilities.

Occupational therapists undertake collaborative roles on a variety of teams:

A. Educational Teams address the needs of students. Teachers, OTs, PTs, nurses, adaptive PE teachers, paraprofessionals, and parents/guardians together design a shared vision of and for students. They collaborate on: planning assessment (evaluation) and service type and delivery; selecting outcome measurements, and designating responsible persons and timetables.

B. Curriculum Teams can be systemwide, consisting of professionals (generally teachers) responsible for curriculum design and implementation. Occupational therapists should be involved at the curriculum design stage. Physical education (PE) teachers; physical therapists; adaptive PE teachers; health education teachers; teachers in music, art and computers; and nurses collaborate on these teams concerning:

- disability awareness issues;
- health maintenance and fitness promotion for all students including students with special needs;
- health screening advisement including fitness testing; scoliosis, hearing and vision screenings;
- learning styles from a developmental, sensory-motor and visual-motor perspective.

C. Health Maintenance Teams are responsible for promoting healthy lifestyles and health maintenance. Occupational therapists may collaborate with PE teachers, physical therapists, nurses, and health teachers to:

- encourage physical activity for all students including those with disabilities and in

special education;
- promote fitness and healthy lifestyles; offer fitness testing;
- identify risk factors for unhealthy living;
- assist in prevention screenings such as scoliosis screenings.

D. School Management Teams address classroom and common room designs and layouts. OTs collaborate with administrative, and buildings & grounds staff concerning accessibility issues such as:

- Americans with Disabilities Act (ADA) interpretation and implications;
- structural barriers in school and community learning settings;
- designing space that promotes access to all in common areas such as cafeteria, gym, music and art rooms, library, bathrooms, outdoor spaces, playgrounds;
- fire drill planning.

E. Administrative Teams consist of school administrators and special education and pupil services directors. Occupational therapists collaborate with the administration team to:

- establish minimum competencies for related services staff, and best practices;
- provide critical current information on licensure and supervisory standards within the profession;
- interpret and implement the ADA;
- identify legal issues;
- communicate guidelines for paraprofessionals employment;
- identify efficient use of limited resources.

F. Family Teams include parents/guardians, to support:

- advice in using adaptive equipment at home;
- minimizing architectural barriers;
- home programs/carryover.

3. Collaboration with School Nurses and Physicians

In order to accomplish effective health care interventions for students, communication among all providers of care within the school setting is critical. Related services professionals have complementary areas of expertise and need to collaborate in order to provide efficient and effective student services. It is particularly important that occupational therapists plan time in their schedules to consult with the building's school nurse regarding students whom they serve and to communicate regularly regarding students with underlying health conditions. This can be accomplished through team meetings, the use of written input sheets or memos, and planned conferencing. They also need to consult and collaborate with the school medical advisor and students' physicians, as appropriate, in planning, providing and evaluating health-related services for students with actual and potential health problems.

Transdisciplinary teaming is based on the concept that the multiple needs of a student are interrelated and sometimes most effectively delivered by more than one or two providers. Such teaming requires cross-disciplinary sharing of expertise and, at times, role release, wherein information and skills of one professional are transferred to a professional in another discipline (or "delegated," if the skills are not within the scope of practice of the second professional). Interdisciplinary and transdisciplinary collaboration and teaming, and use of the school nurse as the school-based coordinator of student health care services, will contribute to

improved accountability of all related service personnel and safer, enhanced services for students.

School nurse responsibilities include the provision of safe environments for all students. To accomplish this, school nurses must maintain an active and collaborative relationship with all school professionals, including other related service providers. School nurses are integral members of the educational team, attend child-study team meetings and, as appropriate, PPTs to provide comprehensive health assessment information, collaborate with related service personnel in writing health-related IEP objectives, and facilitate the optimal wellness of students. School nurses are responsible to assess students to identify health and developmental concerns and health care needs in school, and to plan care, including technological procedures and emergency care interventions appropriate for implementation within the school setting. They are also responsible to refer students to physicians and other team members, as appropriate, for additional assessment, preventive strategies, diagnosis and intervention.

School nurses are licensed to diagnose student responses to actual and potential health problems. Based on their assessment of student needs, they develop Individualized Health Care Plans (IHCP) for students with special health care needs in school. The assessment and IHCP are completed in collaboration with the family, community-based health care providers and school personnel, including occupational and physical therapists and speech and language pathologists. Students' plans should reflect collaboration among all appropriate team members and coordination of services in order to effectively and efficiently meet their special needs. The Connecticut Department of Education's *Specialized Health Care Procedure Manual for School Nurses** defines the IHCP as a "detailed and orderly program of action designed to monitor, prevent, manage, reduce, or eliminate identified health problems in order to maintain or improve the student's learning, independence and positive coping."

When it is either required by licensure of the related service professional or appropriate to meet the needs of the student, occupational therapists and other related services professionals must consult with the appropriate medical providers of the student. This should be done, as much as possible, in collaboration with the school nurse and other school health professionals who are serving the student.

* *Specialized Health Care Procedure Manual for School Nurses* (Connecticut Department of Education 1997). Also see *Serving Students with Special Health Care Needs* (Connecticut Department of Education, 1992).

4. Training

Occupational therapists should have opportunities to obtain training in effective teaming and collaboration skills. Through the federal Integrated Related Services Grant, administered by the Special Education Resource Center (SERC), The State Department of Education encourages institutions of higher education to offer quality pre-service preparation programs for OT students interested in pursuing a pediatric specialty. OT degree programs should include content on educationally based therapeutic services and collaborative roles, as well as traditional service delivery. New/re-entering therapists, along with teachers, particularly new staff and teaching assistants, should be trained to ensure that they understand the working collaborative relationship between therapists, educators, teaching assistants, and families.

An effective OT training program should develop OT students' ability to:

- recognize overlapping areas of expertise, then select the best provider or providers for the students' or families' program;
- participate in role release, and share professional competencies with other team members to facilitate multiple skill opportunities/experiences in natural environments;
- implement innovative methods based on students' and families' individualized needs;
- communicate clearly and effectively in oral and written form, and interact by using mutually understood vocabularies and procedures;
- understand the various stages/phases of the collaborative process;
- exhibit caring, respectful, empathetic and open attitudes during teaming interactions;
- effectively gather information; elicit and share information; explore problems; and set goals, objectives or benchmarks and action plans;
- recognize and acknowledge others' ideas and accomplishments;
- manage potential conflict and confrontation, to facilitate and maintain collaborative relationships;
- manage time required for the collaborative process so that needs of all students and the team are met;
- access and use a variety of data collection measures for problem identification and clarification, goal achievement, and accountability;
- recognize/support administration needs; and
- empower families and students to participate fully as team members.

5. Practices to Achieve Collaboration

Although IDEA does not mandate service coordination, OTs recognize collaboration as best practice. Therapists in a position of initiating collaboration in a school system may wish to use strategies such as:

- initially focusing energies on teachers, therapists and paraprofessionals who are eager to collaborate;
- using these successful relationships as a model to include others;
- having a group focus such as team evaluation; and
- noting that team building is a process — starting small.

The following lists detail competencies for which professionals should strive.

10 Golden Rules of Collaborative Consulting

1. Find common ground.
2. Treat each other with complete respect.
3. Don't pose as an expert.
4. Ask questions.
5. Build on strengths.
6. Do what you say you are going to do.
7. Maintain confidentiality.
8. Listen — really listen.
9. Value relationships over efficiency.
10. Provide positive feedback.

Characteristics Desirable in Team Members are:

- strong professional identity;
- excellent communication skills;
- flexibility;
- respect for cultural diversity;
- respect for other professions;
- respect for role of parents as partners;
- ability to role release appropriately, including knowledge of when to release and when not to release; and
- knowledge of and ability to carry out many different models of service delivery.

The list on the next page, adapted from West and Cannon (1998), is useful as a self-evaluation checklist or in professional development activities.

Collaborative Consultation Competencies

1. Demonstrate knowledge of various stages/phases of the consultation process.
2. Assume joint responsibility for identifying each stage of the consultation process and adjusting behavior accordingly.
3. Match consultation approach(es) to specific consultation situation(s), setting(s), and need(s).
4. Practice reciprocity of roles between consultant and consultee in facilitating the consultation process.
5. Translate relevant consultation research findings into effective school-based consultation practice.
6. Exhibit ability to be caring, respectful, empathic, congruent, and open in consultation interactions.
7. Establish and maintain rapport with all persons involved in the consultation process, in both formal and informal interactions.
8. Identify and implement appropriate responses to the stage of professional development of all persons involved in the consultation process.
9. Maintain positive self-concept and enthusiastic attitude throughout the consultation process.
10. Demonstrate willingness to learn from others throughout the consultation process.
11. Facilitate progress in consultation situations by managing personal stress, maintaining calm in time of crisis, taking risks, and remaining flexible and resilient.
12. Respect divergent points of view, acknowledging the right to hold different views and to act in accordance with convictions.
13. Communicate clearly and effectively in oral and written form.
14. Utilize active ongoing listening and responding skills to facilitate the consultation process (e.g., acknowledging, paraphrasing, reflecting, clarifying, elaborating, and summarizing).
15. Determine own and others' willingness to enter consultative relationship.
16. Adjust consultation approach to the learning stage of individuals involved in the consultation process.
17. Exhibit ability to grasp and validate overt/covert meaning and affect in communications (perspective).
18. Interpret nonverbal communications of self and others (e.g., eye contact, body language, personal boundaries in space) in appropriate context.
19. Interview effectively to elicit and share information, explore problems, set goals and objectives.
20. Pursue issues with appropriate persistence once they arise in consultation process.
21. Give and solicit continuous feedback, which is specific, immediate and objective.
22. Give credit to others for their ideas and accomplishments.
23. Manage conflict and confrontation skillfully throughout the consultation process to maintain collaborative relationships.
24. Manage timing of consultation activities to facilitate mutual decision making at each stage of the consultation process.
25. Apply the principle of positive reinforcement to one another in the collaborative team situation.
26. Be willing and safe enough to say "I don't know...let's find out."
27. Recognize that successful and lasting solutions require commonality of goals and

collaboration throughout all phases of the problem-solving process.

28. Develop a variety of data collection techniques for problem identification and clarification.
29. Generate viable alternatives through brainstorming techniques characterized by active listening, non-judgmental responding, and appropriate reframing.
30. Evaluate alternatives to anticipate possible consequences, narrow and combine choices, and assign priorities.
31. Integrate solutions into a flexible, feasible, and easily implemented plan of action relevant to all persons affected by the problem.
32. Adopt a "pilot problem-solving" attitude, recognizing that adjustments to the plan of action are to be expected.
33. Remain available throughout implementation for support, modeling, and/or assistance in modification.
34. Redesign, maintain, or discontinue interventions using database evaluation.
35. Utilize observation, feedback, and interviewing skills to increase objectivity and mutuality throughout the problem solving process.
36. Develop role as a change agent (e.g., implementing strategies for gaining support, overcoming resistance).
37. Identify benefits and negative effects, which could result from change efforts.
38. Facilitate equal learning opportunities by showing respect for individual differences in physical appearance, race, sex, handicap, ethnicity, religion, socioeconomic status, or ability.
39. Advocate for services, which accommodate the educational, social, and vocational needs of all students, including those with and without disabilities.
40. Encourage implementation of laws and regulations designed to provide appropriate education for all students with disabilities.
41. Utilize principles of the least restrictive environment in all decisions regarding students with disabilities.
42. Modify myths, beliefs, and attitudes, which impede successful social and educational integration of students with disabilities into the least restrictive environment.
43. Recognize, respect, and respond appropriately to the effects of personal values, belief systems of self and others in the consultation process.
44. Ensure that persons involved in planning and implementing the consultation process are also involved in its evaluation.
45. Evaluate the impact of input, process, and outcome variables on desired consultation outcomes.
46. Engage in self-evaluation of strengths and weaknesses to modify personal behaviors influencing the consultation process.
47. Utilize continuous evaluative feedback to maintain, revise, or terminate consultation activities.

Adapted from: J. Fredrick West and Glenna S. Cannon, "Essential Collaborative Consultation Competencies for Regular and Special Educators", Journal of Learning Disabilities, January 1988.

Collaboration Team Meeting Worksheet

Persons Present: *(Note late arrivals)* Absentees: Others Who Need to Know:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Roles:	This Meeting	Next Meeting
Timekeeper:	_____	_____
Recorder:	_____	_____
Equalizer:	_____	_____
Other:	_____	_____
Other:	_____	_____

Agenda

	Items	Minutes	Time Limit
1.	Positive Comments: _____		
2.	_____		
3.	_____		
4.	_____		
5.	Processing (task & relationship): _____		
6.	_____		
7.	_____		
8.	_____		
9.	Processing (task & relationship): _____		

Minutes of Outcomes

Action Items: Person(s) Responsible

1. Communicate outcomes to absent member and others _____ who need to know by _____
2. _____
3. _____
4. _____
5. _____

Agenda Building for Next Meeting

Date: _____ Time: _____ Location: _____

Expected Agenda Items:

1. _____
2. _____
3. _____
4. _____

[sample for consideration]

SECTION IV
Evaluation

1. Educational Interventions

Intended to facilitate student learning in regular educational settings, alternative educational interventions, with accompanying data collection, sometimes called *prereferral*, support regular education teachers. This process may examine work samples, preferred strategies, and problem-solving strategies. LEAs are legally required to provide and to document strategies or adaptations to regular education settings before initiating a referral for student evaluation. Sometimes teachers can make simple changes in classroom environments that avoid going through the relatively complex referral to occupational therapy, resulting in the same change (see following chart).

