Will I See You in September? A Question of Educational Relevance

When should therapists terminate direct occupational therapy in the school system? Is a student entitled to occupational therapy in schools because it is free? How much therapy is enough? Do occupational therapy goals and intervention have a unique focus? When is consultation or monitoring more appropriate than direct service? Who should make the decision to terminate direct therapy?

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The issues and questions that therapists face in public schools are extraordinarily complex; no simple answers exist for any of them (Bundy, 1991a). Although the questions listed above are posed by Nesbit elsewhere in this issue, they might have been (and are routinely) asked by thousands of occupational therapists employed in public schools. These questions are important, but the issue of when to terminate direct therapy reflects a more fundamental set of questions. What is educationally relevant therapy? What are the outcomes associated with direct service, consultation, and monitoring? What are the outcomes (i.e., objectives) sought for this student? What seems to be interfering with this student's meeting the objectives? What types of service provision are most closely associated with this student's needs? When therapists have addressed these fundamental questions, the question of when to terminate direct service in schools will be answered much more readily.

Toward a Working Definition of Educationally Relevant Therapy

A student might have difficulty meeting the demands of school for many reasons. Bundy (1991a) and Bundy et al. (1991) defined four continua that can guide team members' assessments of both the student's performance in school and the curricular demands. These continua are (a) acquiring information, (b) expressing learning, (c) assuming the student role, and (d) performing self-care and mobility activities.

Clearly, not all of these continua pertain equally to the services that occupational therapists provide in schools. Compared with educators, occupational therapists contribute little to students' ability to acquire knowledge; that ability depends largely on students' cognitive powers and on educational instruction. Occupational therapists, however, can contribute much to students' abilities to express what they have learned, to assume the student role, and to perform activities related to self-care and, to a limited degree, mobility (Bundy, 1991a).

The question of educational relevance is complex. Although the four continua serve as general guidelines, statements about educational relevance will not apply immediately and directly to all students. Rather, the educational relevance of therapy services for a particular student must be determined on the basis of the objectives set for that student. That is, the team must first ask, "What are the most important things this student should know or do differently by the end of this school year?" and "How will we know that the student has learned, or can do, these things?" The answers to these questions can be translated into meaningful, measurable objectives. Although objectives are specific, they usually represent broad areas of accomplishment (e.g., level of knowledge in math or reading and mastery of prevocational skills). The team would do better to state a few objectives that represent important accomplishments for the student than to list dozens of objectives reflecting every way in which a student might be different at the end of a school year. In other words, students will benefit from their educational programs in more ways than the team will express in their individualized education programs (IEPs). By limiting the number of objectives, team members create an IEP that represents a cohesive group effort toward the accomplishment of a few objectives that will make a difference for the student (Bundy, 1991a, 1991b).

When objectives have been determined, the team members can analyze them to determine what narrower skills and abilities the student needs to acquire to meet the broader objectives (Mager, 1975) or in what ways the environment must be changed to enable the student to meet the objectives. For example, to be able to write the solutions to addition problems with sums up to 20, the student might need to be able to carry numbers, know the solutions to addition problems with sums up to 10, and align the numbers vertically. The teacher might need to alter the assignment or better understand particular aspects of the student's disability.

When the objectives have been broken down into meaningful components, educational team members can

determine whether the student needs occupational therapy. This decision should be approached carefully, however. Although occupational therapists can contribute considerably to a student's performance in expressing knowledge, assuming the student role, and performing self-care and mobility activities, other educational personnel also have expertise in these areas. The question is, which educational team members can most effectively and efficiently help this student reach his or her objectives?

Once the objectives have been analyzed, a student's need for occupational therapy services outside of school can also be determined. For example, a particular student might need or want to work on a self-care skill that, because of the orientation of the curriculum, is not addressed in his or her IEP. The absence of that skill from the program suggests that, although the skill might be important for the student to acquire, it will have little effect on success in school and thus is not educationally relevant for this student at this time. The situation does not suggest, however, that the development of that skill will never be listed as educationally relevant on another IEP or on this student's IEP at a later time. The acquisition of that skill may be appropriately addressed by a private or clinical occupational therapist.

