The occupational therapy specialty area of school practice was relatively unknown before 1975 when the Education of All Handicapped Children Act (Public Law 94-142) was enacted. School practice consisted of a few therapists working primarily in special schools for children with orthopedic impairments, mental retardation, and blindness or deafness. These facilities were usually residential institutions organized on a medical model of services that focused on curing and training the residents. The educational services in these facilities were often inferior to those offered in public schools.

The Education for All Handicapped Children Act provided funds to assist state and local educational agencies in educating students with disabilities, resulting in increased employment opportunities for occupational therapists in school systems. Now, 20 years later, approximately 18.7% of occupational therapists provide services in school settings either as salaried employees or through contractual arrangements (American Occupational Therapy Association [AOTA], 1995).

The passage of the Education for All Handicapped Children Act produced a diverse public school population that resulted in new conceptualizations and practices for special educators and school-based occupational therapists. As well, both professional groups faced new roles, responsibilities, and colleagues. This legislation was amended in 1990 by the Individuals With Disabilities Education Act (IDEA, Public Law 101-476).

The first occupational therapists working in school systems brought with them the practice approaches they had used in hospitals and rehabilitation facilities. These were usually individual, one-on-one, direct treatment approaches that used a medical orientation of curing or fixing the student's deficit (the weak performance component), such as visual–motor problems, that prevented him or her from successfully performing a task, such as handwriting. Additionally, therapy services of the past tended to be provided in isolated or special locations away from the classroom. In fact, a therapist new to school practice often requested that a separate room be provided in which he or she could administer assessments and provide treatment. In some settings, the space made available was not the well-equipped therapy room envisioned, but a broom closet, the auditorium stage, the hallway, or a corner of the cafeteria or gymnasium.

School-based therapists soon recognized that this medically oriented approach, as well as their pull-out delivery of services, was interfering rather than supporting the educational process. Removing students from the classroom not only fragmented the school day, but also did little to aid the student to benefit from special education as mandated under IDEA. Lessons and educational instruction missed while out of the classroom for therapy could put students at additional academic risk. New approaches to service delivery were required that focused not only on the remediation of performance component deficits, but also on assisting students to function successfully in the school environment.

School-based therapists also recognized that in writing individualized education programs (IEPs), which are required by IDEA, they had to shift from including therapy goals and objectives that would develop or remediate performance components to using those that were educationally relevant. This was a challenging task because most pediatric standardized and criterion-referenced tests focused on identifying the deficits or underlying causes that prevented a student from accomplishing a task. Therapists felt caught between the
values and practices of the medical model and those of the educational model, which created confusion about their identity and roles.

Therapists also recognized the need to work in a closer relationship with teachers and other school personnel and to help these personnel understand the role of occupational therapy in educational environments. These recognitions required new practice approaches and roles.

Present
In the past two decades, school-based practice approaches and the roles of the school-based therapist have slowly evolved to include increased collaboration with teachers, increased use of classroom space in which to deliver services, and increased use of the consultation model. Therapists share their professional knowledge, expertise, and responsibility with teachers and other related service personnel and involve them in providing occupational therapy services to students with disabilities. This indirect service approach not only augments the direct services that the occupational therapist provides once or twice a week, but also permits students to receive services when the therapist is not there. School-based therapists are increasingly providing therapy in classrooms and other pertinent school environments, but some still focus their interventions only on the development or remediation of performance component. Current school-based therapists are also making use of occupational therapy assistants to expand the availability of occupational therapy services to students with disabilities.

The use of consultation has expanded and is recognized now as an appropriate part of the continuum of services in school practice. The shortage of occupational therapy personnel and decreases in funding for education have encouraged school administrators and therapists to use consultation as a way for existing staff members to serve larger caseloads. This is an inappropriate use of the consultation service model. Consultation can require more time than direct service in the initial steps or in complicated situations. The consultation approach requires strong communication skills and knowledge of consultation theory and application to be effective (Jaffe & Epstein, 1992).

To meet individual education needs of a variety of students with disabilities, best practice in schools involves using more than one service delivery model. Direct treatment, monitoring classroom programs, and consultation are the three most common service options that therapists use today (AOTA, 1989). This continuum of services allows the therapist flexibility in selecting the service options best suited to each student's education needs and environment. This flexibility is diluted, however, when a school system formalizes these options by establishing frequency minimums and criteria for selection and including them in district procedures. It is best when a school therapist's caseload reflects the variety of service delivery approaches with variation in number and length of sessions per week.

