

Special Education Related Services

Volume Two



**A Guide for Educators and Parents
In Nebraska Public Schools**

**May 2000
Nebraska Department of Education**

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**Special Education Related Services
Volume Two**

Presented by
Special Education Advisory Council
Ad Hoc Committee on
Special Education Related Services

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The Special Populations Office and the Nebraska Special Education Advisory Council extend appreciation to the ad hoc committee members and to the agencies who provided the release time for these individuals during the development of this document. This document became a reality because of the dedicated committee and individual efforts of . . .

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SPECIAL EDUCATION RELATED SERVICES: VOLUME TWO

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Introduction

The primary purpose of this document is to guide related service providers, school administrators, parents, and interested individuals with guidelines to better understand the scope and application of related services as defined in the Individuals with Disabilities Education Act (IDEA 97) and subsequent federal regulations from the Federal Register, Volume 64, No. 48, Friday, March 12, 1998. Related services are only addressed in Part 300 of the regulations (ages 3 to 21 years). Early intervention addresses many of the same types of services, but defines them as “early intervention services. [34 CFR §303.12] There are no “related services” in early intervention. As such, this document only addresses the related services available to children ages 3 to 21 years as per 34 CFR §300.24. It should be noted that according to federal definition of related services, a child must have a disability verified by a local school district multidisciplinary evaluation team to receive special education related services. [34 CFR ?300.24]

The information is provided as a guideline to facilitate more specific policy development by the individual school districts. Each provider and school district will need to further clarify administrative issues within their own school district or Educational Service Unit (ESU) in application of this guide. This document is arranged alphabetically by related service area. In each area the reader will find the definition of the related service, a description of whom the related service intends to serve, a description of the service provider roles, entrance criteria, methods of assessment, methods of service delivery, the amount of service appropriate for educational benefit, and exit criteria. Also included when appropriate or available are examples of related service activities, workload considerations, equipment and space needed to provide the service, suggested documentation, supervision and evaluation of the service and provider, and a glossary of terminology.

Overview of the Project

During the 1998-99 school year two Nebraska Special Education Advisory Council (SEAC) committees were appointed - an executive committee and a writing committee - to develop a special education related services technical assistance document. The Nebraska Department of Education (NDE) contracted with the Munroe-Meyer Institute to allow Dr. Wayne Stuber to co-coordinate this project

with the NDE Special Populations Office representative, Linda Schafer. Dr. Stuberg and Mrs. Schafer reported progress and sought input from the SEAC during each of the scheduled SEAC meetings during the 1998-99 and 1999-2000 school years. The Executive Committee provided direction and guidance throughout the development of this document. Executive Committee and Writing Committee membership lists are located in the beginning pages of this document.

The Writing Committee represented each of the fifteen (15) related service areas listed in the Individuals with Disabilities Education Act of 1997. Recruitment of Writing Committee members was conducted through a direct solicitation to state professional organizations representing a related service (e.g. Physical Therapy Association) where possible and through general solicitation in the case of services not represented by a professional organization. Two persons for each related service area were selected. The writers followed a specific format, and were asked to go to their respective professional groups to seek consensus on the information each team prepared. A second draft was developed and reviewed statewide. Following final editing by the Writing Committee, a final draft was edited by Dr. Stuberg and Mrs. Schafer and presented to SEAC for approval in January 2000. The document was then finalized, printed, and disseminated. Copies of the document are available from the Nebraska Department of Education Special Populations Office, and a copy is also located on the Nebraska Department of Education, Special Populations web page (<http://www.edneb.org/SPED/sped.html>). Select the "School Support" button and then select this document by name.

Each related service is addressed in alphabetical order as listed in 34 CFR §300.24, the rules and regulations for IDEA '97 and are as follows:

- Audiology
- Counseling Services
- Early Identification and Assessment of Disabilities
- Medical Services
- Occupational Therapy
- Orientation and Mobility
- Parent Counseling
- Physical Therapy
- Psychological Services
- Recreation
- Rehabilitation Counseling Services
- School Health Services
- Social Work Services in Schools
- Speech Language Pathology
- Transportation

General Entrance and Exit Criteria

A child who is between the ages of 3 and 21 years with a verified disability who also demonstrates the need of a related service, as defined by 34 CFR §300.24, to benefit from the special education services may be eligible to receive those related services. The receipt of a related service is based on the documented and assessed needs of the child.

In determining whether or not assessed educational needs should be met by a specific related service the following should be apparent.

- The problem(s) appears to be primarily a problem that could be addressed through the receipt of a specific related service.
- There is potential for positive, progressive, developmental or functional change.
- It appears that without the specific related service, negative change could occur.

The individual education plan (IEP) team should consider terminating the specific service if the IEP goals have been met and no additional services are necessary to meet the child's educational needs. Termination should also be considered when the potential for further change appears unlikely based on previous documented intervention attempts. More detailed criteria are addressed in many of the related service sections. (Schafer, L., 1998)

Determining the Amount of Service for Educational Benefit

This section was excerpted and adapted from *Occupational Therapy Services and Physical Therapy Services in the Educational Setting*, an NDE technical assistance document edited by Linda Schafer, Wayne Stuberg, and Patricia Gromak. (Schafer, L., et al, 1996)

Service delivery, the intensity of the service, and the frequency of service are determined by the IEP team based on the child's educationally related needs. The critical determinants are the individual, unique educational needs of the child and the most appropriate manner in which the special education needs can be supported by the related service in question.

IEP team members should consider the following factors in developing goals and objectives for related services:

- The least restrictive environment needed to accomplish the goals and objectives for the related service;

- The type of skills to be learned and the methods and strategies of intervention anticipated;
- The level of expertise required to provide the service; and
- The need for and availability of others to carry out the child's IEP.

In general, service delivery will vary in frequency depending on the needs of the child. Traditionally this continuum has been labeled as being direct services, integrated services and consultative services. The need for sharing of information among IEP team members and joint program planning and evaluation must be done throughout the continuum. There is a need for the appropriate provider to have some level of direct contact in all models for assessment and program planning so that the division is not based solely on the presence or absence of direct contact with the child.

The amount of service depends on numerous factors, including the existence of changes in the child's status or environment; critical periods for skill development; the special education goals and objectives; and the degree that the problem interferes with the child's special education program. Monitoring of student performance is necessary to determine if the amount of service is appropriate to promote progress toward attainment of the child's special education goals and objectives.

Direct Service

In direct service the related service provider works with a child individually or in a small group on a regularly scheduled basis to assist the child to develop skills relevant to the child's educational performance. The emphasis of direct service is performance and skill acquisition to benefit from instruction. Direct service may also be indicated to maintain newly acquired skills or to slow the rate of regression. Collaboration with parents, teachers, and paraeducators is necessary to achieve goals and carryover of activities into the regular routine. Consultation is needed to maximize the educational benefit of the intervention.

Integrated Service

Integrated service combines direct, hands on child contact and consultation with others directly involved with the child. There is an emphasis placed on the need for practice of skills in the child's daily routine. The process of goal achievement is shared among those involved with the education of the child. Those involved may include the related service provider, teachers, parents, classroom paraeducators.

Intervention typically includes adapting activities occurring in the child's routine and creating opportunities for the child to practice new skills with others. The related service is provided within the child's daily environment, and should always include others involved with the child who can carry out the delegated activities or services.

Consultative Service

The related service provider in consultative service focuses on providing input to the teacher, staff, and parents regarding the child's specific needs rather than providing direct services. This does not preclude the need for the related service provider to work directly with the child to identify needs or problem solve. The related service provider supports the educational program, but is not the primary provider of services. The child's needs may not be rapidly changing or only minimal input is needed from the related service provider. Consequently, only periodic direct contact is needed.

The related service provider's involvement includes providing suggestions to the teacher, staff, and parents for modifications of educational materials and the environment as well as infrequent monitoring of the child's progress and any adaptive devices that may be used.

Definition of Terms

Educational Benefit

The term *educational benefit* was defined for this document by the project Executive Committee as "*Profit or benefit from special education should lead to improved, maintained, or increased access to typical education experiences for the child's age. There is evidence of substantial, consistent progress toward attainment of the goals in the IFSP or IEP, by accomplishing at least a majority of the objectives established in each goal area and may be further evidenced for school age children by:*

- *Increased participation in regular curriculum; and*
- *Participation and evidence of improvement in district wide testing programs.*

The IEP should be reasonably calculated to enable a child to receive educational benefit. [Hendrick Hudson Dist. Bd. Of Ed. V. Rowley, 458 U. S. 176 (1982)] IEP objectives should be written to meet the child's needs that result from the child's disability to enable the child to be involved in and progress in the

general curriculum. The objectives must also meet other educational needs that result from the child's annual goals will be measured, how the parents will be regularly informed of the progress, and the extent to which that progress is sufficient to enable the child to achieve the goals by the end of the year. [20 U.S.C. Chapter 33, Section 1414(d)(1)(A)(ii) and (viii)]"

Related Services

Related services is defined:

"... Transportation, and such developmental, corrective, and other supportive services as required to assist a child with a disability to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification, and assessment of disabilities in children, counseling services, including rehabilitation counseling, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training." [34 CFR §300.24(a)]

Special Education

The term special education means: *"...specially designed instruction, provided at no cost to the parents, to meet the unique needs of a child with a disability..." [34 CFR §300.26(a)]*

Children with Disabilities

The term "children with disabilities" means:

"...Those children evaluated in accordance with [the multidisciplinary evaluation team process] as having mental retardation, hearing impairments including deafness, speech or language impairments, visual impairments including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, specific learning disabilities, deaf-blindness, or multiple disabilities, and who because of those impairments need special education and related services." (Wording added) [34 CFR §300.07(a)(1)]

Least Restrictive Environment

The term "least restrictive environment" means:

"That to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are nondisabled; and that special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in

regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.” [34 CFR §300.550(b)(1) and (2)]

Parent

For this document the definition of parent is taken from 92 NAC 51. “Parent means natural or adoptive parent of a child; a guardian but not the State if the child is a ward of the State; a person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child’s welfare); or a surrogate parent who has been appointed in accordance with Subsection 009.07. A foster parent may act as a parent under this Chapter if the natural parents’ authority to make educational decisions on the child’s behalf has been extinguished under Nebraska law; and the foster parent has an ongoing, long-term parental relationship with the child; is willing to make the educational decisions required of parents under this Chapter; and has no interest that would conflict within the interests of the child.” [92 NAC 51-003.40]

Federal and State Legislation

In 1973 the U.S. Congress became a partner with our state Legislature to appropriately educate children with disabilities when it passed Section 504 of the Vocational Rehabilitation Act (P.L. 93-112) of 1973, and in 1975 when Congress passed P.L. 94-142, the Education for all Handicapped Children Act (EHA). These federal laws combined to provide civil rights protection (Section 504) for children with disabilities and some financial assistance (EHA) to states for special education programs. In 1986 P.L. 99-457 was adopted to include special education services for children birth to age three. In 1990 the Education for all Handicapped Children Act was reauthorized and renamed the Individuals with Disabilities Education Act (IDEA). IDEA was again reauthorized in 1997.

The effect of both state and national legislation has been broad. First, they have provided a vehicle to bring vast numbers of previously unserved students into the public education system. Second, because of the increased school participation of a variety of students with disabilities, there has been a general heightened awareness of the talents and potential of people with disabilities. IDEA 97 and the Nebraska Special Education Act are based on the following premises:

- **A free, appropriate public education** must be provided for all children, without cost to their parents and regardless of

severity or type of disability. No child may be excluded from school because of their perceived educability.

- **Protective, due process rights** must be ensured for all children with disabilities and their parents to ensure free, fair, and unbiased assessment, programming, and placement for students with special needs.
- **Education in the least restrictive environment** must be provided; that is, to the maximum extent possible students with disabilities must be educated with children without disabilities.
- **Individualized educational programming**, the Individual Family Service Plan (IFSP) or the Individualized Education Plan (IEP), must be developed for each student with a verified disability.
- **Parental involvement** is required for all decisions regarding the programming for students with special needs.

Early Intervention

Nebraska became a birth mandate state for early intervention services through passage of Legislative Bill (LB) 889 in 1978, requiring that special education services be provided by local school districts to children birth to age five. Legislative Bill (L.B.) 520, the Nebraska Early Intervention Act, was passed in the 1993 legislative session and was based on federal Public Law 99-457. This Act entitles services coordination within the community for families who have an infant or toddler with a disability. The family-centered interagency coordination of services required by the Nebraska Early Intervention Act and IDEA 97 is designed to maximize the effectiveness of state and community resources already in place, avoid duplication of services, and more clearly define the roles of state and community agencies.

Key components of the Nebraska Early Intervention Act are services coordination, planning regions, interagency collaboration, Medicaid in the public schools (MIPS), and co-lead management between the Nebraska Department of Education and the Nebraska Department of Health and Human Services. For information on services coordination or planning regions contact the Nebraska Department of Education, Special Populations Office (402/471-2471) or the Early Childhood Education Office (402/471-6518).

Nebraska Medicaid in Public Schools (MIPS)

The purpose of Medicaid in Public Schools (MIPS) is to access federal Medicaid funds to pay for educational physical therapy, occupational therapy, and speech therapy services delivered by public schools to Medicaid eligible children from birth to age 21. The federal Medicaid funds that MIPS generates are intended to free up state special education funds to be redirected to pay for services coordination for children with disabilities birth to age three and their families.

The Nebraska Legislature passed (in July 1993) L.B. 520, the Early Intervention Act, which, among other things, requires statewide implementation of MIPS billing for physical therapy, occupational therapy, and speech therapy services delivered to Medicaid eligible children (birth to age 21) beginning with the 1993-1994 school year. The bill also directs that the funds made available through the MIPS program are to be used to support services coordination for infants and toddlers with disabilities, and their families.

MIPS Participants

The State agencies participating in the MIPS program are the Nebraska Department of Education (NDE) and the Nebraska Department of Health and Human Services (DHHS). These State agencies coordinate MIPS activities with school districts, educational service units (ESUs), and cooperatives.

MIPS Providers

In the Nebraska MIPS program, a provider is the school district. Although the school district may not employ the individual(s) providing the service they are still referred to as the "provider" in this program. For purposes of the MIPS program, a "provider" is separate from a "direct service provider." A direct service provider is the actual therapist who conducts therapy with a child. This person may either be employed or contracted by a school district, ESU or cooperative.

For specific information on the MIPS program the reader should refer to the *MIPS Procedural Manual* published by the Nebraska Department of Education and the Nebraska Department of Health and Human Services.

Further information or questions should be addressed to the Early Intervention MIPS Coordinator, 402/471-9126. The Nebraska Department of Health and Human Services and the Nebraska Department of Education jointly support this position. As of this printing

the Early Intervention MIPS Coordinator is Jon Sterns who is located at the Nebraska Department of Health and Human Services, PO Box 95026, 301 Centennial Mall South, Lincoln, NE 68509-5026.

Section 504 of the Rehabilitation Act of 1973

With passage of the Rehabilitation Act of 1973, Congress required that federal fund recipients make their programs and activities accessible to all individuals with disabilities. "No qualified individual with disabilities, shall, solely by reason of her or his disability be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Section 504 protects persons from discrimination based upon their disability status. Section 504 is a civil rights act versus IDEA, which is a federal entitlement program. To qualify under Section 504 definition a person is determined to be disabled if he or she:

1. has a mental or physical impairment that substantially limits one or more of such person's major life activities;
2. has a record of such impairments; or
3. is regarded as having such impairment.

"Major life activities" include functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. When a condition does not substantially limit a major life activity, the individual does not qualify under Section 504.

Section 504 has three major areas of emphasis: employment practices, program accessibility, and requirements for preschool, elementary, and secondary education. The requirements for preschool, elementary, and secondary education are reviewed in this document.

Section 504: Eligibility

If the district thinks that, because of a disability as defined under Section 504, a student may need special accommodations or services in the regular setting to participate in the school program, the district must evaluate the student. If it is determined that the student is disabled under Section 504, the district must develop and implement the delivery of all appropriate services and/or accommodations.

Although Section 504 does not require school districts to develop an IEP with annual goals and objectives, it is recommended the school document that services and/or accommodations for each eligible Section 504 student are being provided. Parent participation is always encouraged.

In summary, some students who have physical or mental conditions that limit their ability to access and participate in the education program are entitled to rights under Section 504 although they may not fall into IDEA categories and may not be eligible to receive special education programs and related services under 92 NAC 51 (Rule 51). Additional information on *Section 504* including services, procedural requirements, parent and student rights, discipline of students with disabilities and program accessibility can be found in the 1994 Nebraska Department of Education technical assistance document, *Section 504 of the Rehabilitation Act of 1973 / Attention Deficit Hyperactivity Disorder / Americans with Disabilities Act*.

For additional information regarding Section 504, contact the Region VII, U.S. Department of Education, Office of Civil Rights located in Kansas City, Missouri. (U.S. Department of Education, Office of Civil Rights, 10220 No. Executive Hills Blvd., Kansas City, MO 64153-1367; (phone) 816/891-8026; (fax)816/374-646)

Nebraska Regulations (92 NAC 51)

Nebraska regulation 92 NAC 51 is the special education rule most often referred to as Rule 51. The process to identify whether or not a child is a child with a disability includes the student assistance team (for school age children only), referral to a multidisciplinary evaluation team, evaluation, verification, and the individual education program (IEP) for children ages 3-21.

