IEP Team Process

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OT and PT Participation in IEP Team Decisions and IEP Documentation

Who determines if a child needs occupational therapy or physical therapy and what criteria do they use?

If the IEP team that includes an occupational therapist or physical therapist decides that the child has an impairment and needs special education, they go on to write an IEP at the meeting or schedule another IEP team meeting. The occupational therapist and physical therapist contribute information to the present level of academic achievement and functional performance statement in the IEP, the determination of the child's educational needs, and the development of goals that address those needs. The team then decides what kind of special education the child needs to meet the goals. Next, the team asks the qualifying question for school occupational therapy and school physical therapy: is occupational therapy or physical therapy required to assist the child to benefit from special education? The determination of the need for these related services flows from knowing the nature of the special education the child will receive. The IEP team may determine that specific services from the special education teacher are sufficient to help the child meet the goals. Conversely, the team may say the therapist has unique knowledge and skills necessary for this child's goal achievement. The timing of this decision helps the team focus on the child's goals and what expertise is needed to help meet them, rather than on identified deficits. Therapists are more certain of how their services relate to the special education and the projected educational outcomes. No assumption is made that the therapist must address what the therapist evaluated, and the process moves away from erroneously qualifying a child for occupational therapy or physical therapy with a test score, specific percentage of developmental delay or other inappropriate criterion.

This sequence of decision-making also can occur at an annual IEP review. If the team recognizes that occupational therapy or physical therapy is not required to assist the child to benefit from special education in order to meet the goals, a rationale for dismissal becomes apparent.

Occupational Therapy

Guiding questions about the performance demands of the educational environment and the child's ability to function within it will help the team integrate information from the occupational therapy evaluation and determine the need for service:

- Is the child having difficulty meeting high priority demands in educational environments of activities of daily living, assuming the student role, social participation, play, leisure or vocational pursuits?
- What are the characteristics of the child, the activities and the environment that promote or hinder success?
- Do the discrepancies between the child's performance and the demands of the activities or environment interfere with the child's ability to benefit from special education; or do the discrepancies interfere with the child having equal opportunity to gain access to, benefit from, or participate in the educational program or services?
- Is intervention, collaboration with teachers, or mobilization of resources by the occupational therapist an effective and efficient way to improve the child's ability to function in the environment?

Physical Therapy

IEP teams consider guiding questions when determining the need for physical therapy.

- Does the child's current educational placement include efforts to address the effects of the disability?
- Can the special education teacher address the child's needs without consulting the physical therapist?
- Does the child have limitations that influence, interfere with, or prevent the child's progress toward academic or non-academic goals in school?
- Are the effects of the child's disability endangering the child or anyone else?
- Do the effects of the child's disability influence, interfere with, or prevent the child's ability to function in the school environment?
- Will the effects of the disability influence, interfere with, or prevent the child's educational progress, safety, or ability to function in the anticipated school environment, particularly if the child is first entering school or is changing environments? (Dunn and Campbell, 1991)

The occupational therapist or physical therapist alone cannot answer these questions. Understanding one another's roles and skills and listening to each other's observations about the child will help the IEP team answer the questions together. Answering the questions may require relinquishing former practices and domains in order to serve the child in the least restrictive environment.

Occupational therapy or physical therapy does not cure a child's medical condition (cerebral palsy, muscular dystrophy, or autism). Therapy helps the child with a disability perform important functions that support or enable participation in academic and nonacademic activities. When deciding whose expertise is needed to assist the child to meet IEP goals, IEP teams consider that according to the Wisconsin Physical Therapy Practice Act, only a physical therapist or physical therapist assistant under the supervision of a physical therapist can provide physical therapy. The physical therapist helps determine whether the service is a physical therapy intervention that only the physical therapist or the supervised physical therapist assistant can provide or whether this is a student activity that is part of classroom routines. Similarly, the occupational therapist helps determine if the service is an occupational therapy intervention that only the occupational therapist or the supervised occupational therapy assistant can provide under state law.

The determination of the need for these related services flows from knowing the nature of the special education the child will receive.

If the IEP team determines that occupational therapy or physical therapy is required to assist the child to benefit from special education, the IEP includes a statement of related services that will assist the child

- to advance appropriately toward attaining the annual goals.
- to be involved and progress in the general education curriculum.
- to participate in extracurricular and other nonacademic activities.
- to be educated and participate with students who are not disabled.

