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The Key to Educational Relevance: Occupation Throughout the School Day

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The Individuals With Disabilities Education Act Amendments of 1997 (IDEA; Public Law 105–17) emphasize that the role of all related services, including occupational therapy, in an educational setting is to ensure that students with disabilities have access to and an opportunity to progress in the general education curriculum to prepare for future employment and participation in their communities. In support of these outcomes, occupational therapy services (and all other related services, such as physical therapy or nursing) must be educationally relevant (i.e., address a student's performance in his or her educational environment whether that be a general education classroom, preschool group, physical education lesson, or the lunchroom). Another federal law, the No Child Left Behind Act of 2001 (Public Law 107–110), also emphasizes the use of scientifically based practices in educational settings.

In addition to these federal laws, the *Occupational Therapy Practice Framework: Domain and Process* (Framework, American Occupational Therapy Association [AOTA], 2002) offers further guidance for school-based personnel by identifying education as one of the key performance areas in occupation (the other areas are activities of daily living, instrumental activities of daily living, work, play, leisure, and social participation). Education, from an occupational therapy perspective, addresses the "activities needed for being a student and participating in a learning environment" (AOTA, 2002, p. 620). The occupation of education includes academic (math, reading, working on a degree), nonacademic (recess, lunch, getting from class to class), extracurricular (sports, band, cheerleading, dances), and prevocational and vocational activities.

This article discusses the key questions that an educational team must consider in its decision-making process for developing an individualized education program (IEP) for a student. Occupational therapy personnel, as part of the educational team, must ensure that their evaluation and intervention services are educationally relevant and enable students with disabilities to participate and learn in the general education curriculum adopted by their local school board for all children. Collaborative team decision making requires shared thinking and interaction among school personnel, parents, and the student whenever possible as well as a desire and knowledge to create a meaningful and relevant educational plan for a specific student. Although the educational team specifies the special education and related services appropriate for helping each student to reach his or her specified goals and objectives, occupational therapists must engage in clinical reasoning to integrate their expertise within the school context.

What does a student need and want to learn?

The first step in any IEP process is to create a team "vision" about who a student is and what a student needs to succeed in school. It is crucial to create this vision before any discussion of annual goals, services, and service providers. To contribute meaningfully, an occupational therapist must first know what the curricular and class expectations are. What does the student need to learn? What behaviors does a teacher expect and allow in the classroom? Where is the student successful? Where academically and socially across the school setting is this student struggling? By collecting information in a variety of ways (observation in natural settings; interviews with parent, student, and school personnel; use of discipline-specific evaluations and record reviews), occupational therapists can begin to formulate ideas about sensory, developmental, cognitive, and environmental factors affecting student performance. These preparatory activities set the stage for an IEP meeting when an educational team, including a student when possible, will develop an appropriate educational program.

Before IEP goals are identified, an occupational therapist summarizes and synthesizes his or her observation and evaluation data to increase the team's understanding of performance components, contextual factors, and activity demands affecting educational outcomes. As information is shared among team members, a clear understanding of the issues contributing to a student's educational performance begins to emerge. The team can now identify key priorities that will have the most impact on school performance.

This current performance and the identified needs are highlighted as "present levels" within the IEP document. Describing current educational skills and behavior is a critical step in establishing educationally relevant goals. For example, listing writing speed, time delay before initiating work, or percentage of time engaged in on- and off-task behaviors emphasize educationally relevant performance levels in the area of written expression. Functional and educational tasks need to be described in jargon-free terms so that all team members can easily visualize the student's performance and contribute to the goal-setting process. Theoretical constructs or general descriptors, such as "poor vestibular integration," "low postural tone," or "weak visual perception," while an important part of clinical reasoning, are not appropriate within the IEP document. Table 1 lists examples of educationally relevant present levels of performance and statements of need.

Once present levels and needs are assembled collectively, the team begins to set goals. The importance of working together at this initial phase cannot be overemphasized. The risk of reducing a student to a series of compartmentalized, fragmented skill areas is otherwise too great. Goals are statements of *measurable behaviors* a child is expected to demonstrate within a year's time. Target behaviors are those actions and skills that students typically do or need to acquire,

