The Implementation of Occupational Therapy Services in Rural School Systems

(program planning, schools, rural communities)

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Factors influencing the integration of occupational therapy services in rural school systems are reviewed in this paper. Differences between urban and rural populations are defined and methods of successfully developing new allied health programs in public schools are discussed. A thorough understanding of the rural educational system and local community is necessary for occupational therapists to provide optimal service delivery.

In the last 10 years occupational therapists have participated in the development of a variety of community-based services (1-4). Much of this growth has occurred as a result of Public Law 94-142, enacted in 1975, which mandates occupational therapy (OT) services for the handicapped child in the public school when such services are deemed necessary for the provision of proper education (5).

In the rural school system the occupational therapist has a particular opportunity for a community-based role, but the transition from a metropolitan medical environment, such as that found in a hospital, university, or medical center, to a rural community school system may be difficult. The therapist entering the rural educational system is often confronted with professionals who do not work within a medical frame of reference. For therapists to integrate their services into the rural school system they need to have an understanding of the system, its educational aims, and its philosophy. A review of how other disciplines entered these systems and integrated their services also would be helpful.

Literature Review

The literature on rural life between 1960 and 1978, the U.S. educational system, and theoretical and documented methods of effecting changes within rural educational systems were analyzed in order to identify the characteristics of rural educational systems and the means by which other disciplines effected new programs in these systems. Occupational Therapy in the Public Schools. Although occupational therapy services in the public school were documented as early as 1941 (6), until recently, the school has been viewed as a "nontraditional" setting for the therapist. The small number of therapists in the school system tended to reinforce this point of view. A study by The American Occupational Therapy Association (AOTA) listed 674 occupational therapists employed in the public schools in the United States in 1975 (4). Following the enactment of PL 94-142 in 1975, the number increased by 1977 to 2,000 (4).

The various roles of occupational therapists in the school system have been documented only recently (7-9). Kinnealy and Morse (7) described the role of the therapist relative to physically handicapped children and Creighton (8), their role in vocational education. Kaufman (10) described the techniques of occupational therapy assessment in educational settings and included among the duties of the school therapist are: advising the local school board, serving on school district councils, and consulting with school personnel. She stated that therapists in the school should be knowledgeable of pertinent educational, as well as occupational therapy, literature in order to serve the school population successfully. Kinnealy (7) also recommended that the profession prepare its members for roles in the public school.

Literature regarding the function of the therapist in the school setting is available, but no literature was identified on the integration of the therapist into the educational system. Occupational Therapy in the Rural Community. Since 1966, several authors have defined the role of the occupational therapist in community health care (1-3). Llorens (11), in the literature she reviewed, noted a shift in occupational therapy practice from a medical model to a community intervention model.

To explore the role of occupational therapy in the rural community, a pilot study was begun in 1970 in which occupational therapy services were offered to a rural population in an economically depressed area of Florida (12). The program lasted 8 weeks, and its effectiveness was then evaluated. The authors determined that a prerequisite to effective delivery of occupational therapy services to a rural community was a thorough understanding of rural community life and a careful identification of community needs.

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Isolation from other therapists in rural areas necessitates the need to use available resources.

Sieg (13) briefly described the culture of the rural community and its implications for the practice of occupational therapy. She stated that, while rural people suffer from medical disorders comparable to those of urban populations, rural culture and isolation from sophisticated medical care make the problems of rural service delivery unique. Devereaux, who also described the culture of the rural environment, stated that to be even "minimally effective, the therapist functioning in a rural community must understand the people, their culture, values, and attitudes." (14, p 653) She stressed the need for therapists to explore the structure of individual cultures within the rural population including those of the Indian, Black, and Appalachian. Although Llorens (15) has described the elements of rural Black cultures and their implications for OT practice, roles with other subcultures are not documented in the professional literature.

**Effective service delivery depends on the active support of the community and school system.**

Occupational Therapy in the Rural School System. Sarason (16) described the public school system itself as a unique culture, and viewed the rural school system as an independent subculture, differing from the urban school system economically and politically.

Llorens and others (9,11,12,14,16) have stressed the importance of a basic knowledge of target populations, focusing on the knowledge of factors that influence acceptance of occupational therapy services. Unfortunately, the factors that influence occupational therapy service delivery in rural school systems are not widely documented in current occupational therapy literature.