The chart on page 14 represents the school age special education process from assessment to implementation of the IEP. The chart includes options for Section 504 of the Rehabilitation Act. Related services providers may be involved at any point in the process.

Student Assistance Team (SAT) or Comparable Problem Solving Team

For a school age student, a general education student assistance team or a comparable problem solving team shall be used prior to referral for multidisciplinary team evaluation. [92 NAC 51-006]

It is intended that this team be a building level regular education team. The goal of a building level student assistance team is educational problem solving, a sound educational practice resulting in the provision of general education intervention without direct special education services. The student assistance team also serves as an intermediate step where problem solving and the generation of intervention strategies by the building level team assists the teacher in dealing with the problem(s) prior to or in lieu of referral for special education evaluation. Special education staff including related services providers may be invited to participate in the SAT process.

If the student assistance team or comparable problem solving team feels that all viable alternatives have been explored, a referral for multidisciplinary evaluation shall be completed. [92 NAC 51-006]

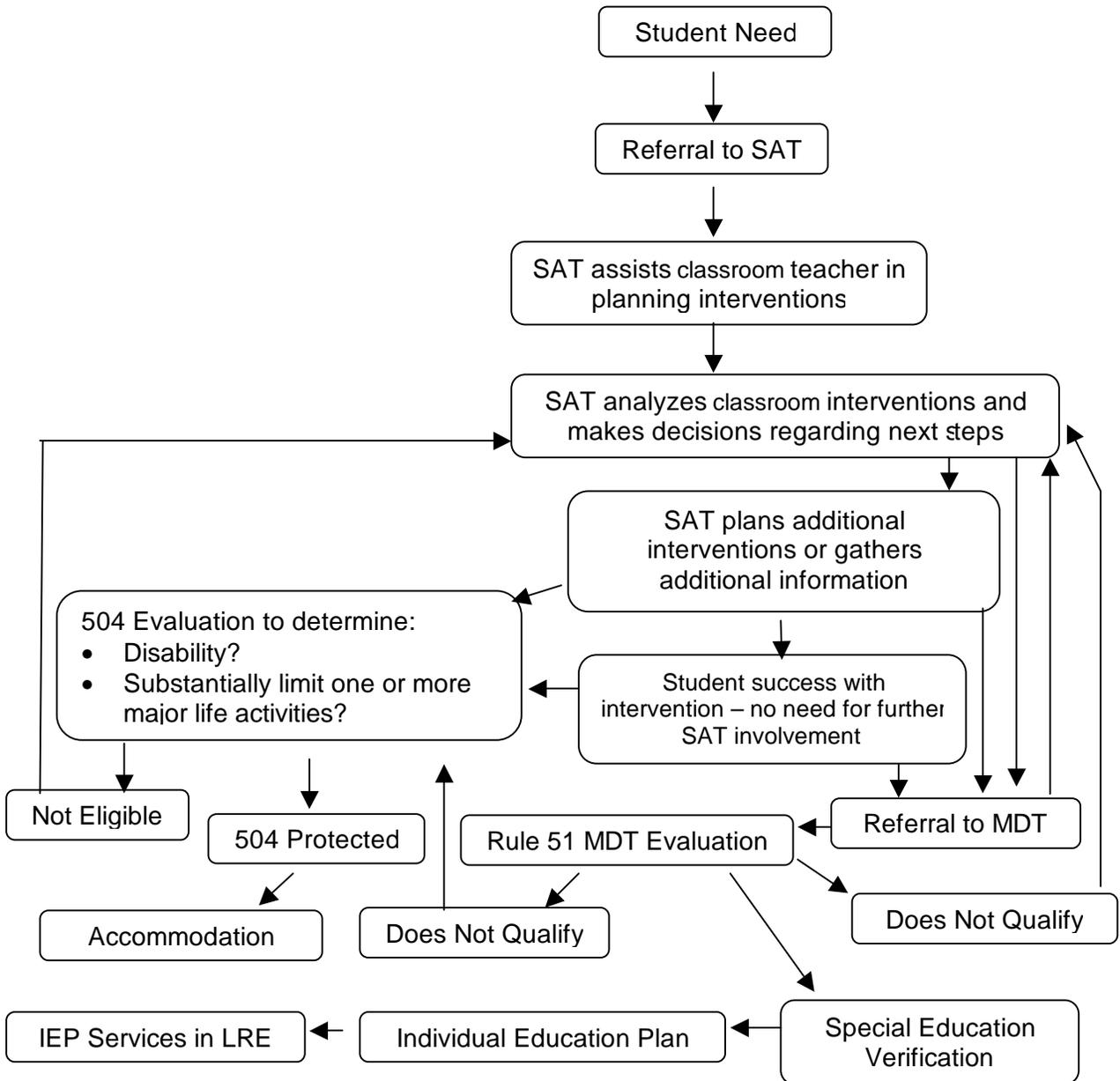
Multidisciplinary Evaluation Team

The purpose of the multidisciplinary evaluation team (MDT) is to analyze, assess, and document the educational and developmental abilities and needs of each student referred. Using the documentation collected, the school district MDT makes all verification decisions. The MDT must also collect enough documented information to facilitate the development of a statement of present level of educational performance for the student's individual education program (IEP).

Individual Education Program (IEP)

If the MDT decides based on the documented evidence, that a child is a child with a verified disability, an IEP will be established for that child. Please refer to 92 NAC 51-007 for regulatory information on the contents of the IEP.

The School Age Special Education Process



A Comparison of IDEA and Section 504 of the Rehabilitation Act

	Section 504	IDEA
Type	A Civil Rights Act	An Education Entitlement Act
Title	The Vocational Rehabilitation Act of 1973	Individuals With Disabilities Education Act
Responsibility	Regular education	Special education
Funding	Local District (no federal or state funding)	Funding provided by the federal, state, and local governments
Administrator	Section 504 Coordinator	Special education director or other appropriate administrator
Service Tool	None required in writing, but can use IEP or similar planning document	Individual Education Program (IEP) Individual Family Service Plan (IFSP)
Purpose	A broad civil rights law that protects the rights of individuals with disabilities in programs and activities that receive federal financial assistance from the U. S. Department of Education	A federal funding statute whose purpose is to provide financial aid to states in their efforts to ensure adequate and appropriate services for students with disabilities
Identification	Identifies student as disabled if he/she has or has had a physical or mental impairment that substantially limits a major life activity, or is regarded as disabled by others	Identifies students in one of 13 disability categories
Free Appropriate Public Education (FAPE)	Both require the provision of a free appropriate public education to students covered under each including individually designed instruction.	
	"Appropriate" means an education comparable to the education provided to nondisabled students	Requires the district to provide IEPs "Appropriate education" means a program designed to provide educational benefit to the student
Special Education vs. Regular Education	A student is eligible so long as he/she meets the definition of qualified person Student is not required to need special education in order to be protected.	A student is only eligible to receive special education and related services if the multidisciplinary evaluation team determines that the student is disabled under one of the thirteen qualifying categories and the student requires special education services
Accessibility	Has regulations regarding building and program accessibility, requiring that reasonable accommodation be made	Requires that modifications must be made if necessary to provide access to a free appropriate education
Procedural Safeguards	Both require notice to the parent or guardian with respect to identification, evaluation, and placement	
	Does not require written notice	Requires written notice

	Section 504	IDEA
Evaluations	<p>Evaluation draws on information from a variety of sources in the area of concern; decisions made by a group knowledgeable about the student, evaluation data, and placement options</p> <p>Does not require consent, only notice (however, best practice would provide for informed consent)</p> <p>Requires periodic reevaluations</p> <p>Reevaluation is required before a significant change in placement</p> <p>No provision for independent evaluations at district expense.</p>	<p>A full comprehensive evaluation is required, assessing all areas related to the suspected disability. A multidisciplinary team evaluates the student.</p> <p>Requires informed consent before an initial evaluation is conducted</p> <p>Requires reevaluations to be conducted at least every three years</p> <p>A reevaluation is not required before a significant change in placement. However, a review of current evaluation data, including progress monitoring, is strongly recommended</p> <p>Provides for independent educational evaluation at district expense if parent disagrees with evaluation obtained by school or is ordered by a hearing officer</p>
Placement	Notice must be given under both Section 504 and IDEA.	
	A meeting is not required for change of placement	An IEP meeting must be conducted before any change of placement
Grievance Procedure	Requires districts with more than 15 employees to designate an employee to be responsible for assuring district compliance with Section 504 and provide a grievance procedure for parents, students, and employees	Does not require a grievance procedure, or a compliance officer

Audiology

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Audiology as a Related Service

Audiology is Intended to Serve...

Children who receive audiology as a related service generally include those with known or suspected hearing or listening disorders, and/or those with speech or language delays. Additionally, the “creation and administration of programs for prevention of hearing loss” [(34 CFR 300.22(b)(i)(iv)] is applicable to all ages regardless of the presence of hearing loss.

92 NAC 51 (Rule 51) defines the qualifications for having hearing impairment as follows: “Hearing impairments shall mean a hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects development or educational performance (emphasis added). Hearing impairments shall also mean a hearing impairment, whether permanent or fluctuating, which adversely affects a child’s development or educational performance. This term parallels the state and federal definitions of hearing impairments including deafness.”

Rule 51 further states in Section 6 that the hearing impairment should be “...expected to produce a delay or interference with the development and maintenance of the following: effective verbal communication; expressive or receptive language development; academic and vocational performance; or adaptive behaviors.” This is consistent with the ASHA (1993) Guidelines for Audiology Services in the Schools, which further details how hearing loss affects vocabulary, sentence structure, academic achievement and psychosocial functioning. Those with hearing impairments may exhibit any or all of the following: poor auditory discrimination, language delay, articulation errors, voice or fluency problems, reading comprehension delay, poor academic achievement, or social-emotional problems (Educational Audiology Handbook 1997, p.155).

The Educational Audiology Handbook (1997, p.156) suggests that “Children with Central Auditory Processing Disorders (CAPD) may be eligible for special education or 504 services depending on the severity and implications of the problem. ...usually students with significant CAPD qualify for eligibility consideration with either a hearing, speech language, or learning disability.”

Audiology is Provided by . . .

Audiologists and speech/language pathologists provide audiology as a related service. The following information assists in the clarification of these provider's roles.

State law defines who is considered an audiologist in Nebraska Licensure Neb. Rev. Stat. §71-1,186: “(3) Audiologist shall mean an individual who practices Audiology and who presents himself or herself to the public by a title or description of services incorporating the words audiologist, hearing clinician, hearing therapist, or any similar title or description of services.”

92 NAC 24 describes Special Services Counseling Endorsements for Educational Audiologists as follows: “Persons with this endorsement may serve as an Audiologist and resource person for programs involving students in pre-kindergarten through grade 12.”

A person who holds a valid endorsement as a speech or hearing specialist, issued by the State Department of Education, may perform speech-language pathology or Audiology services as a part of their duties through the schools without a state license. (See Neb. Rev. Stat. §71-1,187)

It is in the scope of practice for Speech-Language Pathology (SLP) to provide the communication assessment and rehabilitation services to children who are deaf or hearing impaired, as described in the ASHA (1996) Scope of Practice in Speech-Language Pathology:

“Providing aural rehabilitation and related counseling services to individuals with hearing loss and to their families; collaborating in the assessment of central auditory processing disorders (CAPD) in cases in which there is evidence of speech, language, and/or other cognitive-communication disorders; providing intervention for individuals with CAPD; conducting pure-tone air conduction screening (emphasis added) and screening tympanometry for the purpose of the initial identification and/or referral of individuals with other communication disorders or possible middle ear pathology...”

Preferred Practice Patterns (ASHA, 1997) suggests that aural rehabilitation assessment (evaluation) and treatment may be done by either an audiologist or a SLP.

In reference to school-age children, 92 NAC 51- 006 states the need for “A written report signed by a licensed or certified audiologist documenting a unilateral or bilateral hearing loss based on a current

audiological evaluation.” In reference to children below age five, 92 NAC 51- 006 specifies the requirement of “A written report signed by a licensed or certified audiologist documenting hearing loss.” A communication assessment to establish the child’s speech, language and communication skills and areas of need may need to be completed by a SLP or a teacher of the deaf or hard of hearing. For purposes of the Rule 51 multidisciplinary evaluation team (MDT), the audiologist is not a designated member of the MDT, and it is implied that an SLP or teacher does the communication testing. (92 NAC 51- 006)

Qualifications of Providers ...

An audiologist is a professional who has earned a master’s or doctoral degree. Their training makes them uniquely qualified to provide audiological services.

The audiologist is the only professional who is qualified to perform an audiological evaluation for verification purposes. For purposes of the multi-disciplinary team (MDT) evaluation, the Audiologist provides a written report that documents the hearing loss.

This evaluation may include:

- auditory brainstem response (ABR) testing,
- otoacoustic emissions (OAE),
- pure-tone audiometry,
- speech or sound awareness/detection thresholds (SAT or SDT) and/or speech reception thresholds (SRT),
- sound, word or sentence recognition testing, and
- immittance testing.

If the student has amplification, the amplification system or hearing instrument is assessed. If the student does not have amplification, but might benefit from its use that is evaluated. Amplification evaluation and assessment will vary depending on the age of the student, the settings in which the amplification system will be used and the type of amplification system or assistive device. Assessment for amplification might include:

- electroacoustic analysis of the devices,
- probe-microphone measures, and/or

- behavioral tests of auditory performance while wearing amplification (speech awareness threshold/speech reception threshold, word recognition, sound field thresholds and loudness judgements).

The audiologist may also perform testing to assess (and monitor) the students’ speech, language and communication skills, classroom listening performance and areas of need, particularly as these impact academic performance.

Role of Support Personnel

The use of support personnel in the provision of audiology services is well-defined in national guidelines. The ASHA (1997)

Position Statement and Guidelines on Support Personnel in Audiology states that “...support personnel may assist audiologists in delivery of services where appropriate. The roles and tasks of audiology support personnel will be assigned **only** by supervising audiologists. Supervising audiologists will provide appropriate training that is competency-based and specific to job performance.”

Nebraska state law has specific recommendations for use of communication assistants and SLP technicians: Neb. Rev. Stat. §71-1, 195.06 “Communication assistant; duties and activities. A communication assistant may, under the supervision of a licensed audiologist or SLP, perform the following duties and activities:

- Implement programs and procedures designed by a licensed audiologist or SLP which develop or refine receptive and expressive verbal and nonverbal communication skills;
- Maintain records of implemented procedures which document a patient’s responses to treatment;
- Provide input for interdisciplinary treatment planning, inservice training, and other activities directed by a licensed audiologist or SLP;
- Prepare instructional material to facilitate program implementation as directed by a licensed audiologist or SLP;
- Recommend speech, language, and hearing referrals for evaluation by a licensed audiologist or SLP;
- Follow plans, developed by the licensed audiologist or SLP, that provide specific sequences of treatment to individuals with communicative disorders; and

- Chart or log patient responses to the treatment plan.

Neb. Rev. Stat. §71-1, 195.08 specifies Communication assistant; supervisor; duties. “ (1) When supervising the communication assistant, the supervising audiologist or SLP shall:

- Provide direct onsite supervision for the first treatment session;
- Provide direct onsite supervision of at least twenty percent of all subsequent treatment sessions per quarter;
- Provide regular and frequent inservice training, either formal or informal, which is directly related to the particular services provided by the communication assistant; and
- Prepare semiannual performance evaluations of the communication assistant.
- The supervising audiologist or speech-language pathologist shall be responsible for all aspects of patient treatment.”
(Source: Laws 1985, LB 129,30; Laws 1988, LB 1100, 75.)

A Speech Language Technician is described in 92 NAC 24 as, “Persons with this endorsement may provide speech-language services for students from pre-kindergarten through age 21; they may not fulfill the requirement(s) in 92 NAC 51 for membership on a MDT and/or an IEP.”

Additionally, other professionals that provide audiology-related services include the following:

1. Teachers of the deaf and hard-of-hearing: “ Annually conduct [evaluations] to monitor educational performance on all those with known educationally-significant hearing loss (ESHL) who are not staffed; conduct [evaluations] on those referred by audiologist with newly identified ESHL; schedule pre-conferences on all those referred with ESHL to discuss hearing impairment, associated educational concerns, and appropriate instructional modifications and adaptation; schedule pre-assessment conferences and staffing for those with associated educational concerns who need to be considered for hearing disability and services; act as case manager for students with ESHL; provide direct services to students who are deaf or hard-of-hearing.” (Educational Audiology Handbook, 1997, p.21) 92 NAC 24 for Special Education--Hearing Impaired specifies requirements for these teachers.

2. Interpreters (sign language, cued speech or oral interpretation): These professionals interpret for the student who requires them or for the parents who may require interpreters. This does not refer to foreign language interpreters.
3. Nurses: “Conduct screening (preschool and school-age) using criteria determined by Audiologist; cooperate with other agencies to ensure hearing loss identification and appropriate referrals; conduct follow-up to ensure those referred have received appropriate care.” (Educational Audiology Handbook, 1997, p.21)
4. Rule 51 specifically states that the school has a responsibility to assure that hearing aids worn in school are functioning: “Each school district shall insure that the hearing aids worn in school by children who are deaf or have hearing impairments are functioning properly.” Rule 51 does not, however, specify implementation details or who takes the responsibility for performing this task. It is feasible that a teacher, nurse, assistant or paraprofessional, could complete this task.