Nesbit (1993) argued that occupational therapists should not duplicate the services of other professionals. I also believe that the configuration of personnel working with a student should reflect the most effective and efficient means of meeting the objectives. However, I should make clear that occupational therapists practicing in public schools will not (and should only rarely) have unique objectives for the students with whom they work. Rather, they will have unique skills to offer and unique perspectives on the student's strengths and limitations. When they share their perspectives, skills, and common objectives with their colleagues, all team members' approaches to the student will be strengthened.

The students, families, and other educational team members with whom occupational therapists intervene in schools have complex needs. Almost always, the time and expertise of several team members will be required to help a student meet his or her objectives. Sometimes more than one team member will work on the same component of an objective. The issue is not so much a duplication of services, as Nesbit (1993) suggested, as it is of making explicit the contributions of all team members.

The objectives created for, and with, the student should drive all aspects of the student's IEP. They should determine the student's specific placement, the need for occupational therapy services, and the types of service provision best suited for meeting the objectives (Bundy, 1991a).

Guidelines for Matching Objectives With Service Provision Types

Once placement has been determined and the need for occupational therapy established, the team can determine the types of service provision that the therapist will implement. Nesbit argued elsewhere in this issue that decisions about the termination (and presumably the initiation) of services should be made by the therapist alone (after input from the team). Although her intent is correct (i.e., therapists are the experts about therapy), her statement is not. The occupational therapist must specify the anticipated benefits, limitations, and resources necessary for each type of service provision and must offer recommendations. The final decision, however, must rest with all team members because they are responsible for the student's overall educational plan and for providing the necessary resources for intervention. Only when the entire team is involved in the decision-making process can members be expected to commit themselves and their resources to the plan.

If providing intervention in schools meant providing only direct service, then perhaps I would agree that the decision to initiate or terminate intervention should rest with the expert. For example, an educational team might want a student with severe spastic hemiplegia to have good coordination of arms and hands because the demands of school would then be easier. If unattainable, however, that goal would send negative psychosocial messages to the student and occupational therapist and would waste their time. The problem in such a scenario is that the goal is too broad to have much meaning. What, specifically, would this student be able to do if he or she could move his or her arms and hands with coordination? Is that objective attainable? What is the most effective and efficient way to meet that objective?

Although some students will never be able to attain certain skills, they can still learn and benefit from school or therapy. The therapist is responsible for predicting as well as possible how therapy can be most effective for a particular student. The therapist is also responsible, like all team members, for contributing to the development of the most effective plan possible for each student. Perhaps most germane to this discussion, the therapist has a responsibility to view therapy as more than a type of direct service and to make explicit the anticipated benefits and costs of each type of service provision for each student.

An in-depth discussion of each type of service provision is beyond the scope of this paper. Briefly, the outcome of all intervention should be improved student–environment fit. With direct service and monitoring, occupational therapists attempt to change the student to better fit the environment (e.g., develop, maintain, or generalize skills, functions, or abilities). With consultation, we attempt to change the environment (human and nonhuman) to better fit the needs of the student. We give and receive information that enables all team members to view the student in a new and more positive way and we help our colleagues to develop new and better strategies for interacting with, parenting, or teaching the student. In short, we enable the student to succeed in school despite the limitations imposed by the disabling condition.

I believe that consultation should be the primary form of service provision in schools. Direct service and monitoring are additional services that should be used when the objectives or curricular expectations stress the need for the student to develop, maintain, or generalize a particular skill. Consultation, monitoring, and direct service are not different levels of service provision; they are different types. Consultation does not require less time than monitoring or direct service; it results in different outcomes. Thus, the question of when to terminate direct service really plays a

small part in the overall mission of educating the student.

Louisiana Criteria: The Case of Chad Revisited

Elsewhere in this issue, Nesbit supported published criteria for occupational therapy services in the Louisiana Public Schools (Carr, 1989). Carr illustrated the application of the Louisiana criteria with a series of fictitious examples, including one of Chad, a 5-year-old student with severe disabilities. By Louisiana criteria, Chad was ineligible for occupational therapy services because his educational level and his developmental level were comparable.