[sample for consideration]

Classroom Adaptations to be Considered for Common Related Service Referral Complaints *(Prior to Comprehensive Assessment)*	
Referral Complaint	**Possible Adaptations**
Poor lunch skills/behaviors	Provide a wheeled cart to carry lunch tray Provide large handled utensils Clamp lunch tray to table to avoid slipping Serve milk in sealed cup with straw
Poor toileting skills	Provide a smaller toilet Provide looser clothing Provide a setup stool for toilet/sink
Can't stay in seat; fidgety	Allow student to lie on floor to work Allow student to stand to work Provide lateral support to hips or trunk (e.g. rolled towels) Adjust seat to correct height for work Be sure feet are flat on floor when seated Provide more variety in seatwork
Clumsy in classroom/halls; gets lost in building	Move classroom furniture to edges of room Send student to new locations when halls are less crowded Provide visual cues in hall to mark locations Match student with partner for transitions
Can't get on or off bus independently	Allow student to back down stairs Provide additional smaller steps
Can't get jacket/coat on/off	Place in front of student, in same orientation each time Provide larger size for easier handling
Drops materials; can't manipulate books, etc.	Place tabs on book pages for turning Provide small containers for items

	Place all items for one task on a lunch tray
Poor attention, hyperactive, distractible	Decrease availability of distracting stimuli (e.g. visual or auditory) Provide touch cues only when student in prepared for it Touch student with firm pressure Provide frequent breaks in seatwork
Poor pencil/crayon use	Use triangle grip on pencil/crayon Use fatter writing utensil Provide larger sheets of paper Provide paper without lines Provide paper with wider-spaced lines
Poor cutting skills	Provide adapted scissors Provide stabilized paper (e.g. tape it down, use large clips, c-clamps)
Unable to complete seatwork successfully	Provide larger spaces for answers Give smaller amounts of work Put less items per page Give more time to complete task Change level of difficulty
Loses personal belongings; unorganized	Make a map showing where items belong Collect all belongings and hand them out at the beginning of each activity
Doesn't follow directions	Provide written or picture directions for reference Provide cassette tape of directions Allow student to watch a partner for cues

From: Dunn, W. *Pediatric Occupational Therapy: Facilitating Effective Service Provision.* Thorofare, NJ:Slack, 1991. Used with permission.

2. Screening

Screening takes a general, broad view of students, helping verify whether they need further diagnostic evaluations. In accordance with the "Standards of Practice for Occupational Therapy" (AOTA), the OT shall:

1. "conduct screening in accordance with state and federal guidelines, to determine whether intervention or further assessment is necessary and to identify dysfunctions in performance areas.
2. screen independently or as a member of an interdisciplinary team. A certified occupational therapy assistant may contribute to the screening process supervised by a registered occupational therapist.
3. select screening methods that are appropriate to the individual's age and developmental level, gender, education, and cultural background; also socioeconomic, medical and functional status. Screening methods may include but are not limited to interviews, structured observations, and informal testing and record reviews.
4. communicate screening results and recommendations to appropriate individuals."

Examples of informal screening strategies OTs may choose include:

- observation in an educational environment;
- record review;
- work samples review;
- interview with school personnel;
- interview with parents/caregivers.

(A partial list of the formal, standardized screening tests, which OTs may consider, is in the appendices.)

3. Referral

The LEA may make referrals for occupational therapy (OT) services when students demonstrate educationally-related dysfunction in:

- performance areas of self-help or adaptive skills, work, and productive activities;
- play or leisure activities;
- performance components of sensorimotor, cognitive, and psychosocial development that may affect the learning process.

Since referral procedures vary among school systems, therapists should become thoroughly familiar with the process in their assigned school(s). Many schools have an established referral protocol, which may include prereferral, identification of problems(s), accepted strategies, and work samples. The teacher, school psychologist, physician, other related services personnel, community agencies providers, or parents may initiate referrals in the educational setting. Best practice is that collaboration remains the foundation for all procedures.

Referral information should include:

- the screening (if done) and records;
- interviews with parents, school personnel and related professionals; and
- work samples, where relevant.

For best practice in referrals, occupational therapists should refer to the *AOTA Standards of Practice* guidelines, Standard II, which state that a registered occupational therapist:

1. "shall accept referrals in accordance with AOTA's *Statement of Occupational Therapy Referral* (AOTA, 1994) and in compliance with appropriate laws.
2. may accept referrals for assessment or assessment with intervention in performance areas, performance components, or performance contexts when individuals have or appear to have dysfunctions or potential for dysfunctions.
3. responding to requests for service, may accept cases within the parameters of the law.
4. shall assume responsibility for determining the appropriateness of the scope, frequency, and duration of services within the parameters of the law.
5. shall refer individuals to other appropriate resources when the therapist determines that the knowledge and expertise of other professionals are indicated.
6. shall educate current and potential referral sources about the process of initiating occupational therapy referrals."

After reviewing referral information, the evaluation team should select its performance focus - areas, components, and contexts. The data should create a profile of strengths and concerns to:

1) identify conditions that limit performance in educational activities, and
2) formulate an efficient intervention strategy.

4. Evaluation

Federal and state laws and regulations pertaining to special education mandate that the local education agency (LEA) identify, locate and evaluate all students in their jurisdiction who have disabilities and need special education and related services.

The evaluation process should be collaborative, multidimensional, and relevant to the specific concerns or questions that were raised, and provide a reliable and valid baseline for decision making. Evaluation should include some combination of skills observation, interview, record or work sample review, or standardized or criterion referenced evaluations. Federal law requires that the local educational agency (LEA) obtain informed parental consent before conducting an evaluation. Evaluation timeframes also should reflect federal and state requirements - currently evaluations must occur within 45 school days from the initial referral date. Further, consent for evaluation cannot be assumed as consent for placement (1997 IDEA Amendments).

5. Assessment

Occupational therapists should take an active role in helping teachers and special education directors identify when students need occupational therapy assessments. This may necessitate team discussions or in-services for staff, focussing on understanding roles of therapists in educational settings. Therapists and teachers should develop written criteria for teachers to: 1) initially observe students' behavior, 2) document strategies by which teachers tried to address students' needs, and 3) question whether students need occupational therapy assessments.

Assessment within the educational setting is a continuous process where the occupational therapist works in collaboration with the team. The purpose of the assessment is to: a) determine eligibility for service within students' natural environments; b) establish baseline for documenting progress; and c) help plan intervention strategies.

Given the IDEA requirement to educate children in the least restrictive environment, occupational therapists should assess how students function in the classroom, cafeteria, halls, playground, restroom, bus, and anywhere else within the school environment. Students in vocational programs will have a number of different educational goals and settings, implying variation in education-related skills being assessed. When planning begins for transition from school to adult life, assessments may extend to the community environment. Assessments should be:

- in a natural environment;
- peer- and age-appropriate;
- a continuous process;
- cognizant of lifestyle management.

Assessment should include some combination of skilled observation, interview, record or work sample review, or standardized or criterion-referenced tests. Under OTR supervision, a certified occupational therapist assistant may contribute to the assessment.

Practitioners should become very familiar with the content and administration protocol

of any assessment tool before using results as a major consideration in the assessment process. Also, clinical observations within the scope of practice is an essential component of an interdisciplinary assessment. Assessment tools fall into categories such as: curriculum-based measurements, ecological/environment (functional) inventories, criterion-referenced tests and standardized tests.

Screening, assessment, and clinical observation tools and strategies are best used to analyze *why* students are having functional difficulties in educational settings — not to establish interventions. Examples of these tools follow:

1) *standardized tests*, also called norm-referenced tests, use normative data for scoring, which may include performance norms by age, gender, ethnic group, geographic region, and socioeconomic status. Examples include: "Bayley Scales of Infant Development-II", "Peabody Developmental Motor Scales", Bruininks-Oseretsky Test of Motor Proficiency", and "Pediatric Evaluation of Disability Inventory".

   For scores to be considered valid, OTs must follow the specified protocol. If students' disabilities prevent OTs from testing according to standard procedures, the results must clearly indicate this issue. If standardized tests are not appropriate, results shall be expressed in descriptive reports without using standardized scales.

2) *criterion-referenced tests* compare students' performance to a previously established criterion rather than to other students from a normative sampling. One example is the "Hawaii Early Learning Profile". Play based inventories are sometimes criterion referenced tests, for example the "Transdisciplinary Play-Based Assessment" by Toni Linder.

3) *ecological/environment inventories* evaluate students within a variety of educational environments, enabling OTs to analyze tasks that each environment require. Others involved in students' growth and development contribute clinical observations and information/inventories to help OTs determine requirements of students' natural environment. Ecological inventories should consider:
   - environmental demands and opportunities;
   - curricular expectations;
   - tools/instruments to help gather relevant information;
   - whether the team needs expansion to obtain needed information.

   (See appendix for a comprehensive ecological inventory model by Davis, Harper and Scully.)

4) *curriculum based measurements (CBMs)* are based upon students academic performance within a curriculum. OTs should try to become familiar with the curriculum areas relevant to OT services. CBMs are useful to determine functional strengths and weaknesses, providing information to design instructional programs.

Criterion referenced and standardized tests are tools to help therapists identify underlying causes and extent of the functional difficulties. Test scores clarify needs rather than imply entry or exit criteria. Evaluations should include a brief description of each assessment tool used and skill areas it addresses.

Assessment tools should be selected or adapted according to students' age, developmental level, gender, environment, cultural/ethnic and socioeconomic background, medical situation and functional status. If an occupational therapist assistant contributes to the assessment; or if the assessment takes place in a group or individually - these context factors can affect results. Some screening/assessment tools emphasize students' ability to perform tasks and absorb material covered in the curriculum. Low student scores do not necessarily imply need for school-based OT services, or are OTs required to use any particular test(s). However, the 1997 IDEA amendments require that OTs "not use any single procedure as the sole criterion for determining" whether students have a disability, or for identifying needed interventions.

6. Reevaluation

The Planning and Placement Team (PPT) is responsible for determining types of assessments based on the PPT's need for information about students to make continuing eligibility, program and placement decisions. While the areas evaluated and evaluation instruments can differ from those used for preplacement evaluation, reevaluation procedures must meet the same legal requirements:

1) annual reassessment - Intended to monitor students progress, annual re-assessments can be formal or informal. Annual reassessments are not always required.

2) re-evaluation - Federal regulations require evaluation of students receiving related services "every three years or more frequently if conditions warrant, or if the child's parent or teacher requests an evaluation" (IDEA '97). Sometimes OTs conduct individual evaluations; other times professionals collaborate on the triennial evaluation. Since school systems' procedures vary for informing OTs about re-evaluation due dates, OTs need to become familiar with procedures in their school(s). Federal requirements under IDEA are listed as follows:

Evaluation Procedures under IDEA '97

1. Personnel administer non-discriminatory tests and other evaluation materials that are selected and administered so as not to be discriminatory on a racial or cultural basis; and are provided and administered in the student's native language or mode of communication unless it is clearly not possible.
2. Trained and knowledgeable personnel ensure that any standardized tests that are given to the student have been validated for the specific purpose for which they are used and are administered in accordance with any instructions provided by the producer of such tests.
3. No one procedure is the sole criterion for determining whether a student meets the eligibility criteria for special education or determining an appropriate educational program for the student. The results of standardized or local tests of ability, aptitude, affect, achievement and aspiration shall not be exclusively used as the basis for placement.
4. Use a variety of assessment tools and strategies to gather relevant functional and developmental information, including information provided by the parents to assist in determining whether the student meets the criteria for special education and the content of the student's IEP, including information related to enabling the student to be involved in and progress in the general curriculum or, for preschool children, to participate in appropriate activities.
5. Use of technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.
6. The student is assessed in all areas of suspected disability.
7. Assessment tools and strategies that provide relevant information that directly assist persons in determining the educational needs of the student.

SECTION V

Intervention

1. Service Delivery Plan

The occupational therapist develops a service delivery plan in collaboration with others, based on evaluation results and expected outcomes within the student's individualized education program (IEP). The service delivery plan becomes a tool to ensure synchronization with special education and other related services. Three primary purposes of occupational therapy intervention are:

- remediation: establishes or restores students' skills or performance components;
- prevention: reduces students' physical deterioration or emotional distress, usually through positioning, adapting tasks or modifying environments;
- compensation: develops task performance by teaching alternative methods, altering the task, adapting the performance context, or using assistive devices.

The annual goals of the IEP describe functional outcomes in age-appropriate terms. Measurable annual goals and short-term objectives/benchmarks are the basis for OT interventions. The Planning and Placement Team (PPT) should make decisions concerning students' eligibility for OT services based on student performance areas and measurable IEP goals and objectives that the PPT established. All team members including regular education, special education, and related services personnel, administrators, and parents should be involved in collaborative decision-making.