Entrance Criteria

To receive audiology as a related service the child must be verified as hearing impaired. The definition and qualifications for

verification as hearing impaired are in 92 NAC 51-006.04E.

Benefit from the provision of services would be observed through achievement of the IFSP or IEP goals/objectives. For school-age children, benefit would be further evidenced by their increased participation in the regular or general education curriculum.

Methods Used for Assessment

Specific age-appropriate tests and developmental assessments are available. Specific tests are not identified in this document. The tests vary with age and

developmental level and cover performance over a wide range of communication skills (e.g., receptive and expressive vocabulary, semantics, syntax (grammar), pragmatics, phonemic awareness, phonology and articulation, phonological and auditory processing, speech reading). Also, parent report and professional’s observations may be used in the assessment process. In the ASHA Preferred Practice Patterns (1997), the following clinical process is defined:

“Assessment includes evaluation of reception, comprehension and production of language in oral, signed, or written modalities; speech and voice production; perception of speech and nonspeech stimuli in multiple modalities; listening skills; speech reading; and communication strategies.” “Performance in both clinical and natural environments is considered.”
“Audiologic (aural) rehabilitation assessment may be part of an intra-and interdisciplinary process.”

Service Delivery Model(s)

Service delivery may be direct, integrated or consultative. The IEP should specify the method of service delivery for each student.

Examples of each follow.

Direct: Interaction with the student occurs one-on-one or in small groups. The audiologist or SLP is the primary service provider. Intervention may range from weekly sessions in a one-on-one format to a daily self-contained classroom experience with a teacher of the deaf or hard of hearing, or a combination of both. For infants and toddlers, the small group might be the family, with intervention carried out as home-based or center-based or a combination of both.

Consultative: The audiologist is a consultant to the SLP, teacher or parents about the student’s needs, and does not provide direct therapy. This may include monitoring only (no IEP required), and it usually entails only periodic direct contact. For example, a student may be in a self-contained classroom with a teacher of the deaf and hard of hearing as the classroom teacher and may receive periodic speech and language monitoring to assure that adequate progress is being made in the specific areas of concern. Additionally, the audiologist might periodically observe the student in the classroom to assure appropriate use of amplification, or train a teacher how to troubleshoot the child’s amplification. Also, the audiologist would be the professional who chooses and sets the child’s amplification device used at school. An amplification device is one example of assistive technology that may be used in the educational setting as defined in 92 NAC 51-004.13F1C. For example, the student may receive speech language therapy addressing an aural rehabilitation goal and the student may also be seen by an Audiologist to monitor the student’s auditory trainer.

Integrated: This is a combination of direct and consultative approaches.

Methods to Determine the Amount of the Service Appropriate for Educational Benefit

The amount of the service will vary with each student based on a number of factors. These factors include, but are not limited to: degree of hearing loss, co-existing conditions, the type and degree of communication deficits, learning strengths and age of identification

Exit Criteria

Please refer to general criteria listed in the introduction to this document as “general exit criteria for related service”.

Examples of Related Service Activities

Below are examples of delineation of Audiology services for assessment, intervention and amplification-related activities.

Assessment-Related Educational Example:

Concerns exist for hearing impairment because of poor auditory responsiveness, or does not pass the school hearing screening, or a student with known sensorineural hearing loss reports a sudden change in hearing and the school performs (or refers for) audiologic assessment.

Or

The audiologist assesses a student who demonstrated a recently decrease in auditory responsiveness wearing an auditory trainer.

Assessment-Related Borderline Example:

A child has permanent, sensorineural hearing loss and develops a middle ear infection that is being treated by a physician. The infection causes additional, changes in hearing that are noted by the educational staff to be affecting the child’s school performance. An Audiology evaluation is requested by the physician or family to assess whether the treatment has improved hearing.

The responsibility for payment of audiologic assessment that was not specifically requested by the MDT or IEP team is in question.

Assessment-Related Medical Example:

A student has had tympanostomy tubes placed and needs a post-operative audiologic evaluation that is required by the surgeon as part of the surgical protocol.

Or

A child is being considered for a cochlear implant, and must have current audiologic testing as part of determining candidacy.

Intervention-Related Educational Example:

A student uses an auditory trainer in the classroom and uses custom earmolds. The school provides the ear molds as part of provision of the auditory trainer.

Or

A student wears ear muffs in a woodworking class, and the school provides the ear muffs as part of a hearing conservation program.

Or

A student requires training in use of a new FM auditory trainer.

Intervention-Related Borderline Example:

A student has a history of eardrum perforations (holes) and is in a physical education course that includes swimming. The student's physician has recommended the use of water precautions and has approved using swim molds to keep the ears dry. These are used at home for bathing. These swim molds could also be used in the swimming program, or the school could provide a swimming cap

Intervention-Related Medical Example:

The student has hearing loss and is required to wear earmuffs at home per his/her physician's recommendations when in high-noise environments, such as mowing the lawn. The student's family provides this ear protection.

Introduction to Amplification-Related Examples

According to 34 CFR §300.5, an assistive technology device is “any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with disabilities.” This would include the use of an auditory trainer or other assistive listening device that is necessary for the student to benefit from education services. It is questionable whether hearing aids that are worn outside of the classroom or therapy session and would be used whether or not the student was in the educational environment are in this category. (See The Answer Book on Special Education Law, 2nd Edition, Susan Gorn, LRP Publications, Chapter 6, p. 26. and NICHCY News Digest, Volume 1, no. 2, 1991, p.6).

The provision of amplification beyond FM auditory trainers used in the classroom for students with hearing loss has not been addressed. The Nebraska Educational Assistive Technology (NEAT) Center has addressed some of the issues related to provision of appropriate amplification to students in schools that may not have other audiology support. The use of state education funds to pay for hearing aids or FM auditory trainers for home use has not been addressed at the date of this writing, although the use of amplification may be implied in the IEP.

Amplification-Related Educational Example:

A student with unilateral hearing loss requires an auditory trainer in the classroom to hear the teacher’s lecture. The school provides the device. The Audiologist selects and adjusts the device to be appropriate for the student’s hearing loss.

Amplification-Related Borderline Example:

A student with bilateral hearing loss has a Behind the Ear (BTE)/FM system that is used on a full-time basis, at school and at home. During the summer, the child does not receive special education services, but does use his BTE/FM system as a hearing aid on a full time basis.

Amplification-Related Medical Example:

A student requires an appliance to keep his/her ear canal open following surgery. This custom fit appliance improves the student’s ability to hear.

Workload Considerations

ASHA (1993), supported by EAA (1997), recommends one audiologist for every 12,000 preschool through high school students.

However, ASHA (1993) also suggested that several factors should be taken into account to reduce this ratio, such as: “excessive travel time; the number of children with hearing impairments; the number of preschoolers and children with other disabilities; the number of hearing aids and assistive listening devices in use; the quantity of special tests provided, including central auditory processing; the extent of equipment calibration and maintenance responsibilities; the amount of direct habilitative services; and the extent of supervisory/administrative responsibilities.”

Equipment and Space Needed to Provide Service

For hearing screening purposes, ambient room noise should be sufficiently low to allow for reliable responses. Portable audiometers and acoustic immittance meters should be calibrated, at least annually, to American National Standards Institute (ANSI) specifications (1996). A listening check should be performed prior to use of the equipment each day.

Other equipment and space needs are:

- A sound-treated room for audiologic evaluation, with ambient room noise levels as specified by ANSI (1991).
- A clinical audiometer, with sound field capacity and an acoustic immittance meter, with calibration completed at least annually, to ANSI specifications (1996). (A listening check should be performed prior to use of the equipment each day.)
- Audiometric equipment for Visual Reinforcement Audiometry (VRA) and other tools for performing audiometric testing on young children.
- Hearing instrument test equipment/electroacoustic hearing aid analyzer to assess auditory trainers and hearing aids.
- Hearing instrument fitting software and a compatible computer.
- Hearing aid equipment, such as, battery testers and hearing aid stethoscopes, to maintain and service devices.

- Access to loaner or demonstration hearing instruments (hearing aids and auditory trainers) to act as back-up systems and for inservices.
- FM auditory trainers and/or other assistive listening devices to use with students.
- Supplies for taking ear impressions for purposes of acquiring ear molds for children and equipment to modify and clean them.

Documentation

The audiogram format is standard, plotting hearing threshold in decibels (dB) as a function of frequency (usually 250-8000 Hertz, Hz). An example of this format is found at the end of this section.

Other assessment forms are available for testing the many aspects of communication performance. These forms are typically sold as part of each test, and are not reproduced in this document.

Supervision and Evaluation of Service and Service Provider(s)

It is the responsibility of the School Administrator to periodically evaluate the service provider if that service provider is a school employee. If a service provider is not a school employee, but is a consultant hired by the school to provide a service, then the contracting School Administrator should assure that the service provider meets standards. The latter could be assured through review of licensure information or endorsements and surveys of parents, shall participate in a review no less than triennially conducted by the Department of Education.

Glossary of Terms

air conduction: sound is conducted through air and presented through earphones or loudspeakers.

alerting systems: devices that serve to alert the user to the presence of an event, such as a fire or smoke alarm or the ringing of a telephone, doorbell, etc. The alert can be signaled with a flashing light or a vibration, teachers, and other service providers. Per 92 NAC 51-004.09A: “ All special education programs

amplification system: any device that provides an increase in the intensity of an auditory signal to the user. This includes hearing aids, auditory trainers or FM systems, or sound field amplification.

ANSI: American National Standards Institute.

ASHA: American Speech-Language-Hearing Association

assistive listening device (ALD): any device that increases the user’s awareness of auditory signals in the environment, e.g., smoke alarm with a strobe light. This includes amplification systems and alerting devices.

audiology: the study of hearing, hearing disorders, and (re) habilitation.

auditory brainstem response (ABR): a physiological response to sound originating from the hearing nerve and other centers in the brainstem; a test often used to estimate hearing sensitivity in infants and toddlers.

auditory discrimination: the clarity with which a listener can differentiate between sounds; speech sounds, words, or environmental sounds.

auditory trainer: an amplification device where the user has a receiver and the speaker has a microphone/transmitter. Also see FM system.

auditory training: aural (hearing) rehabilitation designed to maximize the use of hearing through structured practice in listening, enhancement of environmental factors, and the use of assistive technology. The focus of this training is on developing auditory awareness, discrimination, and listening skills.

aural rehabilitation: services and procedures to facilitate receptive and expressive communication for persons who are deaf and hard of hearing.

balance system dysfunction: difficulties in balance, sometimes related to inner ear disorders.

BTE/FM: a frequency modulated assistive device with the FM receiver placed in a behind-the-ear hearing aid case (see definition of FM

system for more information). These units may also operate as a personal hearing aid.

central auditory processing disorders (CAPD): disorders in the central auditory system (brainstem and/or brain) which may adversely affect the ability to hear in noise, localize sound, and/or determine auditory patterns.

classroom acoustics: physical characteristics of the classroom that may affect understanding of auditory signals.

cochlear implant: an implant used for those who have bilateral severe-to-profound hearing loss. It is intended to provide auditory awareness (and discrimination abilities) by bypassing the inner ear and stimulating the auditory nerve.

conductive hearing loss: hearing loss due to disorders of the ear canal and/or middle ear.

EAA: Educational Audiology Association

educationally-significant hearing loss (ESHL): hearing loss that affects educational performance.

expressive language: spoken, signed, or written language.

deaf: a hearing impairment that is so severe that limited linguistic information can be processed through hearing, with or without amplification.

decibels (dB): a number that indicates the intensity of a sound.

FM (frequency-modulated) system: an assistive device to improve the delivery of an auditory signal. The primary speaker wears a microphone/transmitter that sends the signal to a receiver worn by a student who has hearing impairment. These systems operate similar to an FM radio. They are used to minimize the detrimental effects of background noise, distance between a speaker and a listener and echoes (reverberation) in rooms. Also called an auditory trainer.

hard of hearing: a hearing impairment, fluctuating or permanent, that interferes with the ability to listen and hear speech or other environmental sounds.

hearing aid analysis: specialized test equipment for hearing instruments to determine if they are functioning within manufacturer's specifications and to assess performance at a variety of settings.

hearing aid evaluation: the assessment of hearing instruments using behavioral or objective methods, usually to determine which device(s) are most appropriate for a given individual.

Hertz (Hz): a number that indicates the frequency (pitch) of a sound.

immittance meter: equipment that is used to assess eardrum movement.

infrared system: assistive listening device that transmits sounds via an infrared signal.

linguistic: related to spoken language.

mixed hearing loss: hearing loss that is due to a combination of middle ear and inner ear disorders.

otoacoustic emissions (OAE): physiological responses from a set of specialized sensory structures in the inner ear. The OAE test is used to obtain an indirect assessment of hearing status and is used in newborn hearing screening and for other audiologic evaluations.

probe-microphone measures: testing done to assess performance of an amplification device while it is worn by the listener. These measures are made in a sound booth or quiet room using highly specialized equipment.

pure tone: a tone with a specific frequency receptive language: the language that is understood by an individual when it is presented via auditory, sign, or written modes.

sensorineural hearing loss: hearing loss that is due to a disorder affecting the inner ear and/or the auditory nerve.

sound field amplification: amplification provided through loudspeakers. This may be an FM signal.

speech reading: observing the lips and facial expressions of a speaker to aid in understanding the spoken message.

threshold: for purposes of hearing testing, it is the softest sound to which the person responds.

TTY (teletypewriter): refers to any number of devices that are used with telephones so that a text signal is sent (rather than an auditory signal). Also called TT (text telephone) or TDD (telecommunication device for the Deaf).

tympanic membrane: eardrum.

tympanometry: a test that measures the movement of the eardrum.

tympanostomy tubes: small tubes that are surgically placed in the eardrum to treat middle ear fluid that does not recover spontaneously or with other medical treatment.

universal newborn hearing screening: a program that screens hearing of all newborns, not just those who have risk factors.

vestibular testing: refers to assessment of the part of the inner ear that assists with maintenance of balance and orientation of the head.

visual reinforcement audiometry (VRA): a test method used to assess hearing sensitivity in children who are 6 months to approximately 2 years (developmental age).

References

- American Academy of Pediatrics. (1999). Newborn and Infant Hearing Loss: Detection and Intervention. Pediatrics, 103 (2), 527-530.
- American Academy of Audiology. (1997). Position Statement. Audiology: Scope of Practice. Audiology Today, 9(2), 12-13.
- American National Standards Institute. (1991). Maximum permissible ambient noise levels for audiometric test rooms (ANSI S3.1-1991). New York: Acoustical Society of America.
- American National Standards Institute. (1996). Specifications for audiometers (ANSI S3.6 1996). New York: Acoustical Society of America.
- American Speech-Language-Hearing Association. (1997). Guidelines for Audiologic Screening Rockville Pike: MD: Author.
- American Speech-Language-Hearing Association. (1993). Guidelines for Audiology services in the schools. ASHA, 35 (Suppl. 10), 24-32.
- American Speech-Language-Hearing Association. (1998). Position statement and guidelines on support personnel in Audiology. ASHA, 40 (Spring, Suppl. 18).
- American Speech-Language-Hearing Association. (1997). Preferred practice patterns for the profession of Audiology. Rockville Pike: MD: Author.
- American Speech-Language-Hearing Association. (1997). Preferred practice patterns for the profession of speech-language pathology. Rockville Pike: MD: Author.
- American Speech-Language-Hearing Association. (1996 Spring). Scope of practice in Audiology. ASHA, 38 (Suppl. 16), 12-15.
- American Speech-Language-Hearing Association. (1996 Spring). Scope of practice in speech language pathology. ASHA, 38 (Suppl. 16), 16-20.
- DeConde Johnson, C., Benson, P.V., & Seaton, J.B. (Eds.). (1997). Educational Audiology Handbook. San Diego, CA: Singular Publishing Group.
- Educational Audiology Association. (1997 Summer). Recommended Professional Practices for Educational Audiology. EAA, p.20-21.
- Gorn, S. (1998). The Answer Book on Special Education Law, 2nd Edition. Horsham, PA LRPPublications.
- NICHCY News Digest (1991, vol. 1, no. 2). Related Services for School-aged Children with Disabilities. Washington D.C.: Author.
- Schafer, L. (Ed.). (1998). Special Education Related Services: A Guide for Educators and Parents in Nebraska Schools, Volume 1. Lincoln, NE: Nebraska Department of Education.

