Special Education and Occupational Therapy: Making the Relationship Work

Martha J. Coutinho, Dawn L. Hunter

Key Words: education, special • legislation • occupational therapy services • public schools

Working as an occupational therapist in publicly funded schools requires a variety of skills. These skills include assessing the needs of children, serving as a member of the multidisciplinary team, developing individualized education program (IEP) goals and objectives in conjunction with other team members, providing services, and coordinating efforts with parents, teachers, and administrators. To fulfill these responsibilities, occupational therapists must have a comprehensive understanding of the complex federal and state laws that mandate the provision of special education and related services. Therefore, the purposes of this article are (a) to describe the legal framework within which decisions are made to provide occupational therapy to students in publicly funded school programs and (b) to highlight the knowledge and skills occupational therapists need to work effectively in schools with teachers, administrators, and parents.

Martha J. Coutinho, PhD, is Education Research and Policy Associate at the National Association of State Directors of Special Education, 2021 K Street, NW, Suite 315, Washington, DC 20006.

Dawn L. Hunter, PhD, is Vice President at Education Policy and Program Solutions, Inc., Reston, Virginia.

Martha J. Coutinho and Dawn L. Hunter wrote this article in their private capacities. No official support or endorsement by the National Association of the State Directors of Special Education or by Education Policy and Program Solutions, Inc., was intended or should be inferred.

This article was accepted for publication July 20, 1988.
on the quality of performance or on the outcome of an educational activity. Discussed below are the educational and legal considerations that affect the provision of occupational therapy in the schools, and the knowledge and skills occupational therapists will need to work effectively in schools with teachers, administrators, and parents.

**Decisions Affecting the Provision of Occupational Therapy**

The decision to provide occupational therapy to a student is guided by several factors. To understand the provision of services, the following questions will be addressed:

- When must occupational therapy be provided?
- How are needs for occupational therapy determined?
- How and where are occupational therapy services provided?
- What rights do parents retain, and how are disagreements over services resolved?
- How has recent legislation affected services to infants and toddlers?

**When must occupational therapy be provided?**

EHA mandates the provision of a free, appropriate public education to all children who are disabled, regardless of the severity of the disabling condition. Under EHA, there are many provisions regulating and guiding the provision of services and programs. State regulations and implementation must be consistent with federal regulations. However, because certain interpretations and variations are legally permissible or because EHA regulations do not address some policy issues, state regulations vary considerably. For example, EHA states that the age range for the mandated provision of services is 5 years through 17 years. However, some states have developed and implemented regulations that mandate services from birth or 3 years of age and/or extend services beyond 17 years of age.

Responsibility for the provision of related services requires that special education administrators make occupational therapy available to meet the unique needs of children identified as disabled. Several provisions of EHA affect the role of occupational therapists who work in public schools. For example, the definitions of terms and services is one provision that has linked special education and occupational therapy in a particular way. Students who are disabled (the term used in EHA is handicapped), are children "who because of [specifically defined] impairments need special education and related services." This requirement is provided for in the regulations developed to implement EHA, which are codified in the Code of Federal Regulations (CFR) at 34 CFR Part 300. (This particular requirement is found at 34 CFR §300.5.) Special education, in turn, represents "specially designed instruction . . . to meet the unique needs of a handicapped child" (34 CFR §300.14). Thus, the regulations link related services to special education. Related services are defined as "developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education" (34 CFR §300.13). Therefore, the answer to the question, When must occupational therapy be provided? is, Only when necessary to assist a "handicapped" child to benefit from the specially designed instruction. The consequence of this particular definition and relationship among terms is that occupational therapists whose services are funded by special education monies in public agencies may serve only children who are both disabled and in need of special education.

**Occupational therapy itself is defined in the implementing regulations of EHA at 34 CFR §300.13(b)(5) as**

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

**How are needs for occupational therapy determined?** The relationship between occupational therapy and special education set forth in 34 CFR Part 300 affects the process of determining the need for occupational therapy. Multidisciplinary evaluation to determine a child's special education and related service needs, provisions for determining eligibility, programming and placement decisions, as well as other general requirements (some of which are described below) are provided for in EHA. These provisions impact significantly on the provision of occupational therapy.