The statement includes:

- Amount and frequency (how often will occupational therapy or physical therapy be provided?)
- Location (will the child be with nondisabled peers during occupational or physical therapy?)
- Duration (how long will physical or occupational therapy continue?)

How must occupational therapy and physical therapy be documented on the IEP?

Occupational therapy and physical therapy are related services. It is sufficient to check the box next to the service on the IEP (form I-9) and to fill in the amount, frequency, location and duration.

- The amount of therapy must be stated in the IEP so that the level of the agency's commitment of resources is clear to parents and all who are involved in the IEP development and implementation.
- The amount of time must be appropriate to the service.

- The amount of therapy may be stated as a range to meet the unique needs of the child. A range may be used for specific circumstances or conditions.
- The amount of therapy should be based upon the student's needs, not the availability of staff.
- The duration of service is considered the length of the IEP unless otherwise stated. When the duration is different than the rest of the IEP, the IEP should show beginning and ending dates.
- Location designates where the student receives services, either in the regular class or outside the regular class. Regular class means with nondisabled peers. Services provided outside the regular class are considered removal from regular education.

Service Delivery Model

Current research supports collaborative consultation instead of the expert model. With the expert model, the specialist independently evaluates needs, develops interventions and provides one-on-one intervention, or makes recommendations to staff. In contrast, with collaborative consultation, the team works together to identify need and develop and implement strategies. Collaborative consultation lends itself to integrated therapy. The following are advantages of integrated therapy:

- Student engages in regular classroom routines.
- Student practices and learns skills in the place he will use them.
- Student has increased practice opportunities.
- Student does not miss out on classroom activities.
- Student's social relationships are fostered.
- Therapist can see whether or not the strategies are working.
- Teachers and therapists focus on skills immediately useful for a child.
- Teachers can see what works and expand their skills.
- Therapists work with teachers to address problems as they arise.

R. A. McWilliam and Stacy Scott (2003) explained:

> Although therapy that is provided in-class may be considered integrated, location is just one of several factors that determine the 'integratedness' of therapy. Other dimensions of therapy include presence of peers, context of intervention, initiation, functionality of skills, and consultation. This continuum serves as a tool for professionals who want to provide more

integrated services to children. A therapist can identify the model typically used with a child and move up the continuum.

Continuum of Service Delivery Models

Model	Location	Therapy Focus	Peers	Teacher's Role
Individual Pull-Out	Anywhere apart from the regular class	Directly on child functioning	Not present	Provide information before therapy and receive information after therapy
Small Group Pull-Out	Anywhere apart from the regular class	Directly on functioning of children with special needs	One to six peers present	Provide and receive information before and after therapy, decide schedule with therapist and which peers will participate
One-on-one in Classroom	Classroom, often apart from other children	Directly on child functioning	Present but not involved in therapy	Conduct activities, play with other children, keep children from disrupting therapy; rarely, watch therapy session, provide and receive information after therapy
Group Activity in Classroom	Classroom; small or large group	On all children in group and on peer interactions, emphasis on meeting special needs of children	All or some children in group have special needs	When small group, conduct activities and play with other children; if possible, watch or participate in therapist's group. When large group, watch or participate in group activity and participate in planning large and possibly small group activity
Individual During Routines	Classroom, or other natural location of child	Directly but not exclusively on the focal child	Usually present	Plan and conduct activity including focal child, observe therapist's interactions with child, provide information before therapy, exchange information with therapist after routine
Collaborative Consultation	In or out of classroom	Teacher, as related to the needs of the child; can vary from expert to collegial model	Present if occurs in class; not present if occurs out of class	Exchange information and expertise with therapist, help plan future therapy sessions, give and receive feedback, foster partnership with therapist

Location is just one factor of integrated therapy. Other factors include presence of peers, context of intervention, initiation, functionality of skills, and consultation.

Service Provider

When the therapist's expertise is required to provide an intervention safely and effectively, the therapist provides the intervention. This is a clinical decision that the therapist makes. Other activities may not require the therapist's expertise and then other school personnel provide the activity.

Direct service occurs when the therapist works with a child, one-on-one. The physical therapist assistant, under the supervision of the physical therapist, may also provide direct service. Likewise, the occupational therapist assistant, under the supervision of the occupational therapist, may also provide direct service. Indirect service occurs when the therapist's knowledge and skills benefit the child without direct interaction. Many parents will assume that related services are always direct and one-on-one. Although not required by law, writing whether service is direct or indirect on the IEP clarifies for parents how service is provided.