Recommended practice for entrance criteria includes consideration if the:

- problem significantly interferes with students' abilities to participate in their educational programs;
- problem appears to be caused by limitations in the performance component(s);
- previous attempts to alleviate the problem have not been successful as documented;
- potential for change in students' problems through intervention appears likely (change unrelated to maturity), or compensatory strategies can be taught;
- unique expertise of therapist is required to meet students' identified needs.

Recommended practice for exit criteria includes consideration if the:

- goals or outcomes requiring therapy have been met and no additional goals are appropriate;
- potential for further change from therapy service appears unlikely;
- problem ceases to be educationally relevant;
- therapy is contraindicated due to medical, psychological or social complications.

2. Direct and Indirect Services

Through *direct and indirect services*, an occupational therapist (OT) uses remediation,

prevention and compensation. With *direct* therapy, the OT interacts directly with students in small groups or one-on-one. Best practice to promote the least restrictive environment is brief, direct occupational therapy, which develops a specific skill, phasing therapy out when students can incorporate skills into daily routines. Direct therapy should be considered when:

- the OT is the only person who can safely provide a necessary intervention;
- the OT has particular skills or judgment necessary for ongoing intervention;
- the team decides that alternatives to direct therapy would be unsafe or ineffective.

Indirect occupational therapy, often called *consultation*, is when OTs use their knowledge and skills to help students, without direct interaction between the two. Through collaboration with educational professionals or paraprofessionals, OTs enable someone other than themselves to implement specific activities. OTs should consider the background and job description of school personnel implementing indirect services. For example, most would not have expertise in neurology, anatomy and biomechanics. Examples are teaching others to:

- follow a routine which enhances sensory processing;
- position students for optimal learning;
- use an assistive technology device effectively.

The OT/team must consider that some professionals use the term *monitoring* synonymously with indirect occupational therapy. Monitoring involves regularly scheduled observations of students, and consultation with others supporting the student's OT program, to evaluate desired outcomes. Other professionals consider regularly scheduled observations of their students interacting with school personnel for purposes of assessing change and evaluating outcomes as direct therapy.

Whether or not students also receive direct occupational therapy, indirect therapy is important to ensure that the interventions remain relevant to needs of students' daily routines. Through collaboration with other team members including teachers and parents, OTs select techniques to meet needs of the diverse school population. (See following table.)

Examples of Methods/Services

Method	Direct Service	Indirect Service
Remediation	Help develop reach and grasp for school work and daily living activities	Design a sensory motor curriculum for fine motor development. Staff implements the goals. OT measures student progress.
Prevention	Provide sensory integration to increase self-regulation and coping during the day	Develop strategies to decrease unnecessary, unexpected or prolonged sensory stimulation in the classroom. Staff implements the goals, OT measures student progress.
Compensation	Develop and teach a cue system for following a required sequence in a job	Change the layout of a work environment to reduce the number of steps required to complete the task. OT monitors student progress and effectiveness of the modification.

Adapted from: *Occupational Therapy and Physical Therapy: A Resource and Planning Guide*. Madison, WI: Wisconsin Department of Public Instruction, 1996. Used with permission.

3. OT Purposes

Usually occupational therapy's purpose is to help students:

- acquire and express sensory motor information;
- perform daily living activities required for school functioning and move through the school environment;
- assume student functions, which include:
  - campus/school mobility,
  - participating on a regular and timely basis,
  - mental storage of material,
  - recording information,
  - studying,
  - using tools and supplies,
  - participating in activities throughout school settings.

School personnel commonly request occupational therapy support when students have difficulty with the following functions as related to educational participation:

- daily living activities (ADL);
- feeding and oral function;
- play skills;
- task organization and completion;
- written communication skills and hand function;
- sensory integration (processing);
- visual perception.

[sample for consideration]

Classroom Strategies Checklist

Student: _____ Teacher: _____

School: _____ Class/subject: _____

DOB: _____ Date completed: _____

What strategies have you tried to correct the problem? Please indicate those strategies you have applied to the problem and give an estimate of how long the strategy has been in effect in terms of days or weeks. Also comment on the success of these strategies in terms of "Yes" or "No".

Strategies	***Duration*** (Specify days/weeks)	***Success*** (yes/no)
Environmental:		
1. Seating change	_____	_____
2. Isolation (how often?)	_____	_____
3. Change subject/class to a different hour, same teacher	_____	_____
4. Change to a different teacher	_____	_____
5. Other: _____	_____	_____
Organizational:		
1. Setting time limits for assignments/ completion during class	_____	_____
2. Questioning at end of each sentence/paragraph to help focus on important information	_____	_____
3. Allowing additional time to complete task	_____	_____
4. Highlighting main facts in the book	_____	_____
5. Organizing notebook or providing folder to organize work	_____	_____
6. Asking student to repeat directions given	_____	_____
7. Other: _____	_____	_____
Motivational:		
1. Checking papers, showing "C's" for correct	_____	_____
2. Sending home daily progress report	_____	_____
3. Immediate reinforcement of correct response	_____	_____
4. Keeping graphs/charts of student's progress	_____	_____
5. Conferencing with student's parents	_____	_____
6. Conferencing with student's other teachers	_____	_____
7. Student reading lesson to aide, peer tutor or teacher	_____	_____
8. Home/school communication system for assignments	_____	_____
9. Using tapes of materials the rest of class is reading	_____	_____
10. Student using tapes at home, school	_____	_____
11. Classmate take notes with carbon	_____	_____
12. Other: _____	_____	_____

Presentation:

1. Giving assignments both orally and visually _____ _____
2. Taping lessons so student can listen again _____ _____ _____
3. Giving student sample or practice test _____ _____
4. Providing legible material _____ _____
5. Immediate correction of errors _____ _____
6. Providing advance organizers _____ _____
7. Providing tests in smaller blocks of questions/wider spaced _____ _____
8. Providing tests in small segments; student hands in at end of each segment and gets next _____ _____
9. Providing modified tests, fewer questions, simpler material _____ _____
10. Giving tests orally _____ _____
11. Other: _____ _____ _____

Curriculum:

1. Providing opportunities for extra practice _____ _____
2. Providing study guide/outline to follow _____ _____
3. Reducing quantity of material _____ _____
4. Providing instructional materials geared to lower level of basic skills _____ _____
5. Vocabulary flash cards _____ _____
6. Vocabulary words in context _____ _____
7. Special materials _____ _____
8. Other: _____ _____ _____

Are there any other strategies you have used that are not listed above? Please describe, including duration and success:

_____
_____
_____
_____
_____
_____

Adapted From: Dunn, W. *Pediatric Occupational Therapy: Facilitating Effective Service Provision*. Thorofare, NJ: Slack, 1991. Used with permission.

4. Functional or Performance Areas

A. Activities of Daily Living (ADL) is a primary performance area. Teachers and paraprofessionals commonly supervise ADL and special education teachers teach it. ADL includes eating, putting on coats and shoes, toileting, and riding the bus. OT intervention may be indirect with school personnel who interact daily with the students; or direct when performance components of specialized skills (e.g. oral-motor) need development.

B. Oral Motor Skills and Feeding needs occur among students with severe disabilities, requiring close collaboration among school staff, parents and medical personnel. Eating and speaking depend upon oral sensory-motor skills. OTs base intervention on students':

- responsiveness to sensory input, such as food textures and temperatures;
- motor performance such as chewing, lip closure, swallowing and self-feeding;
- behavioral responses such as pleasure or aversion during oral motor tasks.

Potentially life-threatening issues such as choking and nutritional intake necessitate that schools obtain medical authorization for feeding students who have:

- frequent respiratory illnesses;
- weight loss or poor weight gain;
- crying or resistance when food approaches the mouth;
- history of dehydration;
- frequent gagging, choking or coughing from food, liquid or their own secretions.

For a medical evaluation related to feeding, parents and school personnel should provide the following information:

- feeding schedules, amounts, and methods of intake;
- role or impact of feeding during the students' typical school day;
- special education and related services the students received and results of specific feeding interventions.

C. Play, another primary performance area in occupational therapy, is an important means of learning by: exploring the environment, interacting with others, and developing sensory motor and social interaction skills. Collaborating with other educators, OTs assess components of students' play and leisure in physical education classes, extracurricular activities and recess. Intervention examples include:

- collaborating with a physical education teacher to design activities for students with low tolerance for touch and movement;
- teaming with a special education teacher to help adolescents explore adult leisure activities and modify them for successful performance;
- developing specific skills which enable the student to play along with typical peers.

D. Task Organization and Completion may require sensorimotor, cognitive or psychosocial abilities beyond the students' current capabilities. The OT collaborates with other school staff to assess the:

- purpose of a task;
- objects, space and time required to complete the task;
- roles and expectations of others involved in the task;
- discrepancies between how students perform tasks and how most other students do them.;

E. Handwriting or written communication is one of the most common reasons students are referred to occupational therapy. Handwriting quality affects how well students organize information and communicate knowledge. As a reaction to handwriting difficulties, students may produce written materials that do not reflect their true capabilities.

Occupational performance components of handwriting include:

- postural control and other neuromusculoskeletal components in the pelvis, trunk, shoulder, and neck;
- level of arousal, attention span, sequencing and other cognitive components;
- visual perception;
- perception of touch, body position and movement;
- motor planning and motor control;
- hand preference and integration of the two sides of the body;
- visual-motor integration;
- basic function of the hand including wrist stability, arch formation and finger dexterity.
- Remedial and preventive interventions include collaborating with others to modify students' seating; designing or procuring assistive technology devices; and training teachers, students and families to use them.

F. Sensory Integration is the neurological process of receiving information from any of the senses and organizing it for use. Learning is based on one's ability to filter, integrate and respond to sensory information. Involved senses are:

- visual and auditory - the far or distal senses most frequently used in classroom learning;
- tactile and proprioceptive - the near or proximal senses of touch and body movement involved in kinesthetic learning;
- vestibular - the sense of head movement and head position;
- olfactory and gustatory - the senses of smell and taste which are closely related to alertness and emotion.

G. Visual Perception is typically used more than 70 percent of the time in school activities. In addition to visual acuity, components of functional vision include:

- eye movement;
- postural control;
- visual perception (i.e. the process of extracting and organizing information from the environment).

Students may have visual impairments as their sole disability or visual impairments related to other disabilities (e.g., cognitive or learning disabilities, orthopedic or other health impairments, traumatic brain injuries, or autism). Intervention may involve sensory and movement activities, and/or collaboration with others to modify the environment or the students' routines.

SECTION IV

Documentation

In addition to meeting federal and state requirements, documentation is an important communication tool between schools and families. All professionals involved should collaborate to document at least quarterly, and **provide reports as often as is done for students without disabilities.** Therapists should keep current on documentation guidelines for the profession, as well as special school-based requirements.

In general, IDEA requires occupational therapists (OTs) to:

- write a report of the evaluation the OT conducted;
- provide information and recommendations for students' IEPs;
- write service plans for students, considering: disability, medical diagnosis, contraindications to therapy;
- help develop IEP goals and determine equipment and personnel/assistance needed to meet therapy goals;
- prepare periodic status reports; and
- write a report when students discontinue therapy.

The law does not specify how long therapists must keep documentation. Connecticut has a retention schedule (available from LEAs) for public records which covers education records LEAs maintain. Medicaid requires documentation be retained for at least six (6) years. *See Medicaid regulations*.

1. IEP Documentation

Based on IDEA and Regulations Concerning State Agencies (RCSA) Sec.10-76d-11(d) regulations, the Individualized Education Program (IEP) should contain:

1. measurable annual goals and measurable short-term objectives/benchmarks for students. Annual educational goals describe what students with disabilities "can reasonably be expected to accomplish within a 12-month period in the child's special education program". Short-term instructional objectives are "measurable, intermediate steps" between the present levels of educational performance and the annual goals. They should be written in behavioral terms to describe what the students are expected to accomplish, in a defined period of time, but not as detailed as lesson plans [CGS Sec.10-76d-11(c)(3)].

2. the specific special education and related services to be provided, including assistive technology services or devices.

3. the amount, frequency, and duration of services.

4. the extent to which the students will participate in regular educational programs.

5. statement of the present level of educational performance, including how the students' disabilities affect involvement and progress in the general curriculum.

6. extent to which the students will be able to participate in regular educational programs, including an explanation of the extent to which the students will not be participating with non-disabled students in the general education class, and in extracurricular and non-academic activities.

7. statement of transition services needed for students, beginning no later than age 14 and annually thereafter. Before students leave the school setting, include, when appropriate, a statement of interagency responsibilities for linkages (C.G.S. 10-76d(a)(6).

   Transition services must be based on students' needs and include instruction, community experiences, employment and other postschool adult-living objectives development, and if appropriate, acquisition of daily living skills and functional vocational evaluation.

8. projected date to begin services, and anticipated duration.

9. appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether objectives are being achieved.

10. notes on annual review and revisions if needed for the students' IEPs.