An important role of a therapist is to assess and evaluate students to determine if there is a need for occupational therapy (Anderson, Chitwood, & Hayden, 1982). Under EHA, the therapist functions as a member of a multidisciplinary team that includes but is not limited to the child's teacher, parents, and other specialists who conduct a preplacement evaluation as a first step in determining whether a child is eligible for services—that is, whether a child is both disabled and in need of special education. If the multidisciplinary team determines that the child is disabled and in need of special education, the occupational therapist must provide team members with the recommendations she or he has formulated. These recommendations must be in a form that is comprehensible to other team members, including parents.
Team members' recommendations are translated into an individualized education program (IEP) for the child. An IEP must be developed for each child identified as disabled and in need of special education (34 CFR §300.340). The IEP document is a written statement describing the kinds of special education and related services the child is to receive and is developed, reviewed, and revised at IEP meetings attended by parents and school personnel. The significance of this requirement is that, first, decisions about the special education and related services a child is to receive must be made on an individual basis, and, second, parents are given the opportunity to participate in decisions about their child.

Although state regulations may require additional information, federal regulations (34 CFR §300.342 and §300.346[c]) require that the IEP state the related services to be provided. To conform with federal requirements at 34 CFR §300.346, an IEP must include statements of (a) the child's current level of educational performance, (b) annual goals and short-term instructional objectives, (c) the specific special education and related services to be provided, (d) the extent to which the child will participate in regular educational programs, (e) the projected dates for initiation of services, (f) the anticipated duration of services, and (g) objective criteria and evaluation procedures for determining, at least annually, if objectives are being met.

Once an IEP has been developed and parental consent for initial placement has been obtained, services are initiated. A child's IEP must be reviewed by a team at least annually (34 CFR §300.343[d]) and a comprehensive reevaluation must be carried out at least every 3 years, or "more frequently if conditions warrant or the child's parent or teacher requests an evaluation" (34 CFR §300.533). Again, serving as part of a team, the occupational therapist would describe (a) the results of the occupational therapy evaluation, (b) the occupational therapy services recommended, and (c) the outcomes expected from the actual intervention. In most instances, the therapist will participate in decisions regarding the child's entire program of regular and special education and related services.

**How and where are occupational therapy services provided?** The IEP describes how special education and any related services are to be provided. At the meeting at which the IEP is developed or revised, team members compare service provision models and decide how the intervention(s) will occur and be coordinated. On the most general level, the role of the occupational therapist is to work with the student's other service providers to ensure services are provided appropriately, given the child's needs as established in the IEP. In general, occupational therapy may be provided by direct service, consultation, or monitoring. An article by Dunn, also in this issue (see pp. 718-723), defines all three types of service provision. Neither of these is inherently better than another; the use of a particular type should be based on the needs of the child.

In addition to the requirement that public schools provide a free, appropriate education uniquely suited to meeting the individual needs of a child with disabilities, EHA embodies another equally important mandate: It requires that services be provided within the least restrictive environment. The least restrictive environment mandate requires that children with disabilities be educated "to the maximum extent appropriate" with children who are not disabled and that they be removed "from the regular educational environment only when the nature severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily" (34 CFR §300.550[b]).

The historical treatment of individuals with disabilities, parental advocacy, and, ultimately, the outcome of several court cases provided the stimulus for the enactment of federal legislation that mandated the provision of services within the least restrictive environment. (Cruickshank & Johnson, 1975). Traditionally, some children with disabilities either were excluded from public schools or were placed in segregated schools (Turnbull, 1986). Unfortunately, the quality and comprehensiveness of services available in separate programs rarely approached that of services available in public school settings. Moreover, opportunities for interaction with nondisabled peers were limited or nonexistent. The least restrictive environment mandate requires that students with disabilities be educated "to the maximum extent appropriate" with students who are not disabled and that they be removed "from the regular educational environment only when the nature severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily" (34 CFR §300.550[b]).

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With respect to participation, parents must provide informed written consent both for the initial evaluation, if it is suspected that the child is disabled, and for the initial placement of the child in a special education program, if it has been determined that the child is disabled and is, therefore, eligible to receive special education and related services (34 CFR §300.504[2][b]). The educational institution must give parents an opportunity to participate in decisions affecting their child by providing them with prior notice before decisions regarding identification, evaluation, placement, and review or revisions in a program are made. Additionally, parents have the right to request and obtain an independent educational evaluation at public expense if they disagree with the evaluation obtained by the educational agency. Finally, parents must be given the opportunity to inspect and review all records that relate to the identification, evaluation, and educational placement of their child.