Table 1. Educationally Relevant Levels of Performance and Educational Need

Present Performance Level	Educational Need
Forms all letters correctly in isolation	Increase speed and spacing so written words and sentences are legible
Highly sensitive to unexpected touch; will push other children when in line or moving through the hallways	Strategies and supports to tolerate being close to peers; accommodations to leave class early to avoid crowded hallways
Eyes remain fixed when reading	Accommodations and instruction to read text without skipping or rereading words
Desk and workspace cluttered; unable to locate assignments and homework	Learn to use an organizational system
Enjoys recess but tires after 5 minutes on the playground	Frequent rest breaks and strategies to understand and communicate fatigue to teaching staff
Has adequate skills for hands-on prevocational work experiences; personal hygiene not sufficient for work settings	Awareness and training for increased independence and carryover in self-care areas

such as writing an essay, participating in physical education, playing with friends, or doing independent seatwork. Discrete clinical or medical skill components should not become short-term outcomes or goals, even though clinical reasoning is guiding intervention strategies. The primary occupation of a student is to learn and interact appropriately at school, not to receive therapy. Using educational descriptors not only is best practice, but also allows all team members to focus on the *same* critical goals (AOTA, 2002). Table 2 illustrates the relationship of clinical and educational issues, using examples from actual student IEPs.

Which strategies and supports will facilitate a student's learning?

Once a team knows a student's "educational destination," it can identify the strategies and supports that will help the student to accomplish each goal. For example, if one of the educational goals for a third-grade student with traumatic brain injury includes writing four sentences within 5 minutes during language arts, then what intervention strategies will help the student achieve this goal? Is a slant board and pencil grip needed to compensate for an immature pencil grasp? Should the classroom environment be modified by providing the correct-height desk and chair to facilitate eye–hand coordination? Can the teacher use a kinesthetic writing program to teach cursive handwriting?

The Framework complements an IEP and guides occupational therapists in considering a range of supports and services to meet identified goals and ensure that they include student, task, and setting components (AOTA, 2002). By emphasizing alternatives to direct intervention, such as task modification, shifting environmental demands, and supporting educational staff, occupational therapists can contribute to educational outcomes in the least restrictive and most developmentally appropriate settings. Consider the following examples:

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Table 2. Relationship of Clinical and Educational Issues

Referral Concern	Discipline-Specific Goal or Benchmark	Educationally Relevant Goal
Joey tires easily.	Increase postural tone and endurance	Walk to the park with his class without stopping
Kianna slumps in her seat and cannot copy from the blackboard.	Hold an antigravity extension position for 10 seconds; track an object smoothly in a horizontal plane	Copy assignments from the blackboard
Justin has poor hand skills for cooking.	Cross his midline, show stability and mobility patterns	Hold containers with one hand while stirring or pouring with the other
Riley screams at transition times.	Increase self-regulation and sensory integration	Move quietly to library and gym with peers
Susie wanders on the playground.	Show a postrotary nystagmus response in a suspended swing	Use climber and swing with one to two peers daily at recess
Isaiah does not hold his pencil correctly.	Touch thumb to fingers with eyes closed	Use a mature pencil grasp for 5 minutes of daily writing

A middle school student with Asperger's syndrome and coordination and social awkwardness had been receiving direct occupational therapy services for many months. One day, he asks to skip therapy because several of his classmates have invited him to shoot hoops in the gym at the same time. Recognizing the socially appropriate opportunity presented, the occupational therapist endorses the student plan and alerts the team to increase opportunities that will support these budding peer relationships.

With two morning bus runs, an elementary school has many students arriving well before class, sitting in the hallways with nothing to do. A resourceful occupational therapist enlists the support of teachers and parent volunteers to develop a "walking club" for all students, with prizes and awards at the end of the season. Several students with targeted motor and attention issues participate daily in this activity. Teachers notice the difference with their now-energized pupils and are willing to help organize the activity for the following year.

Who has the expertise to implement and guide identified strategies and supports to achieve a student's IEP goals?

Occupational therapists are frequently asked, "Does this student need occupational therapy?" and are expected to recommend occupational therapy goals and services for a student's IEP *before* the educational team has identified goals or strategies. Trying to answer this question before team discussion discourages consideration of the much more relevant question, "Is the expertise of an occupational therapist needed to assist this particular student to reach a specific educational goal?" If a team decides that occupational therapy can support a student in participating in the general curriculum, the occupational therapist can then recommend how to provide intervention and how frequently (Vermont Department of Education, 2001).