Related Services Examples: Occupational Therapy and Physical Therapy

- Traditional: Direct physical therapy 2 times per week for 30 minute sessions in the regular classroom.
- Short-Term Intensive: Direct physical therapy 5 times per week at 45 minutes each session for the 1st semester outside the regular classroom.
- Infrequent: Occupational therapy 3 times during the second semester, 40 minutes direct service outside the regular classroom, and 60 minutes indirect service in the regular classroom.
- Group: Occupational therapy for one hour, 2 times per week, in a group of three children in the regular classroom.
- Specific Circumstances: When the wheelchair needs repairs, physical therapy will be provided.
- Conditional: When the child does not get to class on time, occupational therapy will be provided for a total of 180 minutes over 6-8 sessions outside the regular classroom.
- Predicted Schedule:
- September 1 – November 1: Physical therapy 3 times per week for a weekly total of two hours outside the regular classroom.
- November 2 – January 15: Physical therapy 2 times per week, 30 minutes per session in the regular classroom.
- January 16 – June 3: Physical therapy 30 minutes once per week in the regular classroom.

Supplementary Aids and Services

Supplementary aids and services are aids, services, and other supports provided to or on behalf of the student in regular education or other educational settings. The therapist collaborates in the IEP team discussion about the supplementary aids and services the student may need. The therapist may help the IEP team decide on assistive technology and adaptive devices the student may need and train the student to use the equipment. The focus is adapting the environment or providing accommodations to allow student participation in school routines. The amount, frequency, and duration of supplementary aids and services are documented in the student's IEP. For example:

- Laptop computer mounted on desktop or wheelchair for taking notes daily in English, history, and science classes.
- Modified seating for all periods in regular classes.
- Easy Stand stander in regular class for 20 minutes daily.
- Adapted seating whenever seated at desk and computer in the regular class beginning October 15, 2008.

The therapist may collaborate with the IEP team on the particular assistive device or support the student will use. The physical therapist may choose the stander for the student and instruct the student and staff in its use. The occupational therapist may choose the switches the student will use to activate a pointer.

Program Modifications and Supports

Program modifications and supports mean assistance for school personnel on behalf of the student. Again, the therapist collaborates in the IEP team discussion about the program modifications and supports for school personnel. The therapist may be the person designated to provide instruction to staff or may be part of a collaborative team working together to develop activities for the student. The amount, frequency, and duration are noted on the student's IEP. For example:

- Three 50 minute presentations for kindergarten teacher on proper lifting, transferring, and positioning for this student in the classroom, bathroom, playground, and lunchroom.
- Collaborative consultation, 30 minutes per month for PT, OT, ST, classroom teacher, and resource teacher in the conference room.
- 40 minutes quarterly consultation among PT, OT, and SPDE instructor in the gym.

Indirect service occurs when the therapist's knowledge and skills benefit the child without direct interaction. Writing whether service is direct or indirect clarifies how service is provided.

Must the occupational therapist or physical therapist attend a child's IEP team meeting if the child is receiving occupational therapy or physical therapy?

Physical therapists and occupational therapists are required members of the IEP team when a child is suspected or known to need occupational therapy or physical therapy (Ch. P1 11.24(2), WI Admin. Code). The excusal provisions in IDEA permit any required member of the IEP team to be excused from attending the IEP meeting, in whole or part, if the parent agrees in writing. This may occur when occupational therapy or physical therapy will not be discussed or changed. If the meeting involves modification to or discussion of occupational therapy or physical therapy, the respective therapist submits written input into the development of the IEP before the meeting.

The occupational therapist and the physical therapist participate in the development of the IEP for a child who requires their services and do so without canceling therapy for other children. A scheduling system that allows another therapist or assistant of the same discipline to provide therapy to the children while the therapist attends a meeting is one solution. An occupational therapy assistant or a physical therapist assistant cannot represent a therapist at the IEP team meeting, as the interpretation of evaluation results for the purpose of determining the existence of a disability, the need for special education and related services, and programming are not within the scope of an assistant's training. The assistant may contribute to program planning by communicating information about the child to the therapist. Because the therapist and assistant communicate at regular intervals, seldom would it be necessary for both the therapist and the assistant to attend the meeting.

After the annual IEP review and revision, changes in the IEP can be made by either the whole IEP team or some team members and the parents without a meeting if they agree. Parents are given a copy of the revised IEP and the school informs the rest of the IEP team of the changes.