2. Service Process

In traditional hospital/clinic settings, a unit of service typically lasts fifteen minutes. In school settings with transdisciplinary or interdisciplinary programs, some OT interventions may be very modest, such as a few minutes daily. School policies for record keeping should reasonably reflect the OT scope of service, and cost/benefits of extensive documentation.

Documentation in the following areas is recommended:

1. **referral:** initial referral including reason, options considered, regular education interventions, why options rejected. RCSA (Sec. 10-76d-7) requires that referral to PPTs for special education evaluation be noted on the school district's standard referral form.
2. **permissions:** parents' or guardians' written permission for assessment and evaluation, reevaluation, and special education services; also, notice to parents concerning reevaluation.
3. **test protocol data and summary report:** screenings, evaluations, reassessments, IEPs, annual (periodic) reviews and exit results.
4. **intervention:** regular occupational therapy interventions. In addition to evaluation reports and intervention plans, documentation for school occupational therapy typically includes:
   - attendance records: the amount and frequency of service provided students;

- progress notes on services plan and data collection on IEP objectives;
- contacts with vendors and recommendations;
- contacts with parents;
- contacts with physicians and recommendations;
- contacts with teachers and recommendations;
- discontinuance reports;
- any additional records Medicaid or other third party payers require.

3. Confidentiality Laws and Student Records

These limit disclosure of personal information on health or education records such as IDEA, the Family Educational Rights and Privacy Act (FERPA) and state statutes. Also, therapists in school settings should comply with confidentiality standards required by their profession, and by school district policy. Each local educational agency typically requires certain documentation procedures relevant to consent for sharing information.

A comprehensive system for consistent organization and management of records throughout the school district will facilitate case management, program development, coordination, evaluation, and administrative and legal accountability. The system should include records on individual students receiving occupational therapy, and on the overall program. Federal and state laws and regulations which address classification, accessibility, review, challenges, amendments, transfer, maintenance and destruction of student records include:

- Family Educational Rights And Privacy Act of 1974 (FERPA) - all students;
- FERPA incorporated into IDEA at legislation for children with disabilities:
  20 U.S.C Sec 1415(b)(1)(A)
  34 CFR, 300.500, 300.560, 300.562-300.574
- RCSA Sec 10-76d-18;
- Connecticut Public Records Administrator - retention/disposition schedule.
- Regulations concerning confidentiality of education records.

FERPA defines records, files, documents and other materials containing information directly related to students and maintained by an educational agency or institution, or by individuals acting for that agency or institution, as “education records” (20 U.S.C., Sec 1232g(4)(A). This includes therapy evaluation reports, progress and conference reports, treatment plans, test protocols and therapy materials and any additional records school districts maintain to support Medicaid payments for services provided under IDEA - whether stored on paper, audio/videotape or computer. Some third-party records (i.e. from outside agencies or service providers) are not relevant in their entirety; a summary may be transferred to students’ educational records.

Sole possession records that are not available for review by parents, may be made by instructional, supervisory and administrative personnel, and educational personnel ancillary to them, and are not revealed to anyone other than a temporary substitute. Personal notes or anecdotal comments are sole possession records as long as they remain the sole possession of the therapist. When these records are shared, even verbally, they become subject to all FERPA access and review procedures. Anecdotal comments on test forms or therapy materials are educational records.

Therapists working in schools should be aware of legal requirements for confidentiality of school records:

Rationale

A positive atmosphere of cooperation and trust between parents and local school districts is contingent upon protecting parents' rights to privacy, limiting access to personally identifiable information and fully implementing *policies and procedures* related to confidentiality. *Parents* must be confident that they have control over decisions and information regarding their child.

Required Practices

1. Each board of education shall maintain records concerning children requiring special education and related services and shall provide for the filing, protection, confidentiality, classification, review, and when appropriate, destruction of such records (Sec. 10-76d-18).
2. Each board of education shall have policies and procedures to ensure the confidentiality of education records. All such policies and procedures shall be consistent with the requirements of pertinent state and federal law and regulation (Sec. 10-76d-18(a)) and (Sec. 10-76d-18(a)(1)).
3. All such policies and procedures shall be in writing and shall be made known at least annually to parents of children requiring special education and related services and shall be available to the public (Sec. 10-76d-18(a)(2)).
4. Policies and procedures shall include those relating to securing parental consent (Sec. 10-76d-18(a)(3)).
5. Policies and procedures shall include those relating to amendment of information in education records at a parent's request, where the board of education agrees to amend such information (Sec. 10-76d-18(a)(4)).
6. Policies and procedures shall include those relating to the opportunity for a hearing at which parents may challenge the information in education records (Sec. 10-76d-18(a)(5)).
7. Policies and procedures shall include those relating to safeguards to protect the confidentiality of personally identifiable information at collection, storage, disclosure and destruction stages. This shall also include a record of access to all education records. (Sec. 10-76d-18(a)(6)).
8. Parents shall have the right to inspect and review any education records relating to their child which are collected, maintained or used by the board of education (Sec. 10-76d-18(b)).

Source: State of Connecticut Board of Education, "Requirements and Guidelines for Special Education and Related Services for Children (Ages 3-5) With Disabilities", 1991. page 30. These requirements also apply to children 5 through 21 as cited in IDEA.

SECTION VII

Administration

1. School Practice

The state statutes regulating occupational therapy practice in Connecticut do not address practice in specific settings such as schools. Instead, they present occupational therapy as an autonomous clinical discipline primarily for reducing or preventing impairments. In contrast, federal laws are very specific that the purpose of occupational therapy in schools is to ensure that students can participate in the educational process, *not* to reduce impairments. The school occupational therapist's clients are *students* who qualify for instruction in special education because their disabilities adversely affect their educational performance. Therapists are obligated to provide educationally related services and may treat students' impairments only if improvements in those impairments will increase students' educational access and success. (Blossom, Ford, Cruse, 1996)

The occupational therapist's responsibilities include screening, assessment, service provision and documentation. They should be knowledgeable about student eligibility and exit criteria. Budget/resources awareness including appropriate assessment materials, treatment supplies and equipment is also important. Therapists need to be skilled collaborators and communicators. They should be aware of how and what they communicate - think through carefully, plan and deliver communication in a style suitable to each recipient. For example, a formal presentation may be appropriate in one setting; a hand written note in another. (On the following pages are sample job descriptions for an Occupational Therapist and an Occupational Therapy Assistant.)

2. Professional Standards

The director of special education is usually responsible for administration of occupational therapy. The director oversees employment, supervision, budget preparation, IEP implementation, and accountability for related services.

Occupational Therapists (OTR) and Occupational Therapist Assistants (COTA) must be licensed by the Department of Public Health (DPH) to practice in Connecticut (C.G.S. 376a). Certified Occupational Therapy Assistants must receive supervision by a registered, licensed Occupational Therapist responsible for assessments, goals/objectives and triennials. Until state education certification requirements are developed, it is recommended that same discipline supervision be available for therapists with less than three years experience in pediatrics/school settings. (See the American Occupational Therapy Association's "Code of Ethics" in the appendices.)

Sample Job Description

School Occupational Therapist

Position Summary:

- Provides services to students with exceptional educational needs;
- Improves, develops, restores or maintains students' active participation in self-maintenance, work, leisure and play in educational environments; and
- Functions as "related service personnel" under state and federal law and regulations.

Responsible to:

- Director of Special Education.

Qualifications:

- Bachelor's or Master's degree in occupational therapy from a school accredited by the American Occupational Therapy Association;
- Current certification from the National Board for Certification in Occupational Therapy;
- Licensed to practice occupational therapy in Connecticut; and
- If less that three years experience in pediatrics and/or school setting, must have same discipline supervision or mentorship.

Experience and Skills:

Should have skills and knowledge in the following areas:

- screening, assessment, treatment and documentation;
- knowledge of student eligibility guidelines;
- knowledge of student exit criteria;
- managing budgets and resources including appropriate assessment materials, treatment supplies and equipment;
- time management, to handle caseloads, schedule, and conduct paraprofessional training;
- supervision of certified Occupational Therapy Assistants and paraprofessionals; and
- communication strategies for varied target groups including parents and school personnel.

Essential Job Functions:

Must be able to perform the following job roles and functions:

- conduct appropriate evaluation of students referred for possible exceptional educational needs (EEN) and prepare written reports of the evaluations and findings;
- participate in meetings as member of the multidisciplinary team;
- participate in development of IEP's for students with exceptional educational needs;
- provide direct and indirect occupational therapy in educational settings to children with EEN;
- collaborate with other school personnel regarding occupational therapy and students' needs;
- travel to and among schools to provide services;
- maintain records of service provided;
- lift, transfer and position students and equipment as necessary to provide occupational therapy; and
- supervise any assigned licensed occupational therapy assistants.

Adapted from *Occupational Therapy and Physical Therapy: A Resource and Planning Guide.* Madison, WI: Wisconsin Department of Public Instruction, 1996. Pages 180-1. Used with permission.

Sample Job Description

School Occupational Therapy Assistant

Position Summary:

- Provides services to students with exceptional educational needs under the supervision of an occupational therapist;
- Follows a services plan developed by the occupational therapist to improve, develop, restore or maintain students' active participation in self-maintenance, work, leisure and play in educational environments;
- Functions as "related service personnel" under state and federal law and regulations.

Responsible to:

- Director of Special Education; professionally under supervision of a licensed occupational therapist.

Qualifications:

- Completion of an occupational therapy assistant program accredited by the American Occupational Therapy Association;
- Licensed to practice as an occupational therapy assistant in Connecticut;
- Must be supervised by a licensed or registered Occupational Therapist who is responsible for assessments, goals/objectives and triennials.

Job Functions:

Provides occupational therapy services delegated and supervised by a licensed occupational therapist. Under close or general supervision, depending on education experience and service competency, the occupational therapy assistant:

- assists with data collection and evaluation;
- provides direct service according to a written treatment plan that the occupational therapist develops;
- recommends treatment modifications to the occupational therapist based on students' needs;
- adapts environments, tools, materials and activities according to students' needs;
- communicates and interacts with other team members, school personnel, and families in collaboration with an occupational therapist;
- maintains treatment areas, equipment, and supply inventory as the service plan requires;
- maintains records and documentation as the service plan requires;
- participates in policy and procedure development, in collaboration with an occupational therapist.

Adapted from Occupational Therapy and Physical Therapy: A Resource and Planning Guide. Madison, WI: Wisconsin Department of Public Instruction, 1996. Page 182. Used with permission.

Occupational Therapy licensing requires that the individual has:

- attained a bachelor's degree and has graduated from a program accredited by the American Occupational Therapy Association or has completed educational preparation deemed equivalent by the Commissioner of Public Health;
- successfully completed not less than 24 weeks of supervised field work experience at a recognized educational institution or training program approved by the educational institution;
- successfully completed an examination prescribed by the Commissioner. The examination requirement may be waived if:

  a) requirements for certification are equivalent to requirements for licensure in this chapter, or

  b) the applicant is licensed as an OT in another state, District of Columbia or any territory of the U.S. with licensure requirements equivalent to those of this chapter, or

  c) under a limited permit the Commissioner issues, applicants who graduated from an educational program in OT and fulfilled the fieldwork experience requirements. Permits will be in effect until the examination results are announced.

Occupational Therapy Assistant licensing requires that the individual has:

- completed an associates degree or its equivalent and graduated from an educational program approved by the American Occupational Therapy Association or has completed educational preparation deemed equivalent by the Commissioner;
- completed not less than sixteen weeks of supervised field work experience at a recognized educational institution or training program approved by the educational institution where the applicant met the academic requirements; and
- successfully completed an examination prescribed by the Commissioner.

The commissioner may waive examination requirements for:

a) any AOTA-certified occupational therapy assistant, if the commissioner considers their certification requirements equivalent to requirements for licensure in this chapter, or

b) occupational therapy assistants licensed as COTA in another state, District of Columbia, or any territory of the U.S., which has licensure standards equivalent with respect to examination, education and experience.

Occupational therapy assistants can receive a temporary permit prior to licensure, during which they must receive direct, on-site supervision by a licensed OTR.

License renewal is every two years. Therapists and assistants must keep records of continued competency units (OTR: 12 units, and COTA: 9 units) which satisfy renewal requirements, for three years following the license renewal due date. The Connecticut Department of Public Health publishes changes in state requirements (Licensure Law: Chapter 376A, Sec. 20-7A. Renewal and competency chapter 376A, Sec. 20-74a .) (The Connecticut Practice Act for Occupational Therapists and Occupational Therapy Assistant is in the appendices.)

3. Federal Regulations

Under IDEA Part B, occupational therapy is a related service for eligible students ages 3 through 21 who require "…such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education." It includes:

- "Improving, developing or restoring functions impaired or lost through illness, injury or deprivation;
- improving ability to perform tasks for independent functioning when functions are impaired or lost;
- preventing, through early intervention, initial or further impairment or loss of function."

Occupational therapists use purposeful activity to maximize independent function of children with disabilities, prevent disabilities from increasing, and help children achieve and maintain health and productivity. Typically, school occupational therapy helps students assume their role in the educational environment.