Carr's paper (1989) sparked a flurry of letters to the editor (Giangreco, 1990; Rainforth, 1990; Spencer, 1990) suggesting that Chad had definite educational needs for direct service. As Giangreco astutely pointed out, however, and as Carr (1990) acknowledged in her response, no information was given about Chad's IEP; thus, readers could not know whether he (or any of the students described) required any type of occupational therapy intervention to benefit from school. The need for occupational therapy and the specific type of service provision that will most effectively address the student's needs cannot be determined by the student's clinical picture alone. The issue is not whether the student might benefit from occupational therapy, but rather, whether the objectives set by the team require the unique skills and knowledge of the occupational therapist to be met effectively and efficiently.

Carr (1990) indicated that in 5 years she had experienced relatively little resistance to recommendations she made that were tied to the explicit Louisiana criteria. The Louisiana criteria contain serious flaws, but they set forth the criteria for occupational therapy. Carr's argument described the need for therapists to clarify the rationale behind their recommendations about service provision. The responses to a survey of more than 400 educators and educational administrators (Bundy & Lawlor, 1989) expressed the same message. Because the roles and services of occupational therapists in schools are rarely clarified, it is the therapists' responsibility to teach others what they do.

Perhaps the most troubling aspect of the Louisiana criteria as they were interpreted by Carr (1989) is that she made no explicit mention of the importance of the students' educational needs (objectives). In her response to the letters to the editor, Carr (1990) indicated that "in hindsight, examples might better have been summaries of the students' integrated reports, because a determination of need for occupational therapy services is never viewed outside the context of a student's needs as determined by the assessment team" (p. 472). The fact that Carr only thought to discuss this point in hindsight reflects our failure to define educational relevance. A student's objectives should drive the entire educational plan, including the need for occupational therapy services. Any document that seeks to set forth the criteria by which occupational therapy services are determined cannot be meaningful unless the student's objectives have been carefully determined and are clearly factored into the decision-making process.

Conclusion

In this paper, I have offered a perspective on educational relevance and service provision in public schools. I have attempted to define educational relevance as an issue that pertains to specific students' needs. Further, I have suggested that a student's educational objectives should drive the entire educational plan, including the need for, and type of intervention provided by, the occupational therapist. Different service provision types are associated with different anticipated benefits. Occupational therapists must make these differences explicit as they contribute to decisions made by the educational team.

Although I do not discount the importance of Nesbit's question of when to terminate direct service, I think that she—and many therapists—are beginning in the wrong place. Too often, therapists focus on entry and exit criteria without clarifying the definitions of educationally relevant therapy and the benefits and limitations of various types of service provision. When our services are driven by the student's educational objectives, the question of when to discontinue direct service will be much easier to answer. ▲

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LETTERS TO THE EDITOR

Student Perceptions of Psychiatric Disorder

Thanks to Mike Lyons and Robyn Hayes for their timely and insightful paper, "Student Perceptions of Persons With Psychiatric and Other Disorders," which appeared in the June 1993 *AJOT.*

I have been practicing in mental health as an occupational therapist for 15 years and have been troubled by the declining numbers of occupational therapists entering this practice area. I commend the authors for their contribution toward understanding an important issue.

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The Spoon Phase is Another Option for Self-Feeding

The article by Hon Keung Yuen in the May 1993 *AJOT* titled a "Self-Feeding System for an Adult With Head Injury and Severe Ataxia," was of interest to me on two counts. First, as the supervisor of the pediatric occupational therapy staff at Rancho Los Amigos Medical Center, I've encountered the difficult challenge posed by patients with brain injuries, such as the one described in Yuen's article.

Second, earlier in my career, I was involved in developing a self-feeding method to meet a similar situation for a 16-year-old patient with cerebral palsy who had no functional use of her upper extremities. The resulting spoon-plate device was described on pages 333–335 of the May 1982 *AJOT.* I believe that Mr. Yuen might have been interested in the spoon-plate as a trial with his patient but was apparently unaware of its existence. These devices are rarely called for but continue to be available from our Orthotics Department at Rancho Los Amigos Medical Center, Downey, California. Readers may be interested in knowing about this option for self-feeding. ▲

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