Rule 51-Regulations and Standards for Special Education Programs (Title
92, NE

Administrative Code, Chapter 51), (1993), State of Nebraska, Department
of Education, 301 Centennial Mall South, Lincoln, NE 68509

Suggested Readings

- American Speech-Language-Hearing Association. (1998). Maximizing the provision of appropriate technology services and devices for students in schools. ASHA, 40 (Suppl. 18).
- American Speech-Language-Hearing Association. (1997). Preferred practice patterns for the profession of Audiology. Rockville Pike: MD: ASHA.
- American Speech-Language-Hearing Association. (1997). Preferred practice patterns for the profession of speech-language pathology. Rockville Pike: MD: ASHA.
- American Speech-Language-Hearing Association. (1996 Spring). Scope of practice in Audiology. ASHA, 38 (Suppl. 16), 12-15.
- American Speech-Language-Hearing Association. (1996 Spring). Scope of practice in speech language pathology. ASHA, 38 (Suppl. 16), 16-20.
- American Speech-Language-Hearing Association. (1997). Guidelines for Audiologic Screening Rockville Pike: MD: Author.
- Bess, F.H. (Ed.). (1998). Children with Hearing Impairment: Contemporary Trends. Nashville, TN: Vanderbilt Bill Wilkerson Center Press.
- Carney, A.E., & Moeller, M.P. (1998). Treatment efficacy: Hearing loss in children. Journal of Speech, Language, and Hearing Research, 41(1), pp. S61-84.
- DeConde Johnson, C., Benson, P.V., & Seaton, J.B. (Eds.). (1997). Educational Audiology Handbook. San Diego, CA: Singular Publishing Group, Inc.
- Educational Audiology Association. (1997 Summer). Recommended Professional Practices for Educational Audiology. EAA, p.20-21.
- Hull, R.H. (Ed.). (1997). Aural Rehabilitation: Serving Children and Adults, 3rd Edition. San Diego, CA: Singular Publishing Group, Inc.
- Roizen, N.J., & Diefendorf, A.O. (Eds.). (1999). The Pediatrics Clinics of North America: Hearing Loss in Children. Philadelphia, PA: W.B. Saunders Co.
- Roeser, R.R., & Downs, M.P. (Eds.). (1995). Auditory Disorders in School Children, 3rd Edition. New York: Thieme Medical Publishers, Inc.
- Rossetti, L.M., & Kile, J.E. (Eds.). 1997). Early Intervention for Special Populations of Infants and Toddlers. San Diego: Singular Publishing Group, Inc.
- Tye-Murray, N. (1998). Foundations of Aural Rehabilitation: Children, Adults, and Family Members. San Diego: Singular Publishing Group, Inc.

Web Sites

The sites have been restricted to edu, org and gov, and have purposely excluded commercial sites.

Alexander Graham Bell Association for the Deaf:

<http://www.agbell.org/>

American Academy of Audiology: <http://www.audiology.org/>

American Speech-Language-Hearing Association:

<http://www.asha.org/>

Boys Town National Research Hospital:

<http://www.boystown.org/btnrh/>

Disability Rights Education and Defense Fund, Inc.:

<http://www.dredf.org/indextx.html>

Educational Audiology Association: <http://www.edaud.org/>

John Tracy Clinic: <http://www.johntracyclinic.org/>

National Education Association Legislative Action Center:

<http://www.nea.org/lac/>

National Information Center on Deafness:

<http://www.gallaudet.edu:80/~nicd/>

National Institute of Deafness and other Communication Disorders:

<http://www.nih.gov/nidcd/>

National Information Center for Children and Youth with Disabilities:

<http://www.nichcy.org/>

Nebraska Commission for the Deaf and Hard of Hearing:

<http://www.nol.org/home/NCDHH/>

Nebraska Department of Education: <http://www.nde.state.ne.us/>

Nebraska Unicameral: <http://www.unicam.state.ne.us/>

Office of Special Education Programs:

<http://www.ed.gov/offices/OSERS/OSEP/index.html>

OSERS IDEA '97:

<http://www.ed.gov/offices/OSERS/IDEA/index.html>

Where Do We Go From Hear?: <http://www.gohear.org/>

Select National Audiology Organizations

American Academy of Audiology, 8201
Greensboro Drive, Suite 300, McLean, VA
22102, 1-800-AAA-2336, fax 703-610-9005.

American Speech-Language-Hearing Association, 10801 Rockville Pike,
Rockville,

MD 20852, 301-897-5700, fax 301-571-0457, TTY 301-897-0157.

Educational Audiology Association, 4319 Ehrlich Road, Tampa, FL 33624,
1-800-460-7322.

Counseling Services

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Counseling as a Related Service

Federal Definition

Counseling services mean, “services provided by qualified social workers, psychologists, guidance counselors, rehabilitation counselors, or other qualified personnel defined by professional scope of practices.” [34 CFR §300.24(b)(2)]

Counseling services as a related service typically include responsive services such as social skills, peer relationships and crisis intervention. Counseling services may also include classroom guidance including topics such as self-concept, decision making, and problem solving, and systems support. Systems support includes referring children and families to community agencies or providers, support groups, and law enforcement.

Counseling services have been addressed in each of the following sections in this document: parent counseling, rehabilitation counseling, psychology, and social work. Refer to these specific sections for more information on the scope of these related services.

Early Identification and Assessment of Disabilities

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Early Identification and Assessment of Disabilities As a Related Service

As stated by the American Academy of Pediatrics Committee on Children with Disabilities (1994), early identification of children with developmental disabilities leads to effective therapy of conditions for which definitive treatment is available. In conditions that cannot be fully reversed, early intervention improves the child's outcomes and enables families to develop the strategies and obtain the resources for successful family function. An accurate medical diagnosis may be essential to the initiation of related services, providing information to the family and school personnel on the strengths and weaknesses of the child.

Federal Definition

Early identification and assessment of disabilities in children means "the implementation of a formal plan for identifying a disability as early as possible in a child's life." [34 CFR §300.24(b)(3)]

Nebraska Statute Information

In order to engage in the practice of medicine, a physician must be duly licensed by the state in which they practice as outlined in Part IV, VA Descriptions of Qualifications Neb. Rev. Stat. §71-1,102 defines who shall be deemed to be engaged in the practice of medicine and surgery in this state: "(1) Persons who publicly profess to be physicians, surgeons or obstetricians, or publicly profess to assume the duties incident to the practice of medicine, surgery or obstetrics, or any of their branches; (2) persons who prescribe and furnish medicine for some illness, diseases, ailment, injury, pain, deformity, or any physical or mental condition, or treat the same by surgery; (3) persons holding themselves out to the public as being qualified in the diagnosis or treatment of (or maintain an office for examination of) diseases, ailments, pain, deformity, or any physical or mental condition, or injuries of human beings, including persons who attach to their names the title of M.D., surgeon, physician, physician and surgeon, or any word or abbreviation indicating that they are engaged in this treatment or diagnosis; (4) persons who suggest, recommend, or prescribe any form of treatment for the intended

palliation, relief, or cure of any physical or mental ailment of any person; and (5) persons who are physically located in another state but who, through the use of any medium, including an electronic medium, perform for compensation any service which constitutes the healing arts that would affect the diagnosis or treatment of an individual located in the state, unless he or she is providing consultation services to a physician and surgeon who is duly licensed in this state and is the treating physician of the individual.”

Professional Organization Information

The American Academy of Pediatrics Policy Statement from the Committee on Children with Disabilities *Screening Infants and Young Children for Developmental Disabilities* (1994) states that to screen for developmental disabilities and intervene for identified children and their families, the attending physician must have clinical skills to institute procedures to: (1) maintain and update their knowledge about developmental issues, risk factors, screening techniques and community resources; (2) acquire skills to administer and interpret formal developmental screening; (3) develop strategies to provide periodic developmental screening that screens all children; recognizes physical abnormalities, high-risk medical, parent-child and environmental situations; and seeks the observations and the concerns of the parents; (4) maintain information on community resources for serving families; (5) coordinate patient care with the variety of community resources that may be involved with the family; (6) increase parental awareness of developmental issues and resources by discussion and/or distribution of educational materials; and (7) be available to families to interpret consultant’s findings.

Early Identification and Assessment of Disabilities is Intended to Serve...

The physician is charged with providing necessary medical information in the evaluation and assessment process for children suspected of having a disability that may qualify them for special education and related services. The child’s medical history and current health status are integrated into the IEP, and the information is used for the school age child in determining the need for special education and related services in children with orthopedic impairment, visual impairment and other health impairments. Medical personnel

also provide the description of the extent of the head injury during the evaluation process of the child with traumatic brain injury, and may provide educationally related medical findings (such as lead exposure, fetal alcohol effects, etc.) that may be requested in the evaluation of the child with specific learning disabilities. The physician may also be asked to provide medical summary and current health status information for the child who is being considered for services under the category of developmental delay. The shared information must take the form of a signed written report from the attending physician which describes the medical condition, any medical implications on the child's development and/or how educational performance may be adversely affected by the medical condition, as required by 92 NAC 51-006.04.

Early Identifications and Assessment of Disabilities are Provided By...

Neither the federal law and regulations nor the state law and regulations provide guidance on who provides

early identification and assessment of disabilities. It is recommended that the MDT make decisions concerning early identification and assessment of disabilities.

Qualifications of Providers

In the early identification of children with disabilities, there are a variety of providers that are involved in screening young children. Pediatricians, family

practitioners, physician assistants and nurse practitioners in pediatrics and family practice are regularly assessing children in the "well baby/well child" examinations [e.g., Early Periodic Screening Diagnosis and Treatment (EPSDT) and Maternal and Child Health programs, etc.]. Screening for developmental delays and for clinical conditions that put the child at risk for later delays is an integral part of that process. Public health nurses may also perform screening during part of their interaction with the child and family. Any medical provider may make a referral to the local school district.

Entrance Criteria

It is the responsibility of the school district's multidisciplinary evaluation team (MDT) to evaluate a child's eligibility for special education and related

services once the child has been referred because of a suspected disability. The child must then be assessed in all areas related to the suspected disability, particularly as it relates to the child's ability to benefit from the educational process. Medical services are to be provided for any diagnostic or evaluation processes that are deemed relevant.

**Methods Used
for Assessment**

In Nebraska, several of the disabilities that qualify a child for either early intervention or special education services require a signed, written report from a physician which describes the current health status and gives any medical implications of the impairment (92NAC 51-006.04 I3aj). An appropriate medical evaluation can and often should be a part of the process. The method of assessment must be tailored to the specific need of the child.

**Examples of Related
Services Activities**

Examples of early identification and assessment as a related service include the implementation of the local school district child find plan and the evaluation and verification procedures.

References

Rule 51– Regulations and Standards for Special Education Programs (Title 92, NE Administrative Code, Chapter 51), (Draft May 6, 1999)
State of Nebraska, Department of Education, 301 Centennial
Mall South, Lincoln, NE 68509

*Neb. Rev. Stat. 71– Statutes Relating the Medicine and Surgery Osteopathic
Medicine and Surgery Physician Assistants*, 1997. State of Nebraska,
Department of Health and Human Services Regulation and
Licensure, Credentialing Division, 301 Centennial Mall South,
Lincoln, NE 68509

Code of Federal Regulations (Title 34, Volume 2, Parts 300 and 303)
Revised as of July 1,
1998, US Government Printing Office via GPO Access

American Academy of Pediatrics Committee on Children with
Disabilities Screening *Infants and Young Children for
Developmental Disabilities* (RE94149) *Pediatrics*, Volume 93,
Number 5, p863-865, May, 1994

Medical Services

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Medical Services as Related Services

In the school-age population, the child must have a verified disability as per 92 NAC 51-006 that has the potential to interfere with their educational process and school performance. An accurate medical diagnosis provides the family and school personnel information about the child's condition as well as particular precautions that may pertain to the child and impact on the educational program. The attending physician can also be of assistance in the development of expected goals and provide opinion about the provision of related services for the child's special education program.

Federal Definition

Medical services mean, "services provided by a licensed physician to determine a child's need for special education and related services". [34 CFR §300.249(b)(3)]

Nebraska Statute Information

In order to engage in the practice of medicine, a physician must be duly licensed by the state in which they practice as outlined in Part IV, VA, "Descriptions of Qualifications." Neb. Rev. Stat. §71-1,102 defines who shall be deemed to be engaged in the practice of medicine and surgery in this state: "(1) Persons who publicly profess to be physicians, surgeons or obstetricians, or publicly profess to assume the duties incident to the practice of medicine, surgery or obstetrics, or any of their branches; (2) persons who prescribe and furnish medicine for some illness, diseases, ailment, injury, pain, deformity, or any physical or mental condition, or treat the same by surgery; (3) persons holding themselves out to the public as being qualified in the diagnosis or treatment of (or maintain an office for examination of) diseases, ailments, pain, deformity, or any physical or mental condition, or injuries of human beings, including persons who attach to their names the title of M.D., surgeon, physician, physician and surgeon, or any word or abbreviation indicating that they are engaged in this treatment or diagnosis; (4) persons who suggest, recommend, or prescribe any form of treatment for the intended palliation, relief, or cure of any physical or mental ailment of any person; and (5) persons who are physically located in another state but who, through the use of any medium, including an electronic medium, perform for compensation any service which constitutes the healing arts that would affect the diagnosis or treatment of an individual

located in the state, unless he or she is providing consultation services to a physician and surgeon who is duly licensed in this state and is the treating physician of the individual.”

Professional Organization Information

The American Academy of Pediatrics Policy Statement from the Committee on Children with

Disabilities on the *Pediatrician’s Role in the Development and Implementation of the IEP and/or IFSP* (1992) recommends that every child with a disability should have access to the following services provided by their physician: (1) conventional health care; (2) screening and surveillance for handicapping conditions and developmental delay, using a combination of methods best designed to use all sources of information (e.g., formal screening, interview and observation); (3) participation in the comprehensive multidisciplinary assessment, as the referral source with communication with the team, or as a member of the assessment team; (4) counseling and medical advice during the assessment process, to relay information and concerns between the physician, family and assessment team; (5) assistance in formulating the IEP or IFSP to ensure an appropriate and effective plan. (6) The physician must also determine if the health-related services proposed are appropriate and sufficiently comprehensive, and help coordinate medical services when there are health services included as part of the IEP or IFSP; and (7) advocate for comprehensive community services for handicapped children.

Case Law and Regulatory Interpretations

Proper diagnosis and evaluation of students suspected of having a disability is an important component of the special education process. IDEA '97 makes it clear that medical services

can be a related services when used for that purpose.

Seals vs. Loftis, in the 1985 Tennessee district court held that a school district was responsible for payment of a neurologic and psychological evaluation ordered by the child’s physician to investigate a child with known seizure disorder and learning disabilities who showed deterioration in behavior and school performance. [614 F Supp. 302, EHLR 557:110 (ED Tenn. 1985)] (Mehfoud, K. 1997).

Another Tennessee case in 1988, *Doe vs. Nashville Board of Public Education*, further stated that medical evaluations are provided at school

board expense if the medical diagnosis is necessary to plan an appropriate IEP. [EHLR 441:106 (MD Tenn. 1988)] (Mehfoud, k. 1997).

The state of Washington, in their state regulations pertaining to Special Education [Statutory Authority: Chapter 28A.155.95-21-055 (order 95-11), § 392-172-112] states the medical evaluations may be at the expense of a school district or other public agency if during the evaluation process the multidisciplinary team suspects a student of having a health problem which may affect his or her eligibility and need for special education (Mehfoud, K. 1997).

The services of licensed physicians for other than diagnostic or evaluation purposes, and therefore, specifically for treatment, are not related services, and not the responsibility of the school districts. In *Laughlin III vs. Central Bucks School District*, the school was not required to ensure that a physician be on-call and immediately available at all times to respond to emergencies for a ventilator dependent student attending public school. [20 IDELR 894 (ED Pa. 1994)] (Mehfoud, K. 1997).

Excluded medical services cannot be interpreted to mean a service that is performed in accordance with a doctor's prescription or under the ultimate supervision of a physician, such as clean intermittent catheterization as decided in the Supreme Court case in *Irving Independent School District vs. Tatro*, 1983-84 [(EHLR 555:511 (1984)]; or such mundane tasks such as administration of prescription medications, as in *Berlin Brothersvalley (PA) School District* [EHLR 353:147 (OCR 1998)] (Mehfoud, K. 1997).

A separate issue has been addressed in the case of reimbursement for psychiatrists, where their services may fall under "counseling services". In a case where counseling was needed and not provided by the school district, the parents were able to receive reimbursement for part of the child's psychotherapy services, but only to the limit of reasonable and customary charges for a non-physician as stated in IDEA '97. {*Max M. vs. Thompson* 1984-85 [EHLR 556:227 (ND Ill. 1984)]} On the opposite side, *Metropolitan Government vs. Tennessee Department of Education* 1988-89 [EHLR 441:450 (Tenn. Ct. App. 1989)] found that parents could not be reimbursed if they elect to have counseling services provided by a psychiatrist, even when the IEP calls for counseling, if other counseling services are offered (Mehfoud, K. 1997).

As early as 1980, the US Department of Education released a policy interpretation (US Department of Education, policy 86390, 1980) stating that educational agencies could not compel parents of a child with a disability to file an insurance claim that would pose a realistic threat to

the parents in terms of financial loss. Examples of financial loss include but are not limited to: (1) decreases in available lifetime coverage or other insurance benefits, (2) increase in insurance premium, (3) discontinuation of the insurance policy, or (4) out of pocket expenses such as deductibles. Planning for the assessments should focus on the child and family's individual and specific needs. This will help provide a smooth transition to educational services (Mehfoud, K. 1997).

Medical Services Are Intended to Serve...

The physician is charged with providing necessary medical information in the evaluation and assessment process for children suspected of having a disability that may qualify them for special education and related services. The child's medical history and current health status are integrated into the IEP, and the information is used for the school-age child in determining the need for special education and related services in children with orthopedic impairment, visual impairment and other health impairments. Medical personnel also provide the description of the extent of the head injury during the evaluation process of the child with traumatic brain injury, and may provide educationally related medical findings (such as lead exposure, fetal alcohol effects, etc.) that may be requested in the evaluation of the child with specific learning disabilities. The physician may also be asked to provide medical summary and current health status information for the child who is being considered for services under the category of developmental delay. The shared information must take the form of a signed written report from the attending physician which describes the medical condition, any medical implications on the child's development and/or how educational performance may be adversely affected by the medical condition, as required by 92 NAC 51-006.04.