4. Supervision and Evaluation

Supervision is a process where two or more people in concert try to promote, establish, maintain and/or elevate the level of performance and service. A mutual undertaking between supervisor and subordinate, supervision fosters growth and development, effectively utilizes training and potential, and encourages creativity. Supervisors provide guidance, support, encouragement and respect while attaining goals. Supervision should promote quality occupational therapy and professional development. The amount of supervision required varies, depending on the occupational therapy practitioner's clinical experience, responsibilities, and expertise. Employment setting, service methods, practitioner competence, and service demands influence supervision quantity, degree and patterns.

Criteria for evaluating OT practitioners can include their skills in: time management, communication, instruction and planning. Also important is their ability to carry out fundamental professional responsibilities and to foster a positive learning climate. Particularly for the inexperienced occupational therapy assistant, it is important to offer constructive feedback during evaluations so that the staff member feels supported and encouraged to improve. (See appendices for sample COTA and OT performance evaluation criteria.)

The American Occupational Therapy Association maintains that persons not trained and qualified as occupational therapy practitioners cannot supervise occupational therapy practice. (OT practitioners include both registered occupational therapists and certified occupational therapy assistants.) Principals or other school administrators may administratively supervise OT practitioners. All OTs and Occupational Therapy Assistants should meet state and federal regulatory mandates, adhere to relevant Association policies on supervision standards, and participate in continuing professional development.

By virtue of their education and training, occupational therapists have ultimate responsibility for services and provide them independently. However the American Occupational Therapy Association recommends entry-level OTs receive close supervision, and intermediate-level OTs receive routine or general supervision. Certified occupational therapy assistants (COTAs) at all levels require at least general supervision by an OT, with additional supervision depending on the COTA's ability to safely and effectively provide interventions the OT delegates. When occupational therapy aides are delegated routine tasks in specific situations, they must perform them under close supervision of an occupational therapist or occupational therapy assistant. These recommendations assume school system structures having same-professional supervision resources; this may not be feasible in small schools.

The OT supervisor should determine supervision methods before entering into a supervisor-subordinate relationship, periodically evaluating methods for effectiveness. OTs have an ethical responsibility to ensure supervision is consistent with the level of role performance and changes with the practice situation.

Supervision occurs along a continuum of close, routine, general and minimal supervision:

- close supervision - daily, direct contact at work site;
- routine supervision - direct contact at least every two weeks at work site, and interim supervision through telephone or written communication;
- general supervision - direct contact at least monthly with supervision available via other methods as needed; and
- minimal supervision - only as needed, possibly less than monthly.

Supervision should be supportive, based on professional goals established annually. Goals may focus on acquiring personal and professional skills and knowledge specific to the educational setting. For each goal, an action plan with timelines can be reviewed at the mid-year and end-of-year conference between supervisor and subordinate. For each of three basic areas of potential impact, supervisors can evaluate, and their staff self-evaluate how well they have:

- impacted student learning;
- contributed to program(s);
- contributed to the organization.

If supervisors are not of the same discipline as the staff they supervise, peer supervisors or consultants should review discipline-specific job responsibilities such as assessment and treatment. Local school district supervisors, usually Special Education Directors, monitor general performance such as attendance, punctuality, and timeliness with documentation. Depending on local school system structure, other areas including task performance fall within the Special Education Director's scope of supervision. Labor agreements may stipulate supervision standards. Additionally, school systems utilizing a case manager system might choose to involve case manager(s) in evaluating how well OTs function in that system.

5. Service Administration

A. Standards for occupational therapy programs should be founded on the principles that pupil services are:

- an integral part of the total education program;
- organized and delivered to help all students achieve maximum benefits from the school program;
- organized and delivered to enable teachers, parents and other members of the school community to provide optimum teaching and learning conditions for students;
- comprehensive in scope, providing for service needs assessment, monitoring and documenting impact; and
- designed and delivered to ensure personal respect for rights and values of all program participants.

B. Service Time requirements for occupational therapy is the sum of time necessary for a variety of functions, including but not limited to:

- screening and evaluation;
- occupational therapy for all students' IEPs;
- required service for students not in IEPs;
- travel;
- supervision and training;
- case management;
- consultation;
- third-party billing;
- documentation for 3rd party payments; and
- documentation and writing reports.

Examples of documentation, records and planning activities are:

- obtaining medical information and medical referrals;
- preparing for IEP meetings;
- developing and revising service delivery plans;
- maintaining attendance records;
- updating progress notes, including those required for third-party billing;
- writing therapy discontinuance reports;
- recording supervision meetings with assistants;
- preparing statistical reports;
- maintaining a record of therapy supplies and equipment; and
- preparing other documentation the LEA requires.

C. Therapy Service may be direct or indirect, in-groups or given individually. Collaboratively, the IEP group decides how much, often and long the LEA will provide a specific related service. Categories of direct or indirect service include:

- screenings;
- assessment/reassessment;
- service delivery;
- team collaboration;
- documentation including team development of IEP;
- monitoring;
- consultation;
- Planning and Placement Team meetings.

D. Caseload estimates should reflect flexibility needed in service delivery, and result from OTs/administration's collaborative planning. Each local education agency establishes workloads. The AOTA (1977) states that previous guidelines recommended each therapist handle 16-43 students, depending on the type, frequency and duration of service, plus travel expectations.

When determining a reasonable workload for a given number of hours, the following variables should be considered:

- amount of intervention time designated to OT practitioner on child's IEP;
- type and amount of new referral for evaluations;
- prereferral or problem-solving activities;
- geographic area to be covered by the OT practitioner and amount of travel time required;
- corollary duties required of the practitioner (such as in-services to other staff members, required in-service attendance, or staff meetings that are not specifically child focused);
- amount of support available from aides, assistants, and clerical personnel;
- amount of time needed for teaming with staff, parents, and other agencies;
- supervisory duties of other staff (COTA, aides);
- amount of time needed for agency and professional documentation;
- time commitment as service coordinator or case manager.

The therapist should set aside sufficient hours for communication with educational personnel and families, and liaison to the medical community. Paraprofessional training and staff in-services, and documentation also uses considerable OT time.

E. Other School Policies should be familiar to the occupational therapist who should also know local implementation policies. If LEA policies conflict with professional ethics, the latter should override the former. Administrative support is necessary to resolve such conflicts in a manner that does not jeopardize licensure of the occupational therapist. Many specific procedures related to OT services within school settings are determined locally, such as:

- policy on contacting parents;
- attendance at Planning and Placement Team meetings;
- designation of case managers; and
- specific referral procedures.

6. Staff Development

A variety of resources and approaches for professional development exist to help occupational therapists keep current on the many changes in service delivery and laws/regulations. University-based programs may not offer courses related to school settings. Sources for more targeted training include: mentoring arrangements, state- and AOTA-sponsored seminars and conferences, pre- and post-professional practicum opportunities, and professional literature. A pilot Regional Support Group sponsored by LEARN (see appendix "Contacts") anticipates continuing its professional network/sharing opportunities in future years. Professional development resources in these *Guidelines* include:

- bibliography (partial listing – extensive list at SERC);
- list of state resources/contacts;
- list of out-of-state sources; and
- SERC available journals list.

The Special Education Resource Center (SERC) in Middletown, Connecticut assists professionals and parents as they endeavor to provide an appropriate education for students and adults with special needs. SERC's array of services, information and resources include:

- library services: extensive collection of books, journals, tests, pamphlets;
- research abstracts and indexes, references and in-service materials (see sample list in appendices);
- information/publication dissemination on programs and services in Connecticut;
- Child Find, which helps identify children who need services;
- the SERC Newsletter, published several times a year, containing announcements about training's and other activities/developments;
- in-service programs, seminars and conferences at SERC or at various locations throughout the state.

The six Regional Educational Service Centers offer technical assistance to school in their districts (See full names and contact details in appendices):

ACES, Hamden
CES, Trumbull
CREC, Hartford
LEARN, Old Lyme
EASTCONN, North Windham
EDUCATION CONNECTION, Litchfield

Ultimately the occupational therapy practitioner's responsibility, professional development is important for keeping current with changes in education regulations, professional standards, and new knowledge concerning best practice for therapists in school settings.

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Appendices

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Abbreviations & Acronyms

ADA	Americans with Disabilities Act
AES	Alternative Educational Setting
AOTA	American Occupational Therapy Association
APTA	American Physical Therapy Association
C.F.R.	Code of Federal Regulations
COTA	Certified Occupational Therapy Assistant
FAPE	Free Appropriate Public Education
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
LEA	Local Education Agency
LRE	Least-Restrictive Environment
OT	Occupational Therapy
OTR	Registered Occupational Therapist
PT	Physical Therapy or Physical Therapist
PTA	Physical Therapist Assistant
U.S.C.	United States Code

Glossary

adapted physical education
specially designed instruction as prescribed in the IEP which allows students opportunity for active participation in developing physical and motor fitness, fundamental motor skills and patterns, and skills in aquatics, dance and individual and group games and sports, including intramural and lifetime sports appropriate to their individual needs.

adaptive skills
those skills used in daily living such as eating, dressing, sleeping.

advocacy
accessing information and acting on behalf of students' best interest.

assessment
specific tools or instruments used during the evaluation process.

assistive technology
may be part of students' supplementary aids and services, special education, or related services. An assistive technology device is any item, piece of equipment or product system that is used to increase, maintain, or improve the functional capabilities of students with disabilities. Devices can be acquired commercially and used off-the-shelf, modified, or customized to meet the students' needs. An assistive technology service directly helps students with disabilities to select, acquire or use an assistive technology device. A school occupational therapist or school physical therapist may be involved in providing an assistive technology service.

cognitive
ability to learn, understand and problem-solve.

curriculum-based assessment
using teaching curriculum as a criterion or reference to develop students' mastery. For example the third grade curriculum may be multiplication; assessments would evaluate whether or not students have mastered the curriculum content being taught in that third grade class.

developmental delay
being behind other students of the same age in one or more areas of development.

evaluation
the process of obtaining and interpreting data necessary for intervention-- includes planning for and documenting the evaluation process and results.

free appropriate public education
(FAPE) special education and related services provided at public expense under public supervision and at no charge; that meet the standards of the State educational agency; including an appropriate preschool, elementary or secondary school education in the State; and that is provided in conformity with the IEP.

goal-attainment scaling
an effective method of evaluating student performance in school-based occupational therapy practice, which determines whether student goals have been attained.

individualized education program
(IEP) a written statement for a student with a disability that is developed and implemented in accordance with 34 CFR 300.341-300.350. The IEP team determines special education and related services necessary to accomplish the goals, and determines the student's placement. The team initiates and conducts meetings to periodically review and, if appropriate, revise each student's

individualized education program. The team develops an individualized education program before the student receives special education and related services, and implements the IEP as soon as possible following an IEP meeting.

interdisciplinary team

comprised of professionals from various disciplines whose members use their skills and knowledge to work together on common purposes - they plan, coordinate and deliver services collaboratively.

least restrictive environment

(LRE) a key principle in the special education process. The law requires that to the maximum extent appropriate, school districts educate students with disabilities with students who do not have disabilities. The team, which develops the student's IEP, determines the extent to which a student will participate in the general education program. The team may remove a student from the general education environment only when teachers cannot educate the student satisfactorily in the general classroom using supplementary aids and services. In non-academic and extra curricular activities, such as meals, recess periods, clubs, athletics and student employment opportunities, each student with a disability has the right to participate with students who do not have disabilities.

multidisciplinary team

comprised of professionals from various disciplines whose members are responsible for common students or purposes, but use their skills and knowledge independently, periodically informing other team members.

occupational therapy

(OT) uses purposeful activity to maximize independence, prevent disability and maintain health among individuals with physical injury, illness, psychosocial dysfunction, developmental or learning disabilities. It teaches/develops skills such as: perceptual-motor, sensory integrative, daily living, psychosocial, prevocational, and play/leisure. The practice includes posture rehabilitation, tests and measurements of neuromuscular function, and treatment such as orthotic/prosthetic devices, adaptive equipment, and environmental adaptations. School based OT practice is limited to educationally related services. The Code of Federal Regulations (C.F.R.), I.D.E.A. Part B. defines occupational therapy as a related service.