In sum, the prior notice requirement applies whenever the public agency (e.g., the local school district or school) seeks or refuses to initiate or change decisions regarding identification, evaluation, educational placement, or provision of a free and appropriate public education to a child (34 CFR §300.504[a]). Occupational therapists need to be aware of these requirements when working in facilities with children whose programs are supported and bound by EHA. For example, before beginning a pre-placement occupational therapy evaluation, the therapist must provide prior notice to and obtain informed consent from the child's parents. Schools and facilities use somewhat varying forms and procedures to reflect not just federal but state and local practices. Therefore, therapists must work with system personnel to identify the correct forms and to conform with accepted procedures. When a particular occupational therapy intervention is recommended as a part of the entire special education program and services to be provided, occupational therapists should be certain that parents, if not participating directly in the meetings, have at least been given an opportunity to do so. Actual services, when provided for the first time, must not be initiated until parents have given their consent. Failure to conform with these safeguards is sufficient cause for parents to initiate due process procedures.

The due process provisions of EHA enable parents to initiate procedures when they disagree with special education decisions affecting their child (34 CFR §§300.506–513). Matters about which there may be disagreement may range from the initial decision that a child is or is not disabled (and, therefore, is or is not eligible to receive services) to the actual services provided, to the school district's refusal to amend educational records at a parent's request, or to the extent
to which services are provided in the least restrictive environment. The centerpiece of these rights is the right of the parent (or, importantly, a public agency when it disagrees) to an impartial due process hearing, as required under 34 CFR §§300.506–509. If aggrieved by a decision, parents may appeal to the state educational agency and obtain an administrative appeal (34 CFR §300.510). If the parents disagree with the decision reached through the administrative appeal, they retain the right to bring a civil action (34 CFR §300.511). Finally, in 1986, EHA was amended by Public Law 99–372, the Handicapped Children’s Protection Act, which allows parents to recover attorney fees and other costs when they win in a due process hearing or court case proceeding.

When there is a dispute, an occupational therapist may be asked to participate in some fashion, most likely through (a) the provision of records pertaining to the occupational therapy services provided to the child, (b) the provision of testimony regarding an occupational therapy evaluation or intervention services, or (c) the conduct of an independent evaluation. Understanding the requirements under EHA and the conscientious fulfillment of duties ensures that the occupational therapist is working in permissible and appropriate ways to meet the unique needs of the individual children served.

How has recent legislation affected services to infants and toddlers? In 1986, EHA was amended by Public Law 99–457, the Education of the Handicapped Act Amendments. Certain provisions were expanded or modified; for example, federal support for early intervention and preschool services was expanded significantly. Beginning in 1990–1991, states will be required to provide special education and related services to pre-school-age children with disabilities. Occupational therapists will be asked increasingly to provide required services to young children who are disabled.

Occupational therapists employed by programs funded under the provisions of Part H of Public Law 99–457 will be affected by the specific provisions of this amendment with respect to the kinds of services and the nature of the participation required. “Handicapped” infants and toddlers are defined in Section 672 of Part H of Public Law 99–457 as infants and toddlers needing services because they

(A) are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: Cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or (B) have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay. Such term may also include, at a State’s discretion, individuals from birth to age 2, inclusive, who are at risk of having substantial developmental delays if early intervention services are not provided.

This definition of a “handicapped child” differs from that provided in Public Law 94-142 for school-age children. Under Public Law 94-142, school-age children who are “at risk” of becoming disabled are not eligible to receive services.

Under Public Law 99-457, early intervention services are defined as “developmental services” and occupational therapy is included as one type of service. The services provided must be designed to meet needs in the areas of physical, cognitive, or psychosocial development, or development in self-help skills or language and speech. This definition departs significantly from the definition of occupational therapy under Public Law 94-142 as a related service only and provided only when necessary to help a child found to be disabled to benefit from special education. Occupational therapists working in programs funded under Part H of Public Law 99-457 should be alert to this distinction in the definition of allowable services.

Skills and Knowledge Needed to Provide Services to Children Served Under EHA

Occupational therapists face exceptional challenges and opportunities both because of the unique and evolving relationship between special education and occupational therapy and because of the need to allocate schools’ finite resources among programs and services. Some general guidelines are offered below for therapists seeking to work effectively with educators, administrators, and parents of children with disabilities who require occupational therapy.

Understand the requirements of EHA. Occupational therapists should become familiar with the federal and applicable state and local policies and procedures. They should seek assistance from the local special education administrator, special education staff, and professional organizations to make sure they understand current practices. Therapists working with pre-school-age children will find that their role is affected by the amendments contained in Public Law 99-457 and should ask those with whom they work for specific information.