Medical services may also be sought by the family and school personnel if a question arises concerning the child's medical diagnosis and its impact on the IEP for the child who has already qualified for special education services. This service is generally provided if the medical information is needed for the appropriate provision of special education or related services, and has been recommended in the ongoing assessment of the child in the IEP process.

It is also appropriate for the treating physician to assist the evaluation team including the parent in determining whether the child's disability would be eligible for services under Section 504 of the

Rehabilitation Act of 1973, even if the child did not qualify for special education services under IDEA or Rule 51. Accommodations and/or services may be developed so the child receives full benefit of the educational program. These accommodation plans are often put into place for children with physical and mental conditions (e.g., Attention Deficit/Hyperactivity Disorder) that do not fall under the IDEA categories and are not otherwise eligible for special education programs under 92 NAC 51.

Medical Services are Provided By...

Medical services are provided by a licensed physician or by a physician's assistant, or by a registered nurse practitioner supervised by a licensed physician as per Nebraska laws and regulations.

Qualifications of Providers

According to the Neb. Rev. Stat. §71-1,104 " Each applicant for a license to practice medicine and surgery shall--

- Present proof that he or she is a graduate of an accredited school or college medicine,
- If a foreign medical graduate, provide copy of a permanent certificate issued by the Educational Commission on Foreign Medical Graduates that is currently effective and relates to such applicant or provides such credentials as are necessary to certify that such foreign medical graduate has successfully passed the Visa Qualifying Examination or its successor or equivalent examination required by the United States Department of Health and Human Services and the United States Immigration and Naturalization Services, or
- If a graduate of a foreign medical school who has successfully completed a program of American medical training designated as the Fifth Pathway and who additionally has successfully passed the Educational Commission on Foreign Medical Graduates examination but has not yet received the permanent certificate attesting to the same, provide such credentials as certify the same to the Department of Health and Human Services Regulation and Licensure,
- Present proof that he or she has served at least one year of graduate medical education approved by the Board of

Examiners in Medicine and Surgery or, if a foreign medical graduate, present proof that he or she has served at least three years of graduate medical education approved by the board, and

- Pass a licensing examination designated by the board and the department covering appropriate medical subjects.”

According to the Neb. Rev. Stat. ? 71-1,107.16, physician assistants shall mean “any person who graduates from a program approved by the Commission on Accreditation of Allied Health Education Programs or its successor agency and the Board of Examiners in Medicine and Surgery, who satisfactorily completes a proficiency examination, and whom the board, with the concurrence of the Department of Health and Human Services Regulation and Licensure, approves to perform medical services under the supervision of a physician or group of physicians approved by the board to supervise such assistant.”

Nurse Practitioner, according to Neb. Rev. Stat. ?71-1, 107.16 shall mean “a registered nurse who meets requirements established in section 71-1722 and who holds a current license as an advanced registered nurse practitioner...”

Medical providers may become involved with the evaluation process, assist in referral to appropriate community resources for intervention and family support, assist in the understanding of the evaluation results, assist in the coordination of services, and provide further monitoring of the child’s developmental progress as part of the ongoing health care of the child.

The medical provider may make recommendations that the child receive related services (e.g., physical and occupational therapy) as part of the child’s special education, but does not determine the amount or level of the “educationally related” services provided. The individual education service needs will be determined by the local school district multidisciplinary team process and/or by the ongoing IEP process. The physician may be asked by the school district to act as a consultant in coordinating health services that are included in the child’s IEP.

An advanced registered nurse practitioner may provide health care services within specialty areas. An advanced registered nurse practitioner shall function by establishing collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice

of an advanced registered nurse practitioner shall be referred to an appropriate health care provider. Advanced registered nurse practitioner practice shall mean health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and chronic conditions, including:

- Assessing patients, ordering diagnostic tests and therapeutic treatments, synthesizing and analyzing data, and applying advanced nursing principles;
- Dispensing, incident to practice only, sample medications which are provided by the manufacturer and are provided at no charge to the patient; and
- Prescribing therapeutic measures and medications, except controlled substances listed in Schedule II of section 28-405 not otherwise provided for in this section related to health conditions within the scope of practice. An advanced registered nurse practitioner may prescribe controlled substances listed in Schedule II of section 28-405 used for pain control for a maximum seventy-two-hour supply if any subsequent renewal of such prescription is by a licensed physician.

Role of Support Personnel

A medical diagnosis does not automatically qualify a student for special education or a related service. Input from involved teachers and staff is often sought on the classroom concerns, whether the physical deficiencies related to the diagnosis are impacting on the child's ability to meet the classroom expectations. For example, the child who is noted to be hypotonic with resultant poor motor planning, but can successfully access the classroom, may have a "medical diagnosis" but may not have special education and related services needs.

Entrance Criteria

It is the responsibility of the school district's multidisciplinary evaluation team (MDT) to evaluate a child's eligibility for special education and related services once the child has been referred because of a suspected disability. The child must then be assessed in all areas related to the suspected disability question, particularly as it relates to the child's ability to benefit from the educational process. Medical services are to be provided for any diagnostic or evaluation processes that are deemed relevant.

Methods Used for Assessment

In Nebraska, several of the disabilities that qualify a child for either early intervention or special education services only require a signed, written report from a physician which describes the current health status and gives any medical implications of the impairment (92NAC 51-006.04 I3aj). An appropriate medical evaluation can and often should be a part of the process. The method of assessment must be tailored to the specific need of the child.

The Academy of Pediatrics in its Policy Statement on the Provision of Related Services for Children with Chronic Disabilities (1993) states that “the supervision of medical care and health related services for children with chronic and disabling conditions is the responsibility of physicians and the medical community regardless of the location or source of payment for these services.” It should be borne in mind that since these are medical examinations for medical diagnostic purposes, any primary practice physician or subspecialist involved with the child and family should be consulted and involved in the process.

Service Delivery Models

In Nebraska, medical input to be used in the MDT process may be obtained through child development clinics, University affiliated programs, or state run clinics for children with special health care needs. This may include cleft palate teams, genetics teams, or cerebral palsy clinics. When considering methods of service delivery teleconferencing or telemedicine should be considered. Medical reports from outside of Nebraska can be used for verification purposes if there is documentation of their licensure in their state of residence and/or membership of their specialty board, and documentation that they have examined the child to make their diagnosis.

The provision of medical diagnostic services can be provided either in a private office consultation or a multidisciplinary team setting, depending on the needs of the individual school district (one referral versus many) and the time constraints of the individual physician. Multidisciplinary settings can have the advantage of allowing dialogue between the physician, teacher and related service providers concerning the particular needs of the child. When working with individual cases, arrangement for separate consultation may occur around the schedule of the involved parties to allow dialogue to occur (e.g., meeting of the therapists, parents, and teacher with the physician to discuss issues/precautions in the medically fragile child).

Methods to Determine Amount of Related Service Appropriate for Educational Benefit

In an ideal world once a concern has been addressed about a child already in special education, the family and school personnel should reach a consensus. If it is felt that

further medical diagnostic evaluation is required for that child to benefit from a special education program or from related services, the district should then make the appropriate referrals, and include the primary care physician or other attending medical consultants in this decision. Most often the medical evaluations are going to take the form of a one time visit to the consultant or diagnostic multidisciplinary/multispecialty clinic, but may include other diagnostic studies if deemed necessary for the diagnosis of the child and is agreed upon by all parties (the physician, the family and the school district).

Exit Criteria

Once a child has been verified medical services as a related service are no longer required until further evaluation or reevaluation occurs.

Examples of Related Services Activities

Medical Services That Would Be Considered Educational

A kindergartner is noted to have difficulty with her fine motor skills in the classroom. The teacher notes does not use her one hand well, and walks with a limp when tired. The mother has also noted these concerns and also reports intermittent fisting when younger. The child may need a referral for a medical evaluation for verification of diagnosis to receive special education and related occupational therapy services to address the motor concerns in the classroom.

Medical Procedures Used For Medical Diagnosis Services That Would Be Considered Borderline

Concern has been raised that a young man who is involved in special education for mild mental handicap may be having seizures. The episodes noted by the teacher are felt to interfere with his progress in the educational program. It is decided in the

IEP process that the question of the medical diagnosis of seizures needs to be answered for his educational planning. The school agrees to the medical consultation for diagnosis.

Services That Would Be Considered Medical

Ongoing medical care of a chronic condition such as the child with cerebral palsy, juvenile onset arthritis, Down Syndrome. Prescription of medications for treating acute or chronic medical conditions. Routine childcare and immunizations.

Documentation of Services

A variety of different formats have been used for sharing medical information with the school personnel in their consideration of a child for special education services. One of the simpler methods is illustrated by the Early Intervention Project with the Omaha Public Schools included with this document. (See sample form at the end of this section related service) Adequate information is imparted to consider the child for services. For a child who has extensive health care needs, or has had specific concerns raised by the family or school personnel, a more complete consultation note would be appropriate, outlining the child's medical conditions, the impact these may have on the child in the educational setting, and may also include physician's concerns for the provision of certain evaluations or therapies (e.g., request for audiologic evaluation, speech assessment, physical therapy evaluation, etc.).

Supervision and Evaluation of Services and Providers

The Board of Examiners in Medicine and Surgery supervises medical providers in the state of Nebraska.

References

Rule 51– Regulations and Standards for Special Education Programs (Title 92, NE Administrative Code, Chapter 51), (Draft May 6, 1999) State of Nebraska, Department of Education, 301 Centennial Mall South, Lincoln, NE 68509

Neb. Rev. Stat. 71– Statutes Relating the Medicine and Surgery Osteopathic Medicine and Surgery Physician Assistants, 1997. State of Nebraska, Department of Health and Human Services Regulation and Licensure, Credentialing Division, 301 Centennial Mall South, Lincoln, NE 68509

Code of Federal Regulations (Title 34, Volume 2, Parts 300 and 303) Revised as of July 1, 1998, US Government Printing Office via GPO Access

Mehfoud, Kathleen, Esq. *Distinguishing between Educationally and Medically Related Services– The New Case Law*. The 18th National Institute on Legal Issues of Educating Individuals with Disabilities. San Diego, CA May 4-7, 1997, LRP Publications

American Academy of Pediatrics Committee on Children with Disabilities *Pediatric Services for Infants and Children with Special Health Care Needs* (RE9318) *Pediatrics*, Volume 92, Number 1, July, 1993. P.163-165.

American Academy of Pediatrics Committee on Children with Disabilities *Provision of Related Services for Children with Chronic Disabilities* (RE9339) *Pediatrics*, Volume 92, Number 6, December 1993, p. 879-81.

American Academy of Pediatrics Committee on Children with Disabilities *Pediatrician's Role in the Development and Implementation of an Individual Education Plan (IEP) and/or an Individual Family Service Plan (IFSP)* (RE9242) *Pediatrics*, Volume 89, Number 2, February, 1992, p. 340-342.

MEDICAL STATUS

(Sample Form)

(Child's Name) _____ (D.O.B) _____ has been referred for special education and early intervention services. In order to adequately assess your patient for services, some additional information would be helpful.

Medical Diagnosis or Description of Medical Condition

Impact of the Medical Condition on the child's current or future overall development

Any particular precautions or prohibitions for this child because of the child's medical condition

Any other concerns you would like to share with the intervention or education team

(Physician's Signature)

As questions arise regarding your patient's medical condition or the family's concerns, we would appreciate your input. When is the best time to contact you or a member of your office?

Time: _____

Phone: _____

Contact Person: _____

Thank you for your assistance in coordinating the delivery of medical, community, and educational services to this child and his/her family.

Please Return To:

(Name)

(School Address)

Occupational Therapy

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Occupational Therapy as a Related Service

Occupational Therapists (OTs) use purposeful, goal-directed activities and task analysis to enable a child with a disability to benefit from their individualized educational program (IEP). Federal law mandates that occupational therapy (OT) in the school system be educationally relevant. Because of this, the delivery of intervention in the educational setting differs from clinically based, medical treatment. Educational therapy services are those services developed by educational personnel and the family and authorized in a student's IEP.

Federal Definition

Occupational therapy means services provided by a qualified occupational therapist and includes:

- Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- Improving ability to perform tasks for independent functioning if functions are impaired or lost; and
- Preventing, through early intervention, initial or further impairment or loss of function. [34 CFR §300.24(b)(5)]

Occupational Therapy services are provided differently under Part B and Part C of IDEA: (note: from Occupational Therapy Services for Children and Youth under the Individuals with Disabilities Education Act, 1997)

Nebraska Statute Information

The practice of occupational therapy in the state of Nebraska is governed by Neb. Stat.Rev. ?71-6101 to ?71-6116 and the regulations governing the practice of occupational therapy (172 NAC 114).

Occupational therapists traditionally have been trained and employed in the medical setting to evaluate, treat, restore function, and prevent disability primarily with persons with disabilities. Therapists in educational settings need background in human development, neuromotor development and treatment techniques, the design and use of adaptive equipment, parent-teacher-team consultation techniques, the rules and regulations of special education, and in writing the IEP.

The focus of educational services is to promote functional independence or participation within the educational environment. The school therapist's role is to assist in the educational process of enhancing the student's performance. Occupational therapy services are not intended to satisfy the medical needs of a student and therefore may not meet the total therapy needs of the student.

Professional Organization Information

Recommended practice in occupational therapy as a related service focuses on helping the student achieve a level of independence, which is functional for the student in their educational setting. Some students with disabilities may have a medical disability or sensory-motor impairment, identified by a medical practitioner, which does not interfere with functional educational performance. The IEP team may determine that the student does not require occupational therapy through the educational program. However, the student's family may wish to pursue therapy services outside the educational program.

Other students may have a medical diagnosis or sensory-motor impairment that significantly affects their educational performance. In this case, the student may or may not require occupational therapy service in both medical and educational settings. The school therapist's role in this situation would be to provide educationally related services and to communicate with medical personnel involved with the student to allow as much coordination of services as allowed by the family's willingness to have disclosure.

Occupational Therapy is Intended to Serve...

Occupational therapy as a related service is intended to serve children from 3 to 21 years of age who have a verified disability as per 92 NAC 51. Areas that may be addressed and may interfere with a child's educational performance include feeding and self-help skills, fine and visual motor skills, visual processing skills, sensory processing, positioning and adaptive devices or equipment.

Occupational Therapy is Provided by...

Those who are qualified to provide OT as a related service include registered and licensed

occupational therapists, certified occupational therapy assistants, and occupational therapy aides.

The Occupational Therapist (OT) is a graduate of an accredited education program and must successfully pass a national certification examination. In general, the OT receives either a baccalaureate degree, masters, or doctorate degree upon completion of the educational program. The Department of Health, through the Board of Examiners, licenses occupational therapists in the State of Nebraska. Licensure for occupational therapists is voluntary in Nebraska. However, the Nebraska Department of Education requires licensure to receive an approved provider rate for special education and related services.

The Certified Occupational Therapist Assistant (COTA) is a graduate of an accredited education program and must successfully pass a national certification examination. Licensure of a COTA in Nebraska is voluntary. In general, the COTA receives an associate degree upon completion of the educational program. Under the statutes of the OT Practice Act, the COTA assists the OT, and works under the OT's supervision.

Supervision of a COTA is required on-site once every two weeks for the first three years of practice and once per month for individuals with more than three years experience (172 NAC 114). Only the registered OT may evaluate the need for services, establish or change IEP goals and objectives and terminate services.

The following table was taken from the American Journal of Occupational Therapy Issues (AOTA, 1987). The table delineates the rolls of a registered OT and COTA in schools.

The Occupational Therapy Aide is an unlicensed person who assists in the practice of occupational therapy, under the direct supervision of an OT or COTA. (172 NAC 114-002.15) Using the Nebraska Department of Health and Human Services definition, an OT aide is called an OT paraprofessional (471 NAC 25-001.01A). In certain settings the use of the term aide with paraprofessional is interchangeable. In this document the terms are kept separate to provide clarity in who provides supervision, what state statutes pertain to their role in the provision of services, and what the service is named, e.g. "occupational therapy" versus "paraprofessional services provided under the direction of an occupational therapist."

OT and COTA Role Delineation

Occupational Therapist	Certified Occupational Therapy Assistant
1. Determines the information to be collected, evaluates methodology to be employed and chooses appropriate evaluation instruments.	1. Does not participate.
2. Administers standardized tests, criterion referenced tests and skilled clinical observations.	2. – Observes and assists in criterion-referenced tests and skilled clinical observations. – Recognizes the need to observe and assist only on evaluations requiring ongoing interpretation of the response to treatment intervention.
3. Completes data collection procedures such as record reviews, interviews, general observations and behavioral checklists	3. Assists with or completes, if service competency is established with data and collection procedures such as record review, interviews, general observations and behavioral checklists.
4. Scores test protocols.	4. – Scores evaluation procedures that are primarily a source of outcome data as determined by the occupational therapist in establishing competency on each task. – Records and reports to OT information from data collection procedures for which service competency has been established.
5. Analyzes and interprets information gathered in evaluations.	5. Does not participate.
6. Synthesizes, summarizes and reports information both orally and in writing.	6. Does not participate.