Planning and Placement Team

(PPT) the group of public school team members who make decisions about identification, evaluation, services and placement for children aged 3-21 who receive special education and related services.

performance assessments

efforts to develop reliable and valid tests of how students perform in academic tasks as compared to merely measuring their knowledge of academic content.

portfolio assessments

evaluating or assessing student performance based on student work samples. The two main types are: looking at all work samples produced by a particular student from a specified period of time; and letting students select samples that they wish to submit for evaluation and assessment.

physical therapy

(PT) prevents or minimizes disability, relieves pain, develops and improves motor function, controls postural deviations, and establishes and maintains maximum performance within the individual's physical capabilities. PT's serves individuals with handicapping conditions resulting from prenatal causes, birth trauma, illness or injury. In an educational setting, PT services enable students with disabilities to benefit from special education in the least restrictive environment, through maximizing students' physical potential for independence and modifying/adapting students' physical environment.

qualified individual

per the 1973 Rehabilitation Act, Section 504, in public preschool, elementary and secondary schools, a qualified individual is an individual with disabilities who has (1) a physical or mental impairment which substantially limits one or more major life activities; or (2) a record or history of such an impairment; or (3) no physical or mental impairment that substantially limits a major life activity but the individual person is treated by the school district as having such a limitation. Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for one's self and performing manual tasks. The disability need only substantially limit one major life activity for the student to be considered as a qualified individual under Section 504.

rating scales

used to rate or judge the components required to perform a task at competency level. It requires task analysis, using a modified Likert-type scale to award points if students perform the task components. The performance criterion can be whatever is judged necessary.

related services

those necessary to assist students with disabilities to benefit from special education. IDEA specifically includes occupational therapy and physical therapy as related services.

screening

method to verify if students need further diagnostic evaluation, which takes a general, broad view of student skills.

special education

instruction that a team of school staff and parents specially designs to meet the unique needs of students with disabilities, and that the school provides at no cost to parents. It may include instruction in the: classroom, physical education, home, hospital, institution and other settings. A team, which evaluated the student, considers special education when general education with supplementary aids and services is insufficient to meet a student's educational needs. A student's special education program includes special education teacher services or a physical education teacher when specially designed physical education is used to implement the IEP.

transdisciplinary team

comprised of professionals from various disciplines who share expertise, skills and knowledge with each other; sharing roles when working together on common students or purposes. They plan collaboratively, train one another, and deliver services by sharing roles and responsibilities.

transition services

a coordinated set of activities for students, designed within an outcome-oriented process, that promotes movement from school to post-school activities, including: post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living or community participation. The IEP must include a statement of transition services needed for each student 14 years of age or older.

SAMPLE FORMS

[sample for consideration]

Pre-Referral Motor Screening Checklist

Child's Name: _____

DOB: _____ Grade: _____

Please initial after completing checklist. Input needed from all staff listed below:

classroom teacher: _____
special ed. teacher: _____
physical ed. teacher: _____

Check the problems below, which apply to this student. If not applicable, please state N/A

A. Poor Posture:
- ____ Head held to one side
- ____ Shoulder - one higher than the other
- ____ Hip - one higher than the other
- ____ Bowlegged
- ____ Knock Knees
- ____ Slouches

B. Clumsiness, Poor Coordination, Poor Awareness of Space:
- ____ Poor Balance
- ____ Falls Easily
- ____ Runs into chairs, desks
- ____ Trouble catching, kicking or throwing a ball
- ____ Cannot learn new motor activities or games
- ____ Behind others in motor skills
- ____ Poor use of one side of body
- ____ Makes facial grimaces or uncontrolled movements when working
- ____ Other: _____

C. Excessive Restlessness:
- ____ Cannot sit still, fidgets
- ____ Other: _____

D. Weakness or Floppiness of Arms or Legs:
- ____ Cannot easily get up from floor, chair
- ____ Trouble going up or down stairs
- ____ Appears to fatigue easily
- ____ Seems weak or stronger than normal
- ____ Other: _____

E. Breathing Problems:
- ____ Difficulty breathing
- ____ Becomes short of breath
- ____ Chronic congestion
- ____ Other: _____

F. Fine Motor Problems
- ____ Difficulty manipulating small objects (pegs, beads, coins)
- ____ Difficulty using scissors, coloring, writing Please specify _____
- ____ Abnormal Pencil Grip (holds tightly or weakly, immature grasp)
- ____ Jerky or tremor-like motions in hands when drawing
- ____ Difficulty staying on lines when tracing
- ____ Eyes do not follow hands, seem to wander
- ____ Difficulty using isolated finger movements (Uses arm & hand as one unit when writing)

G. Unusual Walking Pattern:
- ____ Limp
- ____ Feet turned in or out excessively
- ____ Walks on toes
- ____ Walks on heels
- ____ Drags one leg
- ____ Other: _____

H. Seems Excessively Distracted by Stimulation
- ____ Dislikes light touch or being touched
- ____ Overreacts to unexpected touch or sound
- ____ Unable to calm down after motor activity
- ____ Other: _____

I. Trouble with Attention:
- ____ Is lethargic at times
- ____ Stares blankly on occasion
- ____ Frequently misses directions
- ____ Has wandering eyes--cannot focus
- ____ Other: _____

J. Pain or Discomfort:
- ____ Unusual or chronic complaints
- ____ Other: _____

K. Equipment:
- ____ Wears braces, uses wheelchair, crutches or other appliances
- ____ (or)you feel student may benefit from these
- ____ Please specify: _____

L. Basic Sensory Functioning:
- ____ Pushes, shoves, kicks when standing in lines
- ____ Dislikes being touched
- ____ Prefers touching rather than being touched
- ____ Difficulty identifying objects by touch alone
- ____ Excessive mouthing of objects
- ____ Cannot find body parts with eyes closed
- ____ Fearful of movement (example: going up and down stairs)
- ____ Never gets dizzy (craves spinning & rolling)
- ____ Gets dizzy easily (avoids spinning & rolling)

M. Visual Perceptual Problems:
- ____ Has a diagnosed visual defect
- ____ Poor understanding of spatial concepts (large, small, and numbers)
- ____ Poor directional concepts (up, down, right, left, in, out)
- ____ Difficulty putting puzzles together
- ____ Difficulty recognizing shapes and colors
- ____ Difficulty identifying object from background
- ____ Poor spacing of work on paper
- ____ Reverses letters, numbers, words or phrases
- ____ Difficulty eye tracking

N. Auditory sensation
- ____ Overly sensitive to noise
- ____ Misses sounds
- ____ Likes to make loud noises
- ____ Has hearing loss

O. Social/Emotional Problems
- ____ Verbally aggressive
- ____ Behavior bothers others
- ____ Happiest playing alone, isolates self
- ____ Cries easily
- ____ Fearful of new situations
- ____ Easily frustrated
- ____ Falls asleep in class
- ____ Can't calm down
- ____ Physically aggressive
- ____ Attention seeking
- ____ Impulsive
- ____ Lacks confidence

P. Bilateral Integration Problems:
- ____ Avoids or has difficulty performing tasks which require eyes or extremities to cross midline
- ____ Neglects or seems unaware of one side
- ____ Doesn't stabilize paper while writing
- ____ Seems to ignore half of a page
- ____ Has an inconsistent hand dominance
- ____ Always uses both hands together

Q. Learning Behavior:
- ____ Short attention span
- ____ Difficulty with change in routine
- ____ Difficulty recognizing own errors
- ____ Difficulty working independently:
  - _____ slow worker
  - _____ easily distracted
  - _____ perservates
  - _____ disorganized, messy
  - _____ talks aloud, hums, sings
  - _____ rushes through work

R. Activities of daily living
- ____ Trouble dressing/undressing (or fastening, buttoning, zipping, shoe tying)
- ____ Needs assistance when toileting
- ____ Trouble grooming (teeth, face)
- ____ Trouble eating (Please explain: _____
  _____
- ____ Drools:
  - _____ always
  - _____ only under stress
  - _____ only when eating
- ____ Avoids eating certain textures of food

How do these problems affect his/her learning?

_____

_____

Comments or additional observations:

Please complete -- school nurse will have information: (please print)

Any known medications: _____

Any known surgery: _____

Any known seizures: If yes, type: _____ Frequency: _____

Other agencies involved: _____

Child's physician: _____

Address: _____

Telephone Number: _____

Any previous OT or PT Therapy: _____ Yes _____ No

If yes, please indicate if reports are available: _____ Yes _____ No

Adapted from: *Guidelines for Providing Occupational, Physical and Speech/Language Therapy in the Schools.* Fairfield, CT: related Services Task Force, Fairfield County and Cooperative Educational Services, 1993. Used with permission.

[sample for consideration]

Motor Screening

Name: _____ DOB: _____
Test date: _____ Examiner: _____
Chronological age: _____

Behaviors noted during screening: _____

_____

Screening strategies used: _____

_____

Functional level: _____

_____

Comments: _____

_____

Fine motor: _____

_____

Screening strategies used: _____

_____

Functional level: _____

_____

Comments: _____

_____

Self care: _____

_____

Screening strategies used: _____

_____

Functional level: _____

_____

Comments: _____

_____

Summary: _____

_____

Recommendations: _____

_____

Adapted from: Dunn, W. *Pediatric Occupational Therapy: Facilitating Effective Service Provision.* Thorofare, NJ: Slack, 1991. Used with permission.

[sample for consideration]

Teacher Questionnaire

Referral Form for Occupational Therapy

Child's Name: _____ Grade: _____

Date: _____ Teacher: _____

School: _____

Teacher making referral: _____

Teachers: Please check the following behaviors that correspond to the concerns you have regarding your student.

____ 1. Demonstrates mixed hand dominance in classroom activities.

____ 2. Grasps pencil/crayon improperly.

____ 3. Does not perform deskwork from left to right.

____ 4. Does not know left from right on self.

____ 5. Has difficulty staying on line and spaces when writing and printing.

____ 6. Has difficulty copying from board or text.

____ 7. Reverses letters/shapes in writing/drawing.

____ 8. Has difficulty completing activities on time.

____ 9. Has difficulty following verbal directions.

____ 10. Has difficulty following written directions.

____ 11. Has difficulty maintaining self in seat for reasonable length of time.

____ 12. Is clumsy at recess, gym, or in classroom.

____ 13. Avoids physical activities with peers.

____ 14. Has extreme reaction to being touched.

____ 15. Has excessively high overall activity level.

____ 16. Has excessively low overall activity level.

____ 17. Projects poor self image.

Adapted from: Gifoyle, E.M. (Ed). *Training: Occupational Therapy Education Management in Schools.* Rockville, MD: American Occupational Therapy Association, 1981. Used with permission.

Classroom Observation

Name: _____ Date: _____ Grade: _____

School: _____ Teacher: _____ Activity: _____

1. Height of chair and desk

   _____

2. Placement of chair

   _____

3. Organization of materials on desk

   _____

4. Placement in room

   _____

5. Writing tool

   _____

6. Attention to task

   _____

7. Grasp

   _____

8. Manuscript

   _____

    1. Handedness _____
    2. Type of paper _____
    3. Placement of paper on desk _____
    4. Quality _____
        1. letter formation _____
        2. spacing _____
        3. placement on lines _____
        4. letter size consistency _____
        5. letter or number reversals _____
        6. print name correctly and legibly _____
        7. ability to adapt letter size to space on paper _____

Observations and suggestions:

_____

_____

_____

Adapted from: Dunn, W. *Pediatric Occupational Therapy: Facilitating Effective Service Provision.* Thorofare, NJ: Slack, 199l. Used with permission.

[sample for consideration]

Referral for Assessment

Name: _____ DOB: _____ Grade: _____

School: _____ Teacher: _____ Date: _____

GROSS MOTOR:

_____ Seems weaker than others his age
_____ Difficulty with hop, jump, skip or run
_____ Appears stiff and awkward in his movements
_____ Clumsy, seems not to know how to move body, bumps into things, falls out of chair
_____ Tendency to confuse right and left

FINE MOTOR:

_____ Poor desk posture (slumps, leans on arm, head too close to work, other hand does not assist)
_____ Difficulty drawing, coloring copying, cutting, avoidance of these activities
_____ Poor pencil grasp, drops pencil frequently
_____ Hand dominance
_____ Quality of written work - too faint, too hard; breaks pencil often

TACTILE SENSATION:

_____ Seems to withdraw from touch
_____ Has trouble keeping hands to self
_____ Apt to touch everything he sees
_____ Dislikes being hugged

VESTIBULAR SENSATION:

_____ Fearful of activities moving through space (swing, teeter totter)
_____ Avoids activities that challenge balance
_____ Excessive craving for swinging, bounding, slides, etc.

VISUAL PERCEPTION:

_____ Difficulty discriminating colors, shapes, doing puzzles
_____ Letter reversals after first grade
_____ Difficulty tracking - following objects with eyes holding head still
_____ Difficulty copying designs, numbers or letters

ADDITIONAL CONCERNS OR COMMENTS:

_____

_____

_____

_____

From: Dunn, W. Pediatric Occupational Therapy: Facilitating Effective Service Provision". Thorofare, NJ: Slack, 1991. Used with permission.

[sample for consideration]

LIST OF TOOLS (Annotated)

ECOLOGICAL ASSESSMENT/INTERVENTION

[sample for consideration]

This is one of many assessment tools. It should be viewed as a sample of an ecological inventory. It does not need to be used in part or whole when evaluating children

L E A R N

ECOLOGICAL INVENTORY

ASSESSMENT MANUAL

and

CURRICULUM GUIDE

Compiled by:
Patricia Davis, MS, CCC-SLP
Patricia Harper, MS, Special Educator

Diane Scully, BS, OT

IDEA Summary and Excerpts

IDEA 1977 AMENDMENTS - Summary

The original 1975 Public Law 94-142 has been amended many times. The latest amendments focus on seven areas key to physical and occupational therapy: State/district-wide assessments, IEP's, parent participation, evaluations, transition planning, voluntary mediation, and discipline/behavior.