**Distinctive Characteristics of the Rural Community**

According to Webster (17), rural is that which is "of or characteristic of the country." This definition depends, however, on the subjective concept of country. For instance, are suburban areas or small towns located in the country considered rural? The U.S. Census Bureau defines rural persons as those who "live in places with fewer than 2,500 people or in open country." (18, p 26) This definition is more precise, yet many Census Bureau statistics are not analyzed by using the term rural; instead, the terms metropolitan, suburban, and nonmetropolitan are used. Metropolitan areas are "counties that contain a city of 50,000 people or more." (20, p 11) Suburban areas are those counties near the metropolitan area "from which substantial commuting occurs." (19, p 34) Nonmetropolitan refers to all other areas. Yet, these terms are crude, for some nonmetropolitan areas are more isolated than others (18). Universities or large institutions can change the atmosphere of a rural area to that of a more cosmopolitan one, whereas some suburban areas may retain the flavor of country life.

Certain sociologists, such as Ford, argue that the United States is becoming a "thoroughly urbanized society, perhaps the first such society in history." (20, p 16) Yet even he acknowledges that many differences exist today between urban and rural America.

Thus, rural areas must be differentiated from urban areas by a variety of parameters—economics, occupations, health care, family groups, religious and moral beliefs, and overall community structure.

Rural areas have been characterized throughout the 1970s by a high incidence of poverty (21). Approximately 25 percent of the nation’s total population and 39 percent of the nation’s poor, live in nonmetropolitan areas. A high frequency of substandard housing and poor nutrition in many rural areas has resulted (26). Rural schools generally have available fewer dollars per pupil than the equivalent urban schools and, therefore, are more likely to lack modern equipment than urban schools (22).

Furthermore, rural areas often have less adequate medical care than urban areas (23). In two studies, a negative relationship was shown to exist between the number of physicians in a community and its degree of ruralness (23, 24). A lack of physicians is not the only problem in rural health care; a lack of nurses, allied health professionals, dentists, and modern...
hospital equipment also exists (25). The isolation from associates and other disadvantages of the rural environment continue to make rural areas less appealing than metropolitan areas for many health professionals despite government recruiting programs (26, 27).

Rural America has a lower percentage of white collar workers, professionals, and managers than either central city or suburban areas, according to 1977 figures (21). Blue collar workers constitute the largest rural occupational group (28), with fewer than 15 percent of rural workers deriving their major income from farming (18). Yet, it must also be noted that, as of 1977, 82 percent of the nation’s farmers lived in nonmetropolitan areas (21).

Rural families tend to be slightly larger, although this difference is almost negligible (3.39 members per family versus 3.37) (21). The rate of divorce in rural areas has been rising during the last decade, yet divorce continues to be less common among rural than among urban couples (21, 29).

The religious and moral values of rural persons can be summarized as more traditional or conservative than those of urban persons (30). Grasmick (31) showed that even urban dwellers with rural backgrounds were more traditional than urban dwellers from urban backgrounds. The church and school are often seen as vital institutions in the rural community (32). The importance of the church in rural society is consistent with findings that rural persons believe more strongly in the power of religion than urbanites (33).

In comparing the structure of rural communities to that of urban areas, the rural community is seen as more homogeneous, with less diversity and mobility between social stratifications (34). Rural power structures often revolve around a few influential families, and social contacts determine available career opportunities more than knowledge or skills (34).

### Understanding the cultural values and lifestyles of community members enables the therapist to better assess and meet their needs.

#### The Rural Community’s Acceptance of an Individual or Agency and Methods for Change

One primary factor influencing the acceptance of a new service in a small community is the method of introduction. Starting a new program in a rural area where the total number of agencies is small may cause changes or tensions to develop between established agencies within the area (35). New service workers may make these changes work to their advantage by gaining community respect and support for their programs (36, 37). To achieve these ends new workers must demonstrate concern for the community by showing interest in its problems and a respect for its values and customs (38). They must also frequent community meetings and social events that will allow them to be seen and assessed by the community (36). As Tranell (36) states, the social acceptance of the service worker as an individual is often more important than a perception of a high level of technical expertise since delivery of services depends on community acceptance.