Role of Support Personnel

The primary role of the paraprofessional who is supervised by a teacher would be to support the educational program developed by the teacher. This might include activities set up by a therapist and coordinated by the teacher and therapist.

In order for the services of a paraprofessional to be called “occupational therapy”, the paraprofessional must meet the qualifications in 114 NAC 114 as an OT aide. This distinction is important to clarify the issue that only services provided under the statutes, rules and regulation of the Department of Health and Human Services qualify as occupational therapy.

Entrance Criteria

To qualify for OT related services, the MDT or IEP team has determined the following.

- The problem interferes with the child’s ability to participate in his/her educational program (This could be due to a limitation in an occupational performance component).
- The problem relates to intervention(s) addressed within the scope of OT services and the unique expertise of the OT is required to address the problem. Previously documented attempts to alleviate the problem have not been successful.
- Potential positive change in the child as a result of the intervention by the OT or negative change without intervention by the OT appears likely. Change as a result of the intervention should be in addition to change due to increasing age or maturation of the student.

Methods Used for Assessment

There are various methods that can be used to assess a child’s needs for occupational therapy as a related service. These may include, standardized testing, criterion-referenced testing, checklists, observations, reports, work samples, interviews and functional assessment tools. Four domains to consider when assessing a child include: 1) methods of instruction, 2) curriculum, 3) environment and 4) the student.

Assessments: 1) should be ecological, including natural environments; 2) include observation in several academic and non-

academic environments; 3) are recommended to consist of at least 3 data points - recordings, days, sources, etc.; 4) include observation of at least one educational personnel who knows the student well; 5) build on past assessment; and 6) should be age appropriate. An assessment by an OT should specifically address the discrepancies between the child's expected performance and his or her present levels of function in the general education curriculum and environment.

Service Delivery Models

The mode and frequency of service are determined by the IEP team based on the student's educationally related needs. The critical determinants are the individual, unique educational needs of each student and the most appropriate manner in which these educational needs can be met.

The OT along with other team members should consider the following factors in developing occupational therapy related services:

- The least restrictive environment needed to accomplish the goals and objectives related to OT;
- The type of skills to be learned and the methods and strategies of intervention anticipated; and
- The level of expertise required to provide the service; and the need for and availability of others to carry out the student's program.

A combination of methods may be needed. Intervention can be defined as a continuum of services from direct and isolated to time spent on behalf of the child. (DiMatties, DuBois, Quirk & Sauerwald, 1994). These interventions include not only personal interactions with the student, family, and teaching staff, but also contact by phone, written correspondence, reports, and visits to agencies working with that student and family. Consultation is an essential part of service delivery.

Method to Determine the Amount of Service Appropriate for Educational Benefit

Specific recommendations for the amount of service need to be made by each IEP team according to the needs of the child. Monitoring of student performance is necessary to determine if the amount of service is appropriate to promote progress toward attainment of the student's IEP goals and objectives.

No matter which services or continuum of services is used, occupational therapy interventions should be specific to each student's educational needs. There are many different intervention philosophies and approaches that the therapist may choose to use. It is the responsibility of the therapist to be aware of current research dealing with practice procedures.

Factors To Consider When Deciding on the Amount of Occupational Therapy Services

The following is an excerpt from *Guidelines for Occupational Therapy Services in School Systems*. Refer to the original document for scoring instructions. (OTA,1990)

Factors	1	2	3	4
Potential to benefit with therapeutic intervention	Student demonstrates minimal potential for change	Student appears to have potential for change but-slow rate	Student appears to have a signif. Potential for change	Student appears to have high potential to improve skills
Critical period of skill acquisition or regression related to developmental or disability	Not a critical period	Minimally critical period	Critical period	Extremely critical period
Amount of program that can be performed by others in addition to therapist intervention	Program can be carried out safely by others with periodic intervention by therapist	Many activities from the program can be safely performed by others in addition to intervention by therapist	Some activities from the program can be safely performed by others in addition to intervention by therapist	A few activities can be safely performed by others but most require the expertise of the therapist
Amount of training provided by therapist to others carrying out program	Teacher, staff &/or parents highly trained to meet, the student's needs. No additional training needed	Teacher, staff &/or parents trained but some follow-up needed	Teacher, staff &/or parents could be trained to carry out some activities	Teacher, staff &/or parents could carry out some activities with extensive training
Amount problem interferes with educational setting	Environment is accommodating & difficulties are minimal	Environment is accommodating & difficulties are moderately interfering	Environment is accommodating but difficulties are significant	Environment is not accommodating or environment is accommodating but problems are severe

Exit Criteria

The following criteria are suggested for use by the IEP team in determining whether to discontinue the related service.

1. Oral-motor, fine motor or other OT related service goals have been met or the unique expertise of the OT is no longer needed.
2. Potential for further progress with OT intervention is unlikely based on previous documentation. Programming has been developed that can continue without the related service.

Examples of Related Service Activities

The following examples were partially developed during a consensus conference in 1996 (Schafer et al., 1996)

Educational Therapy Example

- Activities to improve student's independence in self-feeding at school
- Therapist works with school staff to meet the nutritional/hydration/and eating skill development of a student
- Student requires modified equipment or supplies, or positioning in order to manipulate food containers
- The oral motor stimulation program demands an active participation (response) from the student within the context of the school's eating environment.

Borderline Therapy Example

- Transition from Gastrostomy Tube (G-tube) feeding to oral feeding
- Feeding/eating skills when not a regular part of the daily routine

Medical Therapy Example

- The student is a non-oral feeder. All nutritional needs are met through a G-Tube. The parents request intervention for oral motor training when the IEP team has determined that intervention will not change the child's educational performance. A medical evaluation would be indicated and coordinated through the child's primary physician.

- A student who evidences frequent choking and may be aspirating food/liquid into lungs or has severe difficulty with swallowing. This student probably requires a video fluoroscopy study plus medical assessment to identify the condition, cause of condition and appropriate medical management.
- Specific swallowing and oral motor musculature strengthening exercises for isolated sensory or muscle control, practiced outside of the context of the eating environment in the school day.
- A student who evidences decreased nutritional status, and immediate referral to medical practitioner is imperative.
- A student who requires adaptive equipment for home use.

Intervention: Eye-Hand Coordination/ Environmental Adaptation

Educational Therapy Example

- Student evidences decreased hand skills (weakness, high/low muscle tone and non-functional grasp). Therapy activities include, but are not limited to environmental adaptations that enable student to manipulate essential tools to complete their educational requirements.

Medical Therapy Example

- A student with an injured hand or arm (i.e. tendon injuries, broken arm). The acute rehabilitation intervention should be coordinated and prescribed by the physician's order. Frequently the medical management includes a home program and follow-up for complications (stiff joints, reflex sympathetic dystrophy). These are medical services which must be coordinated through the primary care physician.
- A student who has a sensory motor involvement in one hand or arm, and is capable or uses that arm/hand as a functional stabilizing assist during two-handed activities.
- A decrease in hand skills secondary to acute medical diagnosis or trauma.

Intervention: Activities of Daily Living Skills

Educational Therapy Example

- Student has potential for improved independence to participate in daily routines that require clothing, management (e.g. toileting), use of assistive technology, application/removal of jacket or clothes for recess, physical education class, art, science, or getting ready to go home.

Borderline Therapy Example

- Isolated operating clothing fasteners (buttons, zippers, snaps). Student may need adaptation rather than instruction/practice in managing the existing fasteners.

Medical Therapy Example

- A student rarely uses one upper limb and is functional in managing all classroom materials
- The student has therapy needs, but is independent in using self-care adaptations necessary to benefit from education.
- Adaptation recommendations that require home architectural modifications.
- Showering or bathtub adaptations/modifications for home use only.
- The student is dependent for ADL's or requires additional training to become independent at home.

Intervention: Splinting and Serial Casting

Educational Therapy Example

- Functional splinting: a splint is made to help the child perform an activity. As a result the child is able to participate in self-help tasks, vocational tasks, physical education exercises/games. The splint is worn to assist the child to function in the educational setting.

Borderline Therapy Example

- Static splinting to prevent contractures or hygiene problems.
- Monitor the static splints used following surgery.

Medical Therapy Example

- A student requires splints as a follow-up from surgical intervention or to increase function outside of the school setting.
- Student requires a series of casts or plaster splints to treat contractures, manage tone or spasticity.

Intervention: Range of Motion /Positioning/Postural Control

Educational Therapy Example

- Range of motion during or in preparation for a task that occurs in the normal school day, for example: donning & doffing a coat.
- Use of adaptive equipment (e.g. floor sitter or stander) to maintain or improve range of motion during home based educational activities or school activities.
- Training the student to do self-range of motion which will help the student participate more fully in the school environment.

Borderline Therapy Example

- Family or other care givers have assumed responsibility for maintenance of range of motion and request assistance due to growth or other changes to maintain the program

Medical Therapy Example

- A student requires aggressive post-surgical range of motion exercises to prevent joint deformity, i.e. continuous passive range of motion equipment or high intensity.
- A student has contractures, but the contractures are not worsening or interfering with the educational program.
- Any medical intervention that acutely alters the child's tone or range of motion.

Intervention: Sensory Integration/Sensory Processing

Educational Therapy Example

- The child demonstrates sensory processing difficulties which impede areas of school performance such as attention,

difficulty with touch, intolerance of movement, etc. Interventions could include direct or indirect supportive strategies, alternative and/or preparatory activities which would allow for access to the curriculum.

Medical Therapy Example

- Therapy outcome focuses on specific sensory system change which require long term focused therapy involving parents or care givers for continuation. Typically, the interventions require a specialized setting, and intensive, direct, one on one therapy sessions.

Intervention: Vocational Adaptations/ Job Sites

Educational Therapy Example

- Student is preparing to interact in a new domain, such as domestic(group or supervised living setting),community (shopping, restaurant), leisure(recreational facility) and/or vocational (competitive or supportive employment) and has potential for improved independence in that setting, given the appropriate adaptations, assistive technology, task analysis or other supports. This may include on-site observations.

Non-Educational Example

- Once the appropriate strategies, supports, modifications, etc. have been identified, the actual carry-over, coaching and practicing of skills, on-site on a regular basis. Also, those children who have graduated from the educational program/high school and/or are post-21 years of age.

Workload Consideration

It is recommended an OT or COTA caseload allow time for the provision of quality educational services. Caseload determination should take into consideration the following factors: responsibility of therapist for record keeping; meetings or related administrative duties; the population of children to be served; the need for travel. Other factors for consideration may include time for professional growth and training, program development, the number of children and the ratio of children requiring direct service versus integrated or consultation service.

Equipment and Space Needed

The equipment needed for an effective occupational therapy program varies. Therapists and their assistants should be consulted for input on the type of equipment to be ordered. Determination of space requirements is based on the child's intervention needs. The amount of space available should not dictate the type of intervention a child receives. However, it may have an impact on scheduling.

Documentation

Documentation is crucial to ensure good communication and implementation of the OT programs. Other than the IEP, 92 NAC 51 (Rule 51) does not provide guidelines for the frequency or content of documentation for related service providers in the educational setting. It may be beneficial for documentation to be provided every time a therapist provides an intervention which could include direct service, generation of required documentation, or services coordination activities. A minimum of biannual documentation to parents regarding student's progress is recommended. Progress updates for parents is required on the same schedule as those for regular education students.

Since state rule does not specify content, it is recommended that OT's follow AOTA guidelines for outcome based, reflective, student centered, user friendly documentation with frequency to ensure continuity of services.

Part of the initial assessment process and ongoing reassessment includes documentation of the student's current functioning so that future changes in performance can be measured.

The types of written documentation may include:

- Initial assessment / reevaluation
- IEP progress reporting
- Transition report when student transitions from one placement to another, or from one therapist to another, or has significant change in health or IEP status
- Medicaid In Public Schools' forms
- Correspondence with practitioners in the medical community
- Justification for durable medical equipment
- End of year summary or discharge report

Suggested items that should be included in written documentation include: parental concerns; student information; date;

provider; site of delivery; student's response; IEP goal(s) addressed, intervention(s), and instructions.

**Supervision and
Evaluation of OT /
Assistants / Aides**

Administrative supervision addresses adherence to the general policies and regulations of the school system such as work assignments, schedules, overall job performance, etc. In most school districts, a building administrator generally performs this type of supervision.

An OT systematically reviews his or her performance which can include both self-evaluation and peer review. The OT is directly responsible for selecting and documenting which tasks should be delegated to other personnel, as determined by the therapist's professional judgement.

Supervision of the COTA is required on-site once every two weeks for the first three years of practice and once per month for individuals with more than three years experience (172 NAC 114). Only the registered OT may evaluate the need for services, establish or change IEP goals or objectives and terminate services.

Glossary of Terms

Activities of daily living (ADL)-skills/tasks done throughout a typical day such as eating, dressing, toileting, homemaking, etc.

Attention Span – focusing on a task over time.

Ecological Assessments – assessment completed in the child’s natural environment, eg. school, cafeteria, playground.

Eye-hand Coordination – skillful use of the hand under visual guidance.

Fine Coordination/Dexterity – using small muscle groups for controlled movements, particularly for object manipulation.

Muscle tone-Demonstrating a degree of tension or resistance in a muscle at rest and in response to stretch.

Oral Motor Control – Coordination of oropharyngeal musculature for controlled movements

Perceptual processing – organizing sensory input into meaningful patterns.

Performance Areas – Activities that the occupational therapy practitioner emphasizes when determining functional abilities. They are broad categories of human activity that are typically part of daily life.

Performance Components – Elements of performance that occupational therapists assess and, when needed, in which they intervene for improved performance.

Postural Control – Using righting and equilibrium adjustments to maintain balance during functional movements.

Range of motion – moving body parts through an arc.

Sensory awareness and processing – the ability to receive input, process information and produce output, including the receipt, differentiation and interpretation of the senses.

Strength – Demonstrating a degree of muscle power when movement is resisted, as with objects or gravity.

Tactile – interpreting light touch, pressure, temperature, pain and vibration through skin contact/receptors.

References

AOTA: Roles of Occupational Therapists and Occupational Therapy Assistants in Schools (1987). Prepared by the School Systems Task Force and in conjunction with the ***Guidelines for Occupational Therapy Services in Schools***. American Occupational Therapy Association, Vol.41(12)

AOTA: Guidelines for Occupational Therapy Services in School Systems. (1990) American Occupational Therapy Association, Inc. Rockville, MD

Family-Centered Care - An Early Intervention Resource Manual. (1989) American Occupational Therapy Association, Inc. Rockville, MD

Rule 51- *Regulations and Standards for Special Education Programs* (Title 92, NE Administrative Code, Chapter 51), (1992), State of Nebraska, Department of Education, 301 Centennial Mall South, Lincoln, NE 68509

Schafer, L., Stuberg, W. & Gromak, P (July,1996). *Occupational therapy services and physical therapy services in the educational setting: A guide for providers, educators and parents in Nebraska public schools*. Nebraska Department of Education Special Populations Office, 301 Centennial Mall South, Lincoln, NE 68509-4987.

Suggested Readings

- Hanft B.E. & Place, P.A. (1996). *The consulting therapist: A guide for OT and PT in the schools*. Therapy Skill Builders, San Antonio, TX.
- McWilliams, R.A. (1996). *Rethinking pull-out services in early intervention*. Paul A. Brooks Publishing Co., Baltimore, MD.
- Nebraska Departments of Education and Social Services (1993). *Medicaid in the public schools (MIPS): Procedures manual*. 301 Centennial Mall South, Lincoln, NE 68509.
- Bundy, A.C. (1993). Will I see you in September? A question of educational relevance. *The American Journal of Occupational Therapy*. Vol. 47(9).
- Clark, G.F. & Miller, L.E. (1996). Providing effective occupational therapy services: Data based decision making in school-based practice. *American Journal Of Occupational Therapy*. Vol. 50(9).
- Collins, L.F. (1997). Models for effective school consulting. *OT Practice*. January.
- DiMatties, M.E. (1995). The occupational therapist-certified occupational therapy assistant partnership in a public school. In the *School System Special Interest Section Newsletter*. The American Occupational Therapy Association, Inc. Vol.2(3)
- Drummond, C.W. (Sept.1996). Inclusion and school-based occupational therapy. In the *School System Special Interest Section Newsletter*. American Occupational Therapy Association, Inc. Vol.3(3).
- Virginia Department of Education (March 1997). *Handbook for Occupational & Physical Therapy Services in the Public Schools of Virginia*.

- Hanft, B. (August 1995). Federal laws and appeals rulings governing developmental therapy for children with disabilities in school and early intervention programs: A report for the Human Services Research Institute. United Cerebral Palsy Association, Inc. Washington, D.C.
- Linder, J.A. (1995). School-based early intervention services: An Iowa perspective. In the *School System Special Interest Section Newsletter*. The American Occupational Therapy Association, Inc. Vol. 2(2).
- Mailloux, Z. (September 1997). Sensory integration and role performance in students. sensory integration. In the *Special Interest Section Quarterly*. American Occupational Therapy Association, Inc. Vol. 20(3).
- Muhlenhaupt, M., Miller, H., Sanders, J. & Swinth, Y. (September 1998). Implications of the 1997 reauthorization of IDEA for school-based occupational therapy. In the *School System Special Interest Section Quarterly*. American Occupational Therapy Association, Inc. Vol. 5(3).
- Parette, H.P. Jr. & Bartlett, C.S. (1997). Collaboration and Ecological Assessment: Bridging the gap between medical and educational environments for students who are medically fragile. In *Physical Disabilities: Education and Related Services*.
- Rainville, E.B., Cermak, S.A. & Murray, E.A. (1996). Supervision and Consultation Services for Pediatric Occupational Therapists. *The American Journal of Occupational Therapy*, Vol. 50(9).
- National Information Center for Children and Youth with Disabilities (1991). *Related services for school-aged children with disabilities*. Vol. 1(2), Washington, D.C.
- Rourk, J.D. (1996). Roles for school-based occupational therapists: Past, present, future. *The American Journal of Occupational Therapy*, Vol. 50(9).