State/district-wide assessments - States required to include children with disabilities, with accommodations when necessary, in State and district-wide assessment (testing) programs.

charter and private schools - children with disabilities must also be identified and under certain conditions receive special education services

children in adult prisons - will receive special education and related services through the state-designated agency

IEP's - in addition to previous IDEA requirements, must include information on:

a) how the child's disability affects involvement and progress in the general curriculum
b) special education, related services, and supplementary aids/services child needs to: be involved and progress in the general curriculum; participate in extracurricular and other nonacademic activities; and be educated and participate with other children with disabilities and nondisabled children
c) extent to which child will not participate with nondisabled children in general education, extracurricular and non-academic activities.
d) how State/district-wide assessments will be modified so student can participate. If student cannot, why and alternatives
e) transition service needs starting at age 14
f) how students will be informed about rights at age of majority, and parents regularly informed about child's progress meeting annual IEP goals

IEP's - general educator role in IEP development increased, and "special factors" to consider added:

a) behavior strategies if child's behavior impedes his or others' learning
b) child's language needs related to IEP if limited English proficiency
c) Braille instruction if blind/visually impaired
d) communication needs and specific factors if deaf/hard of hearing
e) whether child needs assistive devices and services.

IEP's - reviews and revisions:

a) at least annually, revision as needed
b) schools must report to parents on progress of child with disabilities at least as frequently as progress of nondisabled children reported
c) if child not making expected progress toward annual goals and in general curriculum, IEP team must meet and revise IEP

Reevaluations - IEP team *is not required to reevaluate child if* they reviewed existing evaluation data and sought parent input and could determine there is enough information to decide whether:

a) child continues to have a disability and need special education and related services
b) child's present levels of performance and educational needs
c) whether modifications to special education and related services needed for child to meet IEP goals and participate in general curriculum.

parents - must be:

a) included in group making eligibility and placement decisions
b) notified that IEP team determines reevaluation not needed
c) informed of right to request their child be reevaluated
d) asked for consent to reevaluate child

e) allowed to review all records

mediation - becomes primary process to resolve conflicts between school and parents of a child with disability. State must ensure it is voluntary, maintain list of qualified mediators, and pay for mediators.

discipline/behavior - issues, definitions, situations covered include: weapon or illegal drugs, alternative educational placements, hearing officer role, "substantial" evidence, "manifestation" determination reviews (Md.'s), appeals, referral to law enforcement and judicial authorities.

a) when disciplinary action considered, must have MDR to assess relationship between the child's disability and the behavior subject to the disciplinary action

b) the IEP team and other qualified personnel conduct MDR. They "may determine that the behavior of the child was not a manifestation of such child's disability only if the IEP Team:
(i) first considers, in terms of the behavior subject to disciplinary action, all relevant information, including - (I) evaluation and diagnostic results, including such results or other relevant information supplied by the parents of the child; (II) the child's disability did not impair the ability of the child to understand the impact and consequences of the behavior subject to disciplinary action; and (III) the child's disability did not impair the ability of the child to control the behavior subject to disciplinary action." [Section 615(k)(4)(C)]

c) a child who violated a rule or code of conduct can assert protections of the Act if the LEA had knowledge of the disability through: the parent expressing concern in writing or requesting an evaluation; the child's behavior or performance indicating services are needed; or "(iv) the teacher of the child or other personnel of the local educational agency has expressed concern about the behavior or performance of the child to the director of special education of such agency or to other personnel of the agency". (Sec 615(k)(8)(B)]

developmental delay - at State's discretion, children with disabilities ages 3-9 can include a child: "(1) experiencing developmental delays, as defined by the State and as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development"

related services - specifically includes orientation and mobility services. Also, "related services" now included in definition of transition services [Section 602(30)]

supplementary aids and services - defined as "...aids, services, and other supports that are provided in regular education classes or other education-related settings to enable children with disability to be educated with nondisabled children to the maximum extent appropriate in accordance with section 612(a)(5)." [latter section refers to least restrictive environment requirements]

procedural safeguards - requirements for nondiscriminatory testing: "Additional procedural safeguards.- Procedures to ensure that testing and evaluation materials and procedures utilized for the purposes of evaluation and placement of children with disabilities will be selected and administered so as not to be racially or culturally discriminatory. Such materials or procedures shall be provided and administered in the child's native language or mode of communication, unless it is clearly not feasible to do so, and no single procedure shall be the sole criterion for determining an appropriate educational program for a child." [Section 612(a)(6)(B)]

performance goals and indicators - States must establish performance goals and progress indicators for children with disabilities.

Reference: ~~News Digest~~. Volume 26. National Information Center for Children and Youth with Disabilities. August 1997.

EXCERPTS FROM GOVERNMENT WEB PAGE - 1997 IDEA AMENDMENTS

(a) Evaluations and Reevaluations. - -

(1) Initial Evaluations. - -

(A) In general. - - A State educational agency, other State agency, or local educational agency shall conduct a full and individual initial evaluation, in accordance with this paragraph and subsection (b), before the initial provision of special education and related services to a child with a disability under this part.

(B) Procedures. - - Such initial evaluation shall consist of procedures - -

(i) to determine whether a child is a child with a disability (as defined in section 602(3));

(ii) to determine the educational needs of such child.

(C) Parental Consent. - -

(i) In general. - - The agency proposing to conduct an initial evaluation to determine if the child qualifies as a child with a disability as defined in section 602(3)(A) or 602(3)(B) shall obtain an informed consent from the parent of such child before the evaluation is conducted. Parental consent for evaluation shall not be construed as consent for placement for receipt of special education and related services.

(ii) Refusal. - - If the parents of such child refuse consent for the evaluation, the agency may continue to pursue an evaluation by utilizing the mediation and due process procedures under section 615, except to the extent inconsistent with State law relating to parental consent.

(2) Reevaluations. - - A local educational agency shall ensure that a reevaluation of each child with a disability is conducted - -

(A) if conditions warrant a reevaluation or if the child's parent or teacher requests a reevaluation, but at least once every 3 years; and

(B) in accordance with subsections (b) and (c).

(b) Evaluation Procedures. - -

(1) Notice. - - The local educational agency shall provide notice to the parents of a child with a disability, in accordance with subsections (b)(3), (b)(4), and (c) of section 615, that describes any evaluation procedures such agency proposes to conduct.

(2) Conduct of Evaluation. - - In conducting the evaluation, the local educational agency shall - -

(A) use a variety of assessment tools and strategies to gather relevant functional and developmental information, including information provided by the parent, that may assist in determining whether the child is a child with a disability and the content of the child's individualized education program, including information related to enabling the child to be involved in and progress in the general curriculum or, for preschool children, to participate in appropriate activities;

(B) not use any single procedure as the sole criterion for determining whether a child is a child with a disability or determining an appropriate educational program for the child;

(C) use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.

(3) Additional Requirements- Each local educational agency shall ensure that - -

(A) tests and other evaluation materials used to assess a child under this section

(i) are selected and administered so as not to be discriminatory on a racial or cultural basis;

(ii) are provided and administered in the child's native language or other mode of communication, unless it is clearly not feasible to do so; and

(B) any standardized tests that are given to the child - -

(i) have been validated for the specific purpose for which they are used;

(ii) are administered by trained and knowledgeable personnel; and

(iii) are administered in accordance with any instructions provided by the producer of such tests;

(C) the child is assessed in all areas of suspected disability; and

(D) assessment tools and strategies that provide relevant information that directly assists persons in determining the educational needs of the child are provided.

(4) Determination of Eligibility. - - Upon completion of administration of tests and other evaluation materials - -

(A) the determination of whether the child is a child with a disability as defined in section 602(3) shall be made by a team of qualified professionals and the parent of the child in accordance with paragraph (5); and

(B) a copy of the evaluation report and the documentation of determination of eligibility will be given to the parent.

(5) Special Rule for Eligibility Determination. - - In making a determination of eligibility under paragraph (4)(A), a child shall not be determined to be a child with a disability if the determinant factor for such determination is lack of instruction in reading or math or limited English proficiency.

(c) Additional Requirements for Evaluation And Reevaluations. - -

(1) Review of Existing Evaluation Data. - - As part of an initial evaluation (if appropriate) and as part of any reevaluation under this section, the IEP Team described in subsection (d)(1)(B) and other qualified professionals, as appropriate, shall - -

(A) review existing evaluation data on the child, including evaluations and information provided by the parents of the child, current classroom-based assessments and observations, and teacher and related services providers observation; and

(B) on the basis of that review, and input from the child's parents, identify what additional data, if any, are needed to determine - -

(i) whether the child has a particular category of disability, as described in section 602(3), or, in case of a reevaluation of a child, whether the child continues to have such a disability;

(ii) the present levels of performance and educational needs of the child;

(iii) whether the child needs special education and related services, or in the case of a reevaluation of a child, whether the child continues to need special education and related services; and

(iv) whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the individualized education program of the child and to participate, as appropriate, in the general curriculum.

(2) Source of Data. - - The local educational agency shall administer such tests and other evaluation materials as may be needed to produce the data identified by the IEP Team under paragraph (1)(B).

(3) Parental Consent. - - Each local educational agency shall obtain informed parental consent, in accordance with subsection (a)(1)(C), prior to conducting any reevaluation of a child with a disability, except that such informed parent consent need not be obtained if the local educational agency can demonstrate that it had taken reasonable measures to obtain such consent and the child's parent has failed to respond.

(4) Requirements if Additional Data are not Needed. - - If the IEP Team and other qualified professionals, as appropriate, determine that no additional data are needed to determine whether the child continues to be a child with a disability, the local educational agency - -

(A) shall notify the child's parents of - -

(i) that determination and the reasons for it; and

(ii) the right of such parents to request an assessment to determine whether the child continues to be a child with a disability; and

(B) shall not be required to conduct such an assessment unless requested to by the child's parents.

(5) Evaluations Before Change in Eligibility. - - A local educational agency shall evaluate a child with a disability in accordance with this section before determining that the child is no longer a child with a disability.

(d) Individualized Education Programs. - -

(1) Definitions. - - As used in this title:

(A) Individualized Education Program. - - The term 'individualized education program' or 'IEP' means a written statement for each child with a disability that is developed, reviewed, and revised in accordance with this section and that includes - -

(i) a statement of the child's present levels of educational performance, including - -

(I) how the child's disability affects the child's involvement and progress in the general curriculum; or

(II) for preschool children, as appropriate, how the disability affects the child's participation in appropriate activities;

(ii) a statement of measurable annual goals, including benchmarks or short-term objectives, related to - -

(I) meeting the child's needs that result from the child's disability to

enable the child to be involved in and progress in the general curriculum; and

(II) meeting each of the child's other educational needs that result from the child's disability;

(iii) a statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child - -

(I) to advance appropriately toward attaining the annual goals;

(II) to be involved and progress in the general curriculum in accordance with clause (i) and to participate in extracurricular and other nonacademic activities; and

(III) to be educated and participate with other children with disabilities and nondisabled children in the activities described in this paragraph;

(iv) an explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in the activities described in clause (iii);

(v) (I) a statement of any individual modifications in the administration of State or district-wide assessments of student achievement that are needed in order for the child to participate in such assessment; and

(II) if the IEP Team determines that the child will not participate in a particular State or district-wide assessment of student achievement (or part of such an assessment), a statement of - -

(aa) why that assessment is not appropriate for the child; and

(bb) how the child will be assessed;

(vi) the projected date for the beginning of the services and modifications described in clause (iii), and the anticipated frequency, location, and duration of those services and modifications;

(vii) (I) beginning at age 14, and updated annually, a statement of the transition service needs of the child under the applicable components of the child's IEP that focuses on the child's courses of study (such as participation in advanced - placement courses or a vocational education program);

(II) beginning at age 16 (or younger, if determined appropriate by the IEP Team), a statement of needed transition services for the child, including, when appropriate, a statement of the interagency responsibilities or any needed linkages; and

(III) beginning at least one year before the child reaches the age of majority under State law, a statement that the child has been informed of his or her rights under this title, if any, that will transfer to the child on reaching the age of majority under section 615(m); and

(viii) a statement of - -

(I) how the child's progress toward the annual goals described in clause (ii) will be measured; and

(II) how the child's parents will be regularly informed (by such means as periodic report cards), at least as often as parents are informed of their nondisabled children's progress, of - -

(aa) their child's progress toward the annual goals described in clause (ii); and

(bb) the extent to which that progress is sufficient to enable the child to achieve the goals by the end of the year.

(B) Individualized Education Program Team. - - The term 'individualized education program team' or 'IEP Team' means a group of individuals composed of - -

(i) the parents of a child with a disability;

(ii) at least one regular education teacher of such child (if the child is, or may be, participating in the regular education environment);

(iii) at least one special education teacher, or where appropriate, at least one special education provider of such child;

(iv) a representative of the local educational agency who - -

(I) is qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of children with disabilities;

(II) is knowledgeable about the general curriculum; and

(III) is knowledgeable about the availability of resources of the local educational agency;

(v) an individual who can interpret the instructional implications of evaluation results, who may be a member of the team described in clauses (ii) through (vi);

(vi) at the discretion of the parent or the agency, other individuals who have knowledge or special expertise regarding the child, including related services personnel as appropriate; and

(vii) whenever appropriate, the child with a disability.