Several studies reinforce Bolman’s statement regarding the importance of public education in the implementation of new programs. Eisendorfer et al. (39) found that educating the community to the potential benefits of a new community health program played a vital role in gaining community support. In the town of Provo, Utah, slide shows and discussion periods at town meetings were used to gain financial support for a new health project. In rural Nebraska, similar techniques were used to foster support of a new medical center. Naturally, methods of gaining community support and obtaining community involvement vary among rural communities. Instead of slide shows and town meetings, a strategy of publicity through local newspapers, school letters, and their parents is a possibility (40).

Other programs have used paraprofessionals in the local community to coordinate the efforts of the health professionals and local individuals when cultural or language barriers interfered with service delivery (41). Local clergy often serve well in this capacity because of the importance of the church in many rural areas (44).

Evaluation of the programs offered by the new service worker is also important. Thomson and Bell (43) suggest that the new service analyze not only its accomplishment of set objectives, but also the degree of acceptance of the service by formally determining which community groups accept and support it.

#### Entering the Educational System

The American educational structure is a complex multisystem with hierarchical levels of control including ever increasing Federal mandates on education, state policies, regional policies, local policies, and administration of these policies in the individual school.

Because therapists entering the school system must understand the system to understand it as a whole in order to perceive their own role more clearly, Berkowitz (44)
found that a frequent problem for psychologists attempting to implement new programs in the school system was the failure of the clinicians to recognize the nature of the educational system and classroom. To overcome the problem of the transition to an educational system, programs orienting psychology students to public school systems have been successfully used (15). Literature describing the American educational system and its administrative structure is readily available in most libraries. Education journals are another source of information regarding the school system and legislation affecting it.

Causing Change in the School System. Rappaport (46) describes a system for budget management that is applicable to the implementation of new services. The first part of Rappaport's system involves the organization and planning of the service. This includes setting major goals and objectives and developing communication links with allies, supervisors, and target populations. He encourages coordination of all support systems, together with the education of the staff about the purpose of the new service (46). With this accomplished, the planner should then go to the administration and obtain approval for the delivery of these services. A review of delivery methods with regard to efficiency, supplies, personnel, and the target population should then be performed, and an exact procedure for implementation outlined (17). After beginning service delivery, the program's success should be reviewed at regular intervals.

On occasion, a new service may be resisted by established services, and changes in the framework of the educational system may prove unnecessary; however, before attempting to make changes in the system, it is important to review past experiences with new programs in that school system. If previous attempts have been unsuccessful, they may have set the tone for the school's opinions on change. Sarason (16) states that, when describing a new program to school officials, he was often met by resistance. He discovered that this resistance was due in part to the frequent past introduction of programs that never became a reality or, if actually begun, were of little use to the target population. Thus, it may be necessary for the therapist to stress the differences between the proposed program and past, unsuccessful programs.

Boles (48) suggests that the person desiring to bring about change evaluate societal forces that affect educational policy. Since the school board is composed of community members, it is certain that community mores, traditions, needs, and economics will reflect themselves in school board policy (48). Service workers can use these community needs to build support for their projects, and with this support the project stands a good chance of being adopted. To get community support, the educational service worker must have open communication channels with the community. The educational worker then becomes a community worker, needing knowledge of community systems and interpersonal skills to gain entry into community organizations and power structures. Landers (49) suggests that the service worker keep a file of local agencies and organizations that have influence in the area.

Holt and Kicklighter (50) list the three important change agents in the school as the administrator, the teacher, and the parent. The type of interaction that occurs between the new service worker and these individuals can determine whether these change agents will assist or hinder the worker in the implementation of any new programs.

Summary
It is not sufficient for the professional to enter the school system, assess individual students' needs, and propose programs addressing those needs, no matter how appropriate those programs appear to be. Effective service delivery to the students, school system, and community depends on the active support of these groups. To this end one must first understand the characteristics and needs of the rural community and school system, discussed briefly in this paper, and then outline specific needs of the target locality. Not until the population's needs and resources, as well as the school administrative structure, are understood can therapists deliver their services with the cooperation and support of the community and the administrative hierarchy.

Acknowledgments
This article is based upon material submitted in partial fulfillment of the requirements for the Master of Science Degree, University of North Carolina, Chapel Hill, 1980. Appreciation is expressed to Marlys Mitchell, Ph.D., OTR, for her assistance as thesis advisor.

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