Future
Words such as accountability, downsizing, reengineering, site-base management, consumer friendly, partnerships, and collaboration that are more closely aligned with business are being used to describe changes in public education and health care as well. Many state education agencies have been downsized; funds and decision-making responsibility have been transferred to local education agencies. The U.S. Department of Education is being targeted by some politicians for elimination. The notion of merging special education and regular education into one comprehensive system to educate all children is also becoming popular. Because special education costs twice that of regular education, educators, parents, and legislators are questioning whether special education, as administered today, is the most efficient and effective way to educate students with disabilities. Under discussion in the debate on school reform is the role and place of special education and related services.

As this special issue of the American Journal of Occupational Therapy goes to press, bills to reauthorize IDEA are being considered in both the U.S. Senate and U.S. House of Representatives. One issue associated with providing related services, especially the specialized therapies of occupational therapy, physical therapy, and speech therapy, is their high cost to school districts. Should other funding sources, such as Medicaid, or other public agencies, such as mental health, be used to help pay for these services? An equally important issue is the qualifications of persons providing related services. Will school systems and early intervention programs continue to use personnel who meet the highest professional standards established in their state? One proposal being considered would allow school systems to receive a waiver to use the most qualified, available person in a profession instead of a person who meets the highest standard for the profession if there is a critical personnel shortage. The occupational therapy profession falls into the category of professions experiencing a critical shortage of available practitioners. Although the practice of using teachers and other educational personnel to augment and extend occupational therapy services have been effective, it is essential that qualified, experienced therapists continue to be used to plan, implement, and supervise occupational therapy services.

Occupational therapy services in schools will continue to be influenced by a number of factors, including legislative mandates, state and local policies and procedures, personnel availability, court decisions, and research on the effectiveness of different approaches for assuring students with disabilities to access and benefit from educational programs. Another major influence on occupational therapy services is the inclusive schooling movement. The purpose of inclusion is to educate students with disabilities in age-appropriate, regular education classrooms in their neighborhood schools, with support and assistance as needed (Stainback & Stainback,
1990). Inclusion is an attitude that supports equality for every student regardless of individual differences and needs. To date, inclusion experiences more often than not have made the student with disabilities fit into the existing regular classroom instead of creating an environment to support and nurture all students (Stainback & Stainback, 1990). Successful inclusion requires considerable thought and planning by parents, administrators, and direct service providers. Additionally, it helps administrators and staff members have positive, supportive attitudes and invests adequate resources to assist educational personnel (Bricker, 1995). In inclusion situations, occupational therapists can help with adapting curriculum, instruction, and school environments to meet the needs of students with disabilities. Integrating therapy services into the routines of regular education classrooms, playgrounds, and other natural school environments will be the challenge of school practice in the future. There is early evidence that students with disabilities who are educated in inclusive schools benefit greatly. They learn better outside the occupational therapy profession support the thinking of school-based practice. The validity of some ideas and theories that have long formed the basis for intervention methods are being questioned. For example, there is not the direct relationship between improvement in performance components and better functional performance that was once believed (Humphry, Jewell, & Rosenberger, 1995). New developments in theories of child development and recognition of the influence of the environment on functioning also support a reevaluation of the evaluation methods and service delivery models school-based therapists use.

School-based occupational therapy practitioners have made major contributions in helping students with disabilities access and benefit from education programs. They have often lead the way for other clinical practice areas in developing different and better ways to provide occupational therapy services. The many reforms in health care and education and the questions being raised about the basis of practice may be frustrating to many therapists. However, the opportunity to study, rethink, and create new and innovative intervention approaches on the basis of the latest and most reliable information offers the promise that all students will have their educational programs individualized to meet their unique needs and that school-based occupational therapy will continue to grow and prosper.

Conclusion
The changes occurring both inside and outside the occupational therapy profession support the thinking of school-based practice. The validity of some ideas and theories that have long formed the basis for intervention methods are being questioned. For example, there is not the direct relationship between improvement in performance components and better functional performance that was once believed (Humphry, Jewell, & Rosenberger, 1995). New developments in theories of child development and recognition of the influence of the environment on functioning also support a reevaluation of the evaluation methods and service delivery models school-based therapists use.

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