(3) Development of IEP. - -

(A) In General. - - In developing each child's IEP, the IEP Team, subject to subparagraph (C), shall consider - -

(i) the strengths of the child and the concerns of the parents for enhancing the education of their child; and

(ii) the results of the initial evaluation or most recent evaluation of the child.

(B) Consideration of Special Factors - The IEP Team shall - -

(i) in the case of a child whose behavior impedes his or her learning or that of others, consider, when appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior;

(ii) in the case of a child with limited English proficiency, consider the language needs of the child as such needs relate to the child's IEP;

(v) consider whether the child requires assistive technology devices and services.

(C) Requirement with Respect to Regular Education Teacher - The regular education teacher of the child, as a member of the IEP Team, shall, to the extent appropriate,

participate in the development of the IEP of the child, including the determination of appropriate positive behavioral interventions and strategies and the determination of supplementary aids and services, program modifications, and support for school personnel consistent with paragraph (1)(A)(iii).

(4) Review and Revision of IEP -

(A) In General - The local educational agency shall ensure that, subject to subparagraph (B), the IEP Team -

(i) reviews the child's IEP periodically, but not less than annually to determine whether the annual goals for the child are being achieved; and

(ii) revises the IEP as appropriate to address - -

(I) any lack of expected progress toward the annual goals and in the general curriculum, where appropriate;

(II) the results of any reevaluation conducted under this section;

Source- http://www.ed.gov/offices/OSERS/IDEA

Professional Development Resources

RESOURCES Contact Information

American Occupational Therapy Association, Inc.
4720 Montgomery Lane, P.O. Box 31220
Bethesda, MD 20824-1220

American Physical Therapy Association
111 North Fairfax Street
Alexandria, VA 22314
(800) 999-APTA

Brain Injury Association of Connecticut
(800) 278-8242

Child Abuse & Neglect (Connecticut)
(800) 842-2288

Child Find
(800) 842-6878

Connecticut Board of Education & Services for the Blind
(800) 842-4510

Connecticut Commission on the Deaf & Hearing Impaired
(800) 708-6796

Connecticut Occupational Therapy Association
125 Douglas Street
Hartford, CT 06114
(860) 956-0555

Connecticut Physical Therapy Association
330 Main Street
Hartford, CT 06106
(860) 246-4414

Department of Children and Families
505 Hudson Street
Hartford, CT 06105
(860) 550-6484

Department of Education
165 Capitol Avenue
Hartford, CT
(860) 566-5497

Department of Labor
Occupational Safety and Health
200 Folly Brook Blvd.
Wethersfield, CT 06109
(860) 566-4380

Department of Mental Health and Addiction Services
410 Capitol Avenue
Hartford CT 06106
(860) 418-7000

Department of Public Health
410/450 Capitol Avenue
Hartford CT 06106
(860) 509-8000

School and Adolescent Health Program
(860) 509-8057

Children With Special Health Care Needs
(860) 509-8074

Licensing: Occupational Therapists & Assistants
(860) 509-7561

Licensing: Physical Therapists
(860) 509-7566

INFO-LINE
(800) 203-1234

Medicaid
(860) 566-5900
TDD/TT 566-7013

New England SERVE
101 Tremont Street
Suite 812
Boston, MA 02108
(617) 574-9493

Office of Protection and Advocacy for Persons with Disabilities
60 B Weston Street
Hartford CT 06120
(800) 842-7303

REGIONAL EDUCATIONAL SERVICE CENTERS IN CONNECTICUT:

Area Cooperative Educational Services **(ACES)**
205 Skiff Street
Hamden, CT 06517-1095
Tel 407-4400. Fax 407-4590.
young@aces.k12ct.us

Capitol Region Education Council **(CREC)**
111 Charter Oak Avenue
Hartford, CT 06106-1912
Tel (860) 247-CREC (2732). Fax 246-3304
jallison@crec.org

Cooperative Educational Services **(CES)**
25 Oakview Drive
Trumbull, CT 06611
Tel (203)365-8800. Fax 365-8804

EASTCONN
376 Hartford Turnpike
North Windham, CT 06256-1612
Tel (860)455-0707. Fax 455-0691
dcalcher@eastconn.k12.ct.us

EDUCATION CONNECTION
355 Goshen Road, P.O. Box 909
Litchfield, CT 06759-0909
Tel (860)567-0863. Fax (860)567-3381
tedder@educationconnection.k12.ct.us

LEARN
44 Hatchett Hill Road
P.O. Box 805
Old Lyme, CT 06371
Tel (860)434-4800. Fax 434-4837
vseccomb@learn.k12.ct.us

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RESOURCES- SERC Library

Sample Listing of Journals and Newsletters

Access Review
Active Living
Adapted Physical Activity Quarterly
ADHD Report
American Journal of Occupational Therapy
American Rehabilitation
Cognitive Development
Current Index to Journals in Education
Disability and Society
Education Index
Educational Technology
Exceptional Children
Inclusion Times
Individuals with Disabilities Education Law
Individuals with Disabilities Law Report
International Journal of Disability, Development and Education
Intervention in School and Clinic
Journal for Vocational Special Needs Education
Journal of Communication Disorders
Journal of Developmental and Physical Disabilities
Journal of Head Trauma Rehabilitation
Journal of Learning Disabilities
Journal of Pediatric Health Care
Journal of Rehabilitation
Journal of Special Education Technology
Journal of the Association for Persons with Severe Handicaps
Journal of Vocational Rehabilitation
Mental and Physical Disability Law
Pediatric Physical Therapy
Perceptual and Motor Skills
Physical and Occupational Therapy in Pediatrics
Physical Disabilities: Education and Related Services
Rehabilitation Counseling Bulletin
Rehabilitation Literature
Remedial and Special Education
Research in Developmental Disabilities
Section 504 Compliance Handbook
Sensory Aids Technology
Special Services in Schools
Technology and Disability

STATE RESOURCES for DEVELOPING
OCCUPATIONAL THERAPY GUIDELINES
in the SCHOOL SETTING

IOWA

"Iowa Guidelines for Educationally Related Physical and Occupational Therapy Services", Des Moines, Iowa: Department of Education, 1993

State of Iowa
Department of Education
Grimes State Office Building
Des Moines, Iowa 5-319-0146

KANSAS

"Kansas Guidelines for Occupational and Physical Therapy Services in Educational Settings", Topeka, KS: Kansas State Department of Education, 1989

Kansas State Department of Education
120 East 10th Street
Topeka, KS 66612

MARYLAND

"Guide for Occupational Therapy and Physical Therapy Services in Maryland Public Schools", Annapolis, MD, 1990

OT & PT Services
Programs and Services
Highland Park Staff Development Center
6501 Lowland Drive
Landover, MD 20785

MONTANA

"Guidelines for the Provision of Occupational Therapy and Physical Therapy Services Under the Individual with Disabilities Education Act (IDEA)", Montana Office of Public Instruction, Helena, Montana, July 1997

OREGON

The Role of the Physical Therapist and Occupational Therapist in the School Setting (1989) ($8.00)

CDRC Publications
CDRC/OHSU
PO Box 574
Portland, Oregon 97207-0574

VERMONT

"Guidelines for Occupational and Physical Therapy Services in Vermont Schools", Vermont Department of Education, 1991

WISCONSIN

"Occupational Therapy and Physical Therapy - A Resource and Planning Guide", Madison, WI: Wisconsin Department of Public Instruction, 1996

State of Wisconsin
Department of Public Instruction
125 S. Webster Street
Madison, WI 53702
1-800-243-8782

OTHER--

"Occupational Therapy Services for Children and Youth under the Individuals with Disabilities Education Act", Bethesda, MD: The American Occupational Therapy Association, Inc., 1997

To obtain a copy of the Code of Federal Regulations, write to:

Superintendent of Documents
U.S. Governments Printing Office
Washington, DC 2040

Request 34 Code of Federal Regulations--Parts 300 to 399 (the most recent revision). The Code of Federal Regulations is revised annually. The 34 denotes regulations dealing with education.

Sample Appraisal Forms

[sample for consideration]

Performance Appraisal
OCCUPATIONAL THERAPIST

Instructions: Rate each element of performance using the numerical values below. Average for each heading to determine appraisal.

1 = unsatisfactory 3 = meets expectations 0 = not applicable
2 = needs improvement 4 = exceeds expectations

EVALUATION

_____ seeks medical information following appointment to interdisciplinary team and prior to conducting an evaluation
_____ evaluates child using procedures appropriate for EEN identification and planning intervention
_____ documents in an individual report:
- identifying and background information on child
- description of evaluation procedures
- summary and analysis of evaluation findings
- child's functional abilities and deficits in occupational performance areas and components
- projected functional outcomes for child as a result of intervention
- recommendations

_____ communicates and interprets results to the team, parents and other appropriate individuals
_____ complies with confidentiality and consent laws and standards
_____ adheres to time frames required by law and school policy
Comments: _____

PLANNING

_____ collaborates with school personnel and parents to develop an IEP
_____ recommends appropriate contexts and models for occupational therapy intervention
_____ identifies assistive technology necessary to implement the IEP
_____ discusses community resources that may benefit the child
_____ documents an occupational therapy treatment plan based on the IEP
Comments: _____

INTERVENTION

_____ implements the occupational therapy treatment plan
_____ collaborates with other school personnel and parents to provide services
_____ evaluates and documents the child's occupational performance areas and components periodically
_____ modifies intervention based on child's response and progress toward goals
_____ provides the amount, frequency and duration of occupational therapy specified in the IEP
_____ discusses discontinuance of occupational therapy at IEP meeting
_____ documents comparison of initial status and status at discontinuance relative to occupational performance areas and components
_____ documents recommendations for child following service discontinuance
Comments: _____

SUPERVISION

_____ determines and adheres to appropriate level of supervision for certified occupational therapy assistants
_____ determines service competency of COTA's and delegates therapy for selected children
_____ documents supervisory visits and modifications of children's treatment plans
_____ supervises occupational therapy aides and students
_____ communicates expectations clearly and collaborates with OTA, aide or student to solve problems
Comments: _____

OTHER

_____ maintains registration and licensing as required to practice in Connecticut
_____ adheres to school district policies
_____ maintains records required by Medicaid or insurance payers
_____ maintains equipment, supplies, and designated space
_____ evaluates the service and performs quality improvement activities
_____ provides in-service education to other team members, parents and/or community
_____ monitors own performance and identifies supervisory and continuing education needs

Comments: _____

Evaluator's summary comments: _____

Occupational therapist's summary comments: _____

Evaluator's signature and date

Occupational therapist's signature and date

Adapted from: *Occupational Therapy and Physical Therapy: A Resource and Planning Guide.* Madison, WI: Wisconsin Department of Public Instruction, 1996. Pages 90-91. Used with permission.

[sample for consideration]

Performance Appraisal
OCCUPATIONAL THERAPY ASSISTANT

Instructions: Rate each element of performance using the numerical values below. Average for each heading to determine appraisal.

1 = unsatisfactory 3 = meets expectations 0 = not applicable
2 = needs improvement 4 = exceeds expectations

EVALUATION
_____ assists the registered occupational therapist (OTR) with data collection
_____ assists the OTR with recording and documenting evaluation results
_____ complies with confidentiality and consent laws and standards
Comments: _____

PLANNING
_____ assists the OTR in developing an occupational therapy treatment plan
_____ establishes service competency in collaboration with the OTR for designated intervention procedures
Comments: _____

INTERVENTION
_____ implements the occupational therapy treatment plan under supervision of the occupational therapist
_____ collaborates with other school personnel and parents to provide services
_____ documents intervention procedures and the child's response
_____ recommends modifications of intervention to the occupational therapist
_____ adapts environments, tools, materials, and activities as the child needs
Comments: _____

OTHER
_____ provides paraprofessional supervision under guidance of OTR
_____ maintains licensure required to practice in Connecticut
_____ adheres to school district policies
_____ maintains equipment, supplies and designated space
_____ assists the OTR in:
- maintaining record keeping and reporting system
- evaluating the service and performing quality improvement activities
- providing in-service education to other team members, parents or community
- providing fieldwork experience to OT and OTA students
- monitors own performance and identifies supervisory and continuing education needs

Comments: _____

Evaluator's summary comments: _____

OTA's summary comments: _____

_____ _____

Evaluator's signature and date Occupational therapist's signature and date

Adapted from: *Occupational Therapy and Physical Therapy: A Resource and Planning Guide.* Madison, WI: Wisconsin Department of Public Instruction, 1996. Page 96. Used with permission.

Professional Standards and Ethics

Excerpts from Relevant Practice Acts
Health Professionals Licensed in State of Connecticut

Connecticut General Statutes Chapter 376a, Sec. 20-74a. Definitions:

(1) "Occupational therapy" means the evaluation, planning and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities, or anticipated dysfunction, using
A) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual,
(B) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped,
(C) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities. Such techniques are applied in the treatment of individual patients or clients, in-groups, or through social systems.

(2) "Occupational therapist" means a person licensed to practice occupational therapy as defined in this chapter and whose license is in good standing.

(3) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy, under the supervision of or with the consultation of a licensed occupational therapist, and whose license is in good standing.

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