Sarracino, T. (September 1997). Applying a sensory integrative frame of reference in school practice. In the *Sensory Integration Special Interest Section Quarterly*. American Occupational Therapy Association, Inc. Vol. 20 (3).

Smith, P.D. (1990). Integrating related services into programs for students with severe and multiple handicaps. In *Kentucky Systems Change Project*. Special Education Programs, U.S.O.E, Washington, D.C.

School Systems Task Force (1987). *Standards of practice for occupational therapy services in schools*. In conjunction with the Guidelines for Occupational Therapy Services in Schools. American Occupational Therapy Association, Vol. 41(12)

Transitioning From School to Community Life: A Qualitative Study. *School System Special Interest Newsletter*, Vol.1(4) December 1994.

Wills, K. & Case-Smith, J. (1996). Perceptions and experiences of occupational therapists in rural schools. *The American Journal of Occupational Therapy*, Vol.50(5).

Suggested Assessment

School Function Assessment (1998). Developed at Sargent College Health and Rehabilitation Services, Boston University. Published by The Psychological Corporation- Therapy Skill Builders.

Orientation and Mobility

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Orientation & Mobility as a Related Service

Orientation and mobility was included the first time as a related service, with the passage of IDEA 1997. Originally developed by the Veteran’s Administration to assist blinded veterans, Orientation and Mobility (O&M) as a profession has expanded to include training from early childhood through adulthood. This service is provided by individuals who are formally educated to help persons with vision impairments attain their O&M goals.

Federal Definition

Orientation and mobility services means, “services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environments in school, home and community; and includes teaching students the following as appropriate:

- Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (for example, using sound at a traffic light to cross the street);
- To use the long cane, as appropriate, to supplement visual travel skills or as a tool for safely negotiating the environment for students with no available travel vision;
- To understand and use remaining vision and distance low vision aids, as appropriate; and
- Other concepts, techniques, and tools as determined appropriate.” [34 CFR §300.24(b)(6)]

Nebraska Statute Information

The State of Nebraska currently does not have either licensure nor certification for Orientation and Mobility Specialists.

Professional Organization Information

Yale, (1999, p. 17) recommends that “A person qualified to teach orientation and mobility in a school system must have completed a specialization in the discipline of orientation and mobility from an AER (Association for Education and Rehabilitation of the Blind

and Visually Impaired) approved baccalaureate or graduate college or university program and hold a current credential as an AER Certified Orientation and Mobility Specialist (COMS).”

The importance of a quality orientation and mobility program for students with visual impairments has been well documented in the literature. Lowenfeldt (1964) stated that “mobility is directly related to the blind student’s ability to function academically.” Wilson (1967, p. 287) goes on to note that “It is important to recognize that mobility represents the avenue through which a person who is born blind or becomes blind at a later age... reaches out into his social, educational, vocational, and economic environment... Independent functioning on the part of the blind person gains the person community acceptance.”

O & M as a related service should be based on a developmental continuum of skills and experiences that are age appropriate. These skills should be consistent with what is known about the developmental tasks of sighted students.

Orientation and Mobility Services are Intended to Serve...

Hazekamp and Huebner (1989) state that: “The ability to understand, interact with, and move within one’s physical and spatial environment is a fundamental developmental skill. This ability is one of the milestones indicative of maturation for sighted students and should be so viewed for visually impaired students as well.” (p. 23)

They go on to note that: “The development of orientation and mobility skills is essential if the visually impaired student is to travel independently in various community settings. The needs of visually impaired students in this area are unique because vision loss required them to learn and travel about their environment in a way different from that of sighted students”. (p. 17)

It is because of these specific needs that orientation and mobility is provided to blind or visually impaired students who demonstrate difficulty in the following areas:

- Understanding physical environment and space
- Orientating to different school and community environments
- Traveling in school and in the community
- Finding opportunities for unrestricted, independent movement and play

Orientation & Mobility Services are Provided by...

Certified Orientation & Mobility Specialists (COMS) and Certified Orientation and Mobility Assistants (COMA) provide orientation and

mobility related services. A (COMS) is an individual with specialized training in orientation and mobility who has completed an approved undergraduate or graduate university training program in this area. Certification in Orientation and Mobility by the Association for Education and Rehabilitation of the Blind and Visually Impaired (AER) is recommended to teach orientation and mobility to children with visual impairments.

The COMS has the primary role of providing orientation and mobility instruction. However, others also have major responsibilities in helping the student to learn and use these skills. Parents of young children with visual impairments, play a direct and influential role in helping them acquire basic mobility skills because they are with their children most of the time. Since they must be knowledgeable about the skills that need to be reinforced and taught, the COMS shows them how and what to teach by modeling. With older children, the instructor becomes the primary teacher. The parents monitor some techniques while providing encouragement and support.

Jacobson (1993, p. 5) discusses the roles of the O & M instructor. He notes that ‘ in the school, the classroom teacher, vision consultant, teacher’s aide, and even a student’s peers all reinforce the skills the student has acquired”. AER COMA, provide follow-up instruction in basic skills under the direction of the COMS.

Hazekamp and Huebner (1989) have defined the roles of the O & M Specialist. The following is a revised list of activities that may be a related service:

- Instruction in the development of skills and knowledge that enables him or her to travel independently to the highest degree possible, based on assessed needs and the student’s Individualized Education Plan (IEP).
- Teaching the student to travel with proficiency, safety, and confidence in familiar and unfamiliar environments
- Providing consultation and support services to parents, regular and special education teachers, other school personnel, and sighted peers
- Conferring regularly with parents, classroom teachers, physical education teachers, and/or other special education

personnel to assist in home and classroom environmental modifications, adaptations, and considerations and to ensure reinforcement of appropriate orientation and mobility skills that will encourage the visually impaired student to travel independently in these settings.

- Works with the teacher of visually impaired students to conduct the functional vision assessment as it relates to independent travel
- Prepares and uses equipment and materials, for example, tactile maps, models, distance low vision devices, and long canes, for the development of orientation and mobility skills
- Transports the student to various community locations, as necessary, to provide meaningful instruction in realistic learning environments
- Provides orientation and mobility instruction, where appropriate, in a number of specific areas.” (p. 26)

Entrance Criteria

A student must be verified as blind or visually impaired by Nebraska Rule 51 to receive orientation and mobility as a related service. (92 NAC 51-006.04M) Children who demonstrate needs in orientation and/or mobility, as identified by the MDT, should be referred for evaluation by the COMS. Any resulting recommendations for direct instruction or consultation in orientation and mobility should be considered by the IEP Team.

Key times when further assessment may be indicated whenever visual function or travel needs change or at transition periods (i.e. kindergarten, middle school, and high school).

Methods Used for Assessment

“Comprehensive assessment tools are designed to be used by university trained COMS to identify a student’s current functioning level in all areas of orientation and mobility in order to determine student needs for programming.

An assessment may include:

- Level of vision (medical/functional)
- Use of travel tools
- Proficiency in use of travel tools
- Current age-appropriate independence
- Complexity or introduction of new environment
- Caregiver input

Assessments can be divided into five general areas based on environments:

- Home/Living Environment
- Campus Environment
- Residential/Neighborhood Environment
- Commercial Environment
- Public Transportation

These items should be sequentially structured based upon a student's need for instruction in age appropriate travel skills by a certified orientation & mobility instructor with input from the parents other staff and other interested individuals.

Service Delivery Models

Monitoring/Consultation ? The student is seen by a COMS 1 to 5 times per school year. An annual evaluation may be conducted by the Certified Orientation & Mobility Specialist. Contact may be with the student or other pertinent individuals.

Supportive – The student is seen directly by the COMS 1 to 2 times a month or during regularly scheduled times throughout the school year for 20 to 60 minutes each session. In addition, the COMS may provide direct support to pertinent individuals.

Intensive ? This direct service model is designed for a severely visually impaired traveler who may need to carry a cane for identification purposes/limited use or for a traveler with emerging orientation and mobility skills. A non-visual traveler who is maintaining and applying orientation and mobility skills in various settings would also be included. The student in this model requires direct service from the COMS 1 to 2 times a week for 30 to 90 minutes each session. The COMS provides regular communication to pertinent individuals regarding the student's needs.

Comprehensive ? The student is seen by the COMS 3 or more times a week for 20 to 90 minutes each session. This model is designed primarily for a non-visual traveler who requires an inclusive program in all areas of instruction related to becoming a safe and independent traveler.

Actual service delivery is determined by the IEP team based on assessed needs of the student and may not always fit precisely within this model.

Exit Criteria

Exit criteria for students may include:

- Completion of the O&M curriculum, IEP goals and objectives
- Reassessment of skills and demonstration of competence in assessed areas
- Changes in visual condition (improvement of visual condition)

Workload Considerations

Caseload formulation should consider the following factors: travel time for the instructor; time necessary for consulting with the classroom teacher, other staff and parents; time to develop adapted teaching materials and appropriate sites for instruction; time for completion of documentation; ages of students, the severity of their needs and the instruction necessary to meet those needs.

Hazekamp and Huebner (1989) suggest a caseload range of 8-12 students for O&M specialists. Actual caseloads may fall above or below these ranges, given time requirements needed to achieve the goals and objectives on the student's IEP. If caseloads are excessive, ability to provide services for children may be impeded.

Equipment or Space Needs

The COMS teaches skills specific to each student's needs in a variety of settings. Free access should be given within the school building and any buildings of an individual district. More advanced training will be accomplished through travel in community environments.

Specific equipment may be necessary to address the needs of students with impairment. Equipment needs are based on assessment and may include: telescope, long cane, pre-cane device, maps, computer programs, public transportation, and other sensory aids.

Documentation of Service

Types of written documentation may include:

- IEP progress reporting
- Summary statements of regularly scheduled lessons
- Initial assessment/reevaluation
- Transition reports

One tool that the COMS may find helpful is the Orientation & Mobility Severity Rating Scale (O&MSRS). This tool has been developed to assist COMS in making recommendations for services to the blind and visually impaired. It is suggested that an O&MSRS should be completed

before every IEP and up-dated at the end of each school year. This scale can be found at the end of the O & M section in the Appendix.

Supervision and Evaluation of Services and Providers

The supervision and evaluation of COMS should be consistent with

the supervision and evaluation of other teaching staff members. The COMA is supervised by the COMS.

Glossary

The following glossary includes common terminology in O & M training and definition, to terms used in the O & M guideline.

- access ramp** A slope which allows a wheelchair to enter or exit a location.
- adaptive mobility device** A device designed to facilitate independent movement for some students who cannot initially use a long cane for travel. In most cases, adaptive mobility devices are replaced with the use of a long cane at some point in training.
- AER** Association for Education and Rehabilitation of the Blind and Visually Impaired
- arc definer** A device designed to give feedback to a blind student regarding arc width while moving when learning the touch or constant contact cane techniques.
- berm** The strip of cement found in parking lots which stops the tires of a parked car from going any further forward.
- blended curb** Where the street and sidewalk are at the same level and there is no drop-off.
- clearing** The process of ensuring the safety of an area either with a sweep of the cane tip on the ground or with a sweep of the hand on a surface.
- COMS** AER Certified Orientation and Mobility Specialist
- COMAS** AER Certified Orientation and Mobility Assistants
- constant contact technique** Using the cane in a side-to-side motion maintaining continual contact of the cane tip with the walking surface as the cane clears the area ahead of the forward foot.
- curb trailing** Using touch technique along the curb face.
- Using two-point curb trailing by touching the street with one arc and the top of the curb with the other arc.
 - Using three-point curb trailing by touching the street, the curb face, and the surface beyond the curb.
- diagonal technique** Using the cane held diagonally across the body as protection and to gather information.
- direction taking/parallel alignment** Getting a straight parallel line or course from a fixed object or a sound to better facilitate traveling in a straight line (toward a desired objective).

directionality The ability to differentiate between another person's left and right, and to judge the position of objects in the environment relative to one's own body.

drop-off A step down such as a curb or stair.

drop-off lesson A training procedure in which students are taken to a point within the boundaries of a familiar environment and are instructed to independently determine their location. They then find a specific destination by evaluating environmental landmarks and clues available while traveling.

echolocation Auditory skill of locating openings along a wall or other surface by recognizing the absence of sound waves.

flagging Moving the cane back and forth in an arc pattern with the tip down before stepping off the curb when crossing a street to give more warning of one's intention to cross.

hines break technique A systematic method of disengaging unwanted or incorrect sighted guide assistance.

identification cane technique Utilization of the long cane by a person with low vision in order to be recognized by others as having a visual impairment. In the interest of safety and/or better understanding, the cane is used in a diagonal cane technique (across the lower body) with the tip toward the parallel traffic, rather than the touch technique.

kinesthetic sense The ability of the mind to perceive the location or relationship of parts of the body as they are moving, without using any other sense to check.

laterality Knowing one's own left and right sidedness.

light perception The ability to distinguish light from dark.

midline axis An imaginary line, roughly corresponding to the verticality of the spinal column, used as a referent for orienting the movement of the body's extremities in symmetrical patterns.

null point Position in which the eyes are turned where nystagmus is dampened or minimal.

object perception The ability to auditorally or visually detect the presence of an object or wall without direct contact.

offset Intersection An intersection in which two 90° turns are required in order to continue traveling in the same direction on one of the streets.

orientation The cognitive process of utilizing the senses in establishing one's position and relationship to all other significant objects in one's environment (e.g., knowing where one is in space).

orientation and mobility Knowing one's spatial relationships to the features of the travel environment and keeping track of those relationships (e.g. mental or spatial mapping, familiarization with the layout of a room, etc.) while moving safely, efficiently, and comfortably within that environment.

orienteering Navigation around a course or space in a timed or untimed period using clues, landmarks, and other techniques (e.g., maps, compass, electronic devices) to locate a specific point. A modification of competitive orienteering can be used as a teaching method to make orientation more enjoyable for the student.

pre-cane device A term previously used to describe an adaptive mobility device.

press/release pressure A technique for applying resistance to the movement of a limb in order to increase the subject's awareness of the movement; pressure is applied, then released, then applied again.

proprioceptive sense The ability of the mind to perceive the location or relationship of parts of the body in stationary positions without the need to use any other sense to check.

recovery The process of reorienting one's self in the environment.

room familiarization A technique used to provide a student with a systematic procedure for independently examining an unfamiliar room and for developing a clear understanding of the spatial relationships of objects within the room.

scanning A systematic procedure using auditory, visual and tactile cues to obtain information and ensure the safety of an area.

search pattern A systematic method for recovering a dropped object.

self-protective techniques

- a. Forearm Protective Technique: Protecting the upper part of the body during travel.
- b. Lower Body Protective Technique: Protecting the waist, hip, and upper leg areas of the body during travel.

shoreline/guideline A line formed by the meeting of two surfaces, in either plane or texture. The line gives the traveler direction and/or location (e.g., grass and sidewalk edge, blacktop and cement of parking area or gas station).

sighted guide technique Guiding a person with a visual impairment in a recommended manner.

- sound echo** A sound which is reflected from an object in the environment, such as a building or wall.
- sound shadow** An object in the environment which is between the sound and the traveler.
- squaring off** Placing one's backside against an object in order to obtain a perpendicular line of direction.
- tactile defensiveness** Acute sensitivity to kinds of touch.
- tactile map** A three dimensional or raised line representation of a specific location in the environment (e.g., a map of a residential training area, school campus).
- tactile model** A three-dimensional representation of a generic concept or environmental situation (e.g., a model of an intersection, a model of a revolving door).
- three point search technique** Searching directly in front, to the left, and to the right with the cane to locate a sidewalk.
- three point touch technique** Using the cane to locate an objective on a higher plane by moving the cane in three motions' a regular arc away from the vertical surface, trailing the vertical surface, and the other arc on the higher horizontal surface (e.g., traveling in the gutter along a curb to locate a sidewalk after a crossing).
- touch and drag technique** Using the cane to follow a guideline or shoreline of a different texture to locate an intersecting surface (e.g., sidewalk) or to regain a parallel line of travel by maintaining the tip's contact with the ground during the arc toward the guideline being followed.
- touch and slide technique** Using the cane to locate drop-offs (e.g., curbs or stairs) or texture changes by keeping the cane tip on the ground and letting it slide slightly forward when making the arc of the touch technique to provide more feedback.
- touch technique** Using the cane in a rhythmic side-to-side motion making
- two point touch technique** a low, flat arc to clear the area for the traveler's next step, as the cane tip contacts the walking surface on the opposite side of the forward foot.
- trailing** Using the cane and/or the hand to lightly follow along a surface (e.g., wall, lockers, desk, tables) for one or all of the following reasons:
1. to determine one's place in space
 2. to locate specific objectives
 3. to get a parallel line of travel.

verification cane technique A modified diagonal cane technique utilized by some persons with low vision. The user determines the amount of contact the cane tip has with the ground based on the need for verification of obstacles, surfaces, and drop offs. The technique is also used to identify the person as visually impaired.