Traditionally, occupational therapists have selected *among* direct, consultation, and monitoring service models (Dunn, 1988) for a set amount of time per week (typically 30–45 minutes of direct service, 1–2 times/week). The IDEA does not mandate any one service delivery model and encourages IEP teams to provide all special education and related services in the least restrictive environment to help students participate in the general education curriculum. Rather than selecting only one model to deliver services to a student for an entire school year, occupational therapists should consider providing flexible services that combine direct, "hands-on" intervention integrated within school activities with consultation and coaching for educational personnel (AOTA, 1999; Hanft & Place, 1996; Muhlenhaupt, 2000; Swinth, in press; Swinth & Hanft, 2002). For example, occupational therapy personnel can do the following:

- Consult with a classroom teacher for 2 to 3 months to modify instructional materials for a student with physical or organizational needs, followed by less intensive classroom consultation to support educational staff.
- Work directly with a student for an intensive period to develop a specific skill and teach a strategy or procedure to support the skill, followed by consultation with an educator or paraeducator to ensure generalization in all classroom tasks.
- Provide intensive, direct service through small transition groups (twice/week for 6 weeks) at the beginning of the school

year to support students in adjusting to a new grade or school, followed by direct service once a month to make adjustments and ensure that students are using strategies effectively.

- Specify an aggregate number of hours *per year* on a student's IEP to allow flexibility for introducing new concepts or supports, making environmental modifications, and then decreasing the intensity of service as the student gains mastery over the targeted skill.
- Identify occupational therapy "supports and services" necessary for reaching IEP goals and objectives (e.g., staff training, in-service education, videotaping and discussion, reading materials and resources, adapting materials and classroom activities).

How will I translate my knowledge and experience to others?

Once a student's educational goals have been identified and the team has discussed which disciplines have the necessary expertise to help a student reach desired goals, the next decision should be *how* to provide identified services. All direct services to a student should be paired with collaborative consultation or coaching other key adults in the student's school and home environments. Collaborative consultation is a process that facilitates solving the problems of teaching and learning in partnership with other team members through shared thinking and mutual decision making (Clark, 2000). Colleague-to-colleague coaching, also known as peer coaching, has been used since the early 1980s in educational settings to help educators integrate new information within their instructional practices (Hanft, Rush, & Shelden, 2004; Joyce & Showers, 1982).

An occupational therapist who wants to consult with or coach another team member must understand what knowledge and skills the other team member needs to follow through with recommended occupational therapy supports and strategies. The therapist has the added responsibility of *translating* his or her knowledge and experience to provide alternative perspectives and strategies for another team member, appropriate to his or her knowledge, experience, and role with a particular student and family (Hanft & Place, 1996). Occupational therapists may choose to translate their knowledge and experience through modeling; instruction; demonstration; print, audio, or video resources; and suggestions of other supports, such as observing peers implementing similar recommendations. The key is to determine how best to support other team members in their roles as educators, classroom assistants, parents, and therapists, not to teach them to be occupational therapists. If the recommendations and strategies that therapists provide during consultation and coaching look like what they would do themselves when working with a student, then they are probably not adapting their consultation or coaching to fit the role and context of their teammates.

Case Study

Often, a student is flooded with a river of services, as individual team members feel duty-bound to address problem areas that fall within their professional domain. As related-service members of the educational team, occupational therapists can help to look at the full scope of the student's day and guide the team to selecting supports and services that give what is needed while not burdening the student with more supports than are necessary or useful. The following case study illustrates this issue and the steps an occupational therapist is currently taking to provide appropriate and effective related services under IDEA.

A fourth grader struggling with academics is referred for evaluation. Testing shows that he has a language-based learning disability, poor auditory processing, short attention span, and weak short-term memory. The team develops a 20-page IEP that attempts to address each individual issue found in the evaluation. The student's program becomes a revolving door of isolated components, including visual tracking, reading recovery, sensory diet activities, math tutoring, and having a para-educator scribe. This youngster with demonstrated difficulty understanding and organizing information is presented with a service package involving 10 different adults and 25 different interventions in the course of a week, interrupting more than half of each academic day.

The occupational therapist who recently joined this team questioned the overall direction of the program: Did it really meet the student's needs? Did this student need so many different services? Was direct occupational therapy a good choice or even necessary? By looking at what the student needed to learn, the therapist discovered that the student's academic skills had, in fact, declined over the past 2 years of interventions, including direct occupational therapy. She recognized that the team had not clearly identified specific *strategies* to support learning, choosing instead to provide *services* as the only way to address academic needs. She recommended changes to IEP goals to more specifically focus on the student's core issues of attention and processing. Her goal now is to guide the team toward more appropriate service delivery by highlighting the relationship between the constant interruptions in each day and the student's declining attending and task completion skills that she has documented.

Through collaborative consultation, the occupational therapist plans to increase the team's understanding of how effectively designed in-class supports, adapted class lessons, and alternative presentation styles can help this student to attend to and complete class work. She will share how having a targeted data collection system will enable the team and family to track the effects of different accommodations and supports. This will ensure that only those interventions that truly make a difference are being used and that the emphasis is on student achievement. Intervention from special educators, occupational therapists, and other related service providers should be the means, not the end, to achieving student goals. ■

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