Because of the significant changes to EHA provided for in Part H of Public Law 99-457, occupational therapists serving disabled infants and toddlers should familiarize themselves with the particular procedures used in the state in which they work. They should determine who the designated lead state agency is, because it is not necessarily always the department of education; what the parental procedural safeguards are; what the minimum components of the “individualized family service plan” and “case management services” are; and what the federal and state standards regarding the definition of a “qualified” service provider are.
Communicate effectively and resolve challenges cooperatively. As previously suggested, besides providing services to children with disabilities, occupational therapists must be able to communicate effectively with other service providers. Public school personnel are sometimes not familiar with occupational therapy as a discipline. Therefore, therapists must possess the skills and knowledge that will enable them to share their expertise with other specialists, classroom teachers, and administrators. Occupational therapists working in school systems must be able to explain how the occupational therapy services they recommend for a particular child are consistent with the intent of EHA. This may involve translating medical or biophysical terms into words that administrators, educators, and parents can understand. Another role of the therapist is to make certain that the sections of the IEP related to the provision of occupational therapy accurately communicate the type of occupational therapy to be provided. For each student, the occupational therapist must be able to assure that the evaluation findings support the specific services recommended and that the intended therapy (a) will help the child benefit from special education services and (b) is designed to meet the unique needs of the child.

Therapists must also possess good interpersonal skills. To provide occupational therapy services in a coordinated and educationally relevant manner, occupational therapists in public school settings are required to interact with a variety of people (e.g., teachers, aides, principals, physical therapists, speech therapists, nurses, psychologists, parents). Therefore, when serving as a member of a multidisciplinary team, recommending services, implementing services, arranging schedules, or resolving disputes regarding services, a therapist must work conscientiously with others. A useful strategy in effective communication involves getting to know the key players. Therapists, like special educators in school settings, may be inadvertently isolated unless they make a concerted effort to be included. It is advantageous to become an integral part of the total school structure by attending faculty meetings, school assemblies, and after-school activities, and by serving on schoolwide committees.

Foster an individual commitment to provide services in a professional and responsible manner. Besides understanding the requirements of EHA and having the skills to communicate effectively, therapists must be adequately prepared to meet the diverse challenges they will face in school settings. Therapists must be competent in a wide variety of skills (e.g., evaluating the needs of children, writing and monitoring individualized goals and objectives, providing direct and consultative services, supervising occupational therapy assistants and other personnel who are implementing programs). In addition, as "best practices" in special education evolve, the locus of occupational therapy services may change. For example, special education instruction is focusing increasingly on areas involving functional life skills. Consequently, more and more therapy is being provided in natural environments, including community environments (e.g., job-training sites, the student's home, restaurants, stores, recreational facilities). Because advances in research and technology are rapidly expanding the knowledge bases of special education and occupational therapy, it is essential that therapists engage in activities that will contribute to their professional development (e.g., attend courses offered by professional associations or colleges, attend in-service training sessions, attend conferences, visit sites that are implementing best practices, read professional and research journals).

Another key element in working in school settings is flexibility. Not only does a therapist have many diverse responsibilities, but the therapist will have the opportunity to work with children who have diverse needs. In addition, a therapist working in a school setting must always be prepared for the unexpected (e.g., a child having a seizure, a child having a temper tantrum), which may result in a disruption in the schedule, or may require the therapist to assist a teacher or administrator in some unplanned way.

Finally, because of the many responsibilities of an occupational therapist in a school setting, there is often a great temptation to serve the caseload rather than the individual students making up the caseload. Educational progress and the child's well-being are threatened by recommendations or practices that do not account for the child's entire program and unique needs. Maintaining a philosophy dedicated to serving each child, as well as the whole child, will enhance services to the child. By keeping the child's needs clearly in focus, the therapist will enhance his or her ability to obtain relevant input from educators and parents and ensure that parents are afforded a meaningful opportunity to participate in decisions affecting their child.

References


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### Publications Related to Occupational Therapy in the Schools Available from AOTA

**Available from AOTA Products**

1. All products on pp. 8 and 9 of the 1988 (Products) Catalog

2. Brochures
   - Occupational Therapy Makes Good Sense
   - Occupational Therapy Makes Learning Possible

3. COTA Supervision Guide

4. Practice Information Packets
   - Accessibility and Architectural Modifications
   - Cerebral Palsy
   - Computers
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   - Hearing Impaired/Visually Impaired
   - Independent Living
   - Mental Retardation
   - Prevocational/Vocational
   - Seating and Positioning
   - Sensory Integration

5. Therapy as Learning
   - Richard K. Schwartz, OTR

6. Special Interest Section Newsletters
   - Developmental Disabilities
   - Physical Disabilities
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7. Guidelines for Occupational Therapy Services in Early Intervention and Preschool Services (available in early 1989)

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