Suggested Readings

- Blasch, B., Wiener, W., & Welsh, R. (1997). ***Foundations of orientation and mobility***. New York: American Foundation for the Blind.
- Bureau of Education for Exceptional Students. (1987). ***A resource manual for the development and evaluation of special programs for exceptional students, volume V-I, orientation and mobility for visually impaired students***. State of Florida.
- Dodson-Burk, B. & Hill, E. W. (1989). ***An orientation and mobility primer for families and young children***. New York: American Foundation for the Blind.
- Chen, D. & Dote-Kwan, J. (1995). ***Starting points: Instructional practices for young children whose multiple disabilities include visual impairment***. Los Angeles: Blind Children's Center.
- Dodson-Burk, B. & Hill, E. W. (1989). ***Preschool orientation and mobility screening***. Alexandria, VA: Association for Education and Rehabilitation of the Blind and Visually Impaired.
- Hazekamp, J., & Lundin, J. (Eds.). (1996). ***Program guidelines for visually impaired individuals***. Sacramento: California Department Education.
- Hill, E. W., & Ponder, P. (1976). ***Orientation and mobility techniques: A guide for the practitioner***. New York: American Foundation For The Blind.
- Hug D., Chernus-Mansfield, N., & Hayashi, P. (1987). ***Move with me: A parent's guide to movement development for visually impaired babies***. Los Angeles: Blind Children's Center.
- LaGrow, S. J., & Weessies, M. J. (1994). ***Orientation & mobility: Techniques for independence***. Palmerston North, New Zealand: Dunmore Press.
- Pogrund, R.L., Healy, G., Jones, K., Levack, N., Martin-Curry, S., Martinex, C., Marz, J., Roberson-Smith, B., & Vrba A. (1993). ***Teaching age-appropriate purposeful skills: An orientation and mobility curriculum for students with visual impairments***. Austin: Texas School for the Blind and Visually Impaired.
- Smith, A., & O'Donnell, L. M. (1992). ***Beyond arm's reach: Enhancing distance vision***. Philadelphia: Pennsylvania College of Optometry Press.

References

- Hazekamp, J., & Huebner, K. M. (Eds.). (1989). *Program planning and evaluation for blind and visually impaired students: National guidelines for educational excellence*. New York: American Foundation for the Blind.
- Wilson, E.L. A developmental approach to psychological factors which may inhibit mobility in the visually handicapped person. *New Outlook for the Blind*, 61, 1967, 283-89.
- Yale, K. (1999, Winter). *Division nine newsletter: association for the education and rehabilitation of the blind and visually impaired*, 7(2).

Orientation & Mobility Appendix

The following is a draft of an Orientation and Mobility Severity Rating Scale that was developed in 1998, by Division 9 of Michigan AER. It was adapted from Pennsylvania's Montgomery County Intermediate Unit 23, Program for the Visually Handicapped, Severity Rating Scales Handbook, March, 1991.

This draft is included to assist COMS in developing appropriate Orientation and Mobility programs for students with visual impairments.

Each of the six categories (below) included on the scale is structured in terms of impact on independent travel skills as it relates to the student's age appropriate needs. When using the O&M Severity Rating Scale, criteria provided within each of the categories is not all inclusive and many criteria overlap from one severity level to the next. The Scale may assist in documenting change from one service delivery model to another. Additional factors may influence the selection of the severity level by the Orientation & Mobility Specialist.

The O&M Severity Rating Scale consists of the following six categories:

- 1. Level of Vision (Medical)**
- 2. Level of Vision (Functional)**
- 3. Use of Travel Tools**
- 4. Proficiency in Use of Travel Tools**
- 5. Current Age-Appropriate Independence**
- 6. Complexity or Introduction of New Environment**

This scale is sequentially structured based upon a student's need for instruction in age appropriate travel skills by a certified Orientation & Mobility Instructor with input from the parents other staff and other interested individuals.

The severity level descriptors within each category purposely overlap. To aid the Orientation & Mobility Specialist in the selection of the level that is most characteristic of the visually impaired student, additional evaluations may be necessary.

Category Definitions

Level of Vision (Medical) - refers to the student's level of vision as reported by an eye care specialist.

Level of Vision (Functional) - refers to the student's ability to use vision for all travel tasks (i.e. movement within the classroom, school building and community) as reported by the Orientation & Mobility Specialist.

Use of Travel Tools - refers to the student's need for use of a white cane or alternative mobility device (i.e. pre-cane, etc.).

Proficiency in Use of Travel Tools - refers to the student's skill level in use of a travel tool.

Current Age - Appropriate Independence - refers to the student's ability to travel safely and proficiently in a developmentally age appropriate manner.

Complexity or Introduction of New Environment - refers to the type of environment in which instruction is required (i.e., business district, new school, neighborhood).

Examples of Vision Related Travel Tasks

Student is able to:

- visually track a moving object
- imitate gross motor movements based on visual observation
- see facial expressions and gestures
- visually discriminate basic colors and geometric shapes
- visually scan area and avoid large obstacles in path
- visually locate or identify familiar rooms in school
- visually distinguish shorelines and/or intersecting sidewalks
- visually detect steps and drop-offs
- visually detect blended curbs see turn signals on cars while standing at a corner
- see drivers inside cars motioning to pedestrians
- see color change on walk/don't walk signal
- see color change on traffic signal
- read walk/don't walk signal without a distance aid
- read name of approaching bus without a distance aid
- visually determine desired bus stop without assistance from driver
- visually locate doors to stores and other commercial buildings
- read grocery store aisle signs without a distance aid
- understand how lighting conditions affect travel skills
- explain the status of own vision related to travel (day / night)

Professional Judgment Factors

On occasion the professional judgment of the Certified Orientation & Mobility

Specialist can influence the selection of a service delivery model that has been determined by the Severity Rating. The selection of one or more of the Professional Judgment Factors on the O&M Severity Summary may be used to place a student at a higher or lower level Model of Service Delivery than indicated by the Severity Rating alone.

The use of the Professional Judgment Factors may be necessary when it appears that the Model of Service Delivery indicated by the Severity Rating does not reflect the true needs of the visually impaired student. Based upon the professional judgment of the Certified Orientation & Mobility Specialist, all factors, which influence the modification of the Model of Service Delivery, should be marked.

The following factors are to be considered:

- Posture, gait and motor development
- Cognitive ability of the student
- Other physical or mental impairments
- The nature of eye disease / condition
- Transition to a new school, neighborhood, work site, etc.
- Recent vision loss
- New, hazardous, complex or difficult environment
- Potential for improvement
- Age of on-set of blindness
- Maturity and motivation
- Parental concern / input
- Parental commitment for follow-up
- Travel time needed to transport student to area of instruction
- Availability of Certified Orientation & Mobility Assistant
- Instruction in low vision aids
- Instruction in electronic travel aids
- Other (explain)

Remember, each of these factors may be either positive or negative and should be marked if modifying a service delivery rating.

Directions For Completing The Orientation & Mobility Severity Characteristics and Orientation & Mobility Severity Summary

This chart (found on page 121) may be used three times. Category names are listed vertically along the left hand side of the O&M Severity Characteristics Worksheet. Descriptors are listed horizontally for each category. The descriptors are listed sequentially in terms of severity, from mild to profound. The numbers attached to each severity are considered part of continuum. The specific numbers under each severity name are the numerical rating to be given for that severity. For example, under MILD, a numerical rating of 0, 1, or 2 is possible, while under SEVERE, a numerical rating of 6, 7, or 8 is possible.

For each category, mark the descriptor that best describes the visually impaired student. Place the appropriate severity number in the right hand column (SEVERITY SCORE COLUMN). Three columns are provided for evaluation on three separate occasions.

Note: The LEVEL OF VISION (MEDICAL) category may receive two scores under MODERATE or SEVERE if the student has both a field loss and an acuity loss.

Total the right hand column to get a TOTAL SEVERITY SCORE. Using the TOTAL SEVERITY SCORE, refer to the O&M SEVERITY SUMMARY to determine:

- Severity rating
- Frequency of service
- Total minutes of service per week
- Model of service delivery
- Record these findings in the Recommendations of Services section on the Orientation & Mobility Severity Summary

Orientation & Mobility Severity Characteristics Worksheet

Student:		Birth Date:			
	Rating	Mild Needs 0-2	Moderate Needs 3-5	Severe Needs 6-8	Profound 9-11
Category					
Level of Vision (Medical)	Distance	20/120-20/200	20/200-20/600	20/600-Light Perception	Light Percepti
	Visual Field	No score here No visual field loss	And/or 30 degree field – 10 degree field	And/or 10 degree field – 1 degree field	No score No periphera
Level of Vision (Functional)		Visual skills adequate for developmentally age appropriate independent travel	Visual impairment affects ability to travel in most environments	Visual impairment affects ability to travel in all environments – instruction needed for future independent travel.	No usable vis has need immedi independent t 1 or mo environm
Use of Travel Tools (Cane / Alternative Mobility Device, i.e. pre-cane device)		Travel tool not needed except as identifier	Travel tool used in some travel environments	Travel tool used in most travel environments	Travel tool us travel enviro
Proficiency in use of travel tool		Proficiency is adequate for present travel needs	Competency - May review or refine skills using existing tool	Refining current skills. Introduction of new skills and/or travel tool	Introduction skills and/or tool
Current age appropriate independence		In all environments	In most environments	In some environments	In no enviroi
Complexity or introduction of new environment		Travel needs me t in current environment	Maintains & refines skills in all current travel environments	Needs some instruction of skills in all current travel environments	Needs exte instruction in more com environm
Total Severity Scores ____					

Orientation & Mobility Severity Summary

Student _____	Birth date _____	
Grade/Program _____	O&M Specialist _____	Date Completed _____
Grade/Program _____	O&M Specialist _____	Date Completed _____
Grade/Program _____	O&M Specialist _____	Date Completed _____

Recommendations for Services

Date	Severity Rating	Frequency	Min/Week	Model of Service Delivery

Severity Score	Severity Rating	Frequency or Minutes/ week	Model of Service Delivery
0-17	1	1-5 times/ year	Monitoring/ Consultation
18-34	2	1-2 Times/ month 20-60 min. each	Supportive
35-50	3	1-2 times/ week 30-90 min. each	Intensive
51-66	4	3 or more times/ week 20-90 minutes each	Comprehensive

	Professional Judgement Factors
_____	1. Posture, gait and motor development
_____	2. Cognitive ability of student
_____	3. Other physical or mental impairment
_____	4. Nature of eye disease
_____	5. Transition to a new school, neighborhood, etc.
_____	6. Recent vision loss
_____	7. New, hazardous, complex or difficult environment
_____	8. Potential for improvement
_____	9. Age of on-set of blindness
_____	10. Maturity and motivation
_____	11. Parental concern / input
_____	12. Parental commitment for follow-up
_____	13. Travel time needed to transport to school, etc.
_____	14. Certified orientation & mobility instructor
_____	15. Instruction in low vision aids
_____	16. Instruction in electronic travel aids
_____	17. Other (explain) _____

Parent Counseling

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Parent Counseling as a Related Service

Parent Counseling addresses the needs of parents and the role they play in the lives of their children. School guidance counselors work with all students and families, as an integral part of the education program.

Federal Definition

Parent counseling and training means “assisting parents in understanding the special needs of their child and providing parents with information about child development and helping parents to acquire the necessary skills that will allow them to support the implementation of their child’s IEP.” 34 CFR. §300.24(b)(7) According to the federal Office of Special Education Programs (OSEP), “any related service provided for parents must assist the child in developing skills needed to benefit from special education or correct conditions that interfere with his or her progress toward the goals and objectives in his IEP.” [*Letter to Dagley*, 17 EHLR 1107 (OSEP 1991)].

Nebraska Statute Information

Parent counseling as a related service may be provided by school guidance counselors, social workers, psychologists, or other qualified personnel. School guidance counselors are not licensed, but certified by the Nebraska Department of Education. Social workers and psychologists are licensed in the state of Nebraska. Information on these two providers state practice acts can be found in their respective related service area in this document.

Professional Organization Information

“Parent Counseling and Training addresses the needs of the parents and the vital role they play in the lives of their children. Parent counseling is provided when necessary to help a child or youth with a disability benefit from their educational program. Parent counseling:

- assists parents in understanding the special needs of their child;
- provides parents with information about child development; and
- provides parents with referrals to parent support groups, financial assistance resources, and professionals outside the school system.”

[NICHY News Digest, Vol. 1, No. 2, 1991].

Case Law and Regulatory Interpretations

“34 CFR §300.16(b)(12)(ii) identifies ‘group and individual counseling with the child and his

family’ as a component of social work services in schools. Please note that the current C.F.R. reference is 34 CFR §300.24(b)(2). While no further definition or guidelines are provided by The Office of Special Education Programs (OSEP), Office of Civil Rights (OCR) has stated in a Letter of Findings that family counseling may be provided informally, when needed as well as more systematically. Provision of services by telephone is permitted. This Letter of Findings utilized case law, Township High Sch. (IL) Dist. #211, ELHR 352:289 (OCR 1986)” (Ibid.) (Gorn, S., 1997).

“Family therapy is not an explicitly listed related service. Also, it seems inconsistent with the goals and objectives of providing related services to parents only to the extent they allow the student to benefit from special education (*Letter to Dagle*, 17 EHLR 1107 (OSEP 1991) to provide a service whose stated objective is to benefit the entire family unit.” (Gorn, S., 1997)

Parent Counseling is Intended to Serve...

According to 34 CFR §300.20; a “parent” is defined as:

- A natural or adoptive parent of a child;
- A guardian but not the State if the child is a ward of the State;
- A person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child’s welfare); or
- A surrogate parent who has been appointed in accordance with § 300.515.
- Unless State law prohibits a foster parent from acting as a parent, a state may allow a foster parent to act as a parent under Part B of the Act if –
 - The natural parents’ authority to make educational decisions on the child’s behalf has been extinguished under State law; and
 - The foster parent:
 - Has an ongoing, long-term parental relationship with the child;
 - Is willing to make the educational decisions required of parents under the Act; and

- Has no interest that would conflict with the interests of the child [34 CFR ? 300.20].

Any of the disabilities through which the child can become eligible for special education are avenues that would make parents potential recipients of parent counseling as a related service. The parent counseling related service provided to parents must assist the child in developing skills needed to benefit from special education, or correct conditions that interfere with his or her progress through the goals and objectives in the IEP.

Qualification of Providers

Providers of parent counseling, may include school guidance counselors, school psychologist, licensed social workers, licensed psychologists, licensed mental health practitioners, and licensed counselors, employed or contracted by schools. School guidance counselors have received a Masters in School Counseling either Elementary or Secondary by completing an accredited counseling program from a University.

The school counselor is a certified professional educator who assists students, teachers, parents and administrators. School guidance counselors meet the certification standards. School counselors work cooperatively with individuals and organizations to promote the overall development of children, youth, and families in their communities. The qualifications for social workers or psychologists, who may also provide counseling services, are listed in this document under their respective related service areas.

Role of Support Personnel

Teachers, especially resource teachers, who may be spending a good deal of time with the child every day, as well as paraprofessionals, are in an excellent position to initiate referrals for parent counseling, based on staff's observations and family contacts. When written information is sufficient to meet the parent need and enhance the child's benefit from special education, teachers and paraprofessionals are in an excellent position to deliver that information in the course of customary school routine.

Entrance Criteria

The need for parent counseling may be assessed by any member of the multi-disciplinary team and reported to the team at scheduled meetings, including the IEP meetings. The referral would be based on team

consensus, inferred from the quality and quantity of information passing from school to home and back, either through the child or in direct written and spoken communication. Parents may also request such assistance and initiate the process.

Service delivery issues for parent counseling are frequently only logistical, e.g., parents who are working during school hours and can receive only emergency calls, families without phones, or families where parents are not fluent in English. These considerations can often be addressed by flexible hours for staff, home visits especially when the school social worker is delivering the service, sending written communication home with children, and the use of interpreters skilled in the parents' native language.

In order to determine that parent counseling is needed in the IEP team will typically consider the following.

- Does the problem relate to assisting parents to acquire the necessary skills that will allow them to support the implementation of their child's IEP? Does the problem interfere with the child's ability to participate in his/her educational program?
- Can the problem be ameliorated by assisting parents in problem-solving or decision making, by providing parents with information specific to their child's disability, or by making referral to relevant community resources? Previous measures, if any, have not involved parent counseling, and have not succeeded in alleviating the problem.
- Can positive change for the child's ability to participate in his/her education program be reasonably anticipated as a result of parent counseling, or negative change prevented? Changes resulting from parent counseling should be beyond that anticipated as a feature of maturation and development in the student.

Methods Used for Assessment

Assessment of the need for parent counseling will often begin with the student assistance team, as it formulates the need for educational assessment and obtains parental consent, especially when social and emotional assessment is requested. Qualified personnel may interview parents directly and also solicit parent input on measures such as adaptive behavioral checklists or child behavior rating scales. Classroom staff and resource teachers frequently provide input regarding the need for parent counseling based on previous contact. (If, during the MDT

process, standardized assessment is conducted, qualified staff will compile the results, and the team will then formalize parent counseling goals or service objectives.)

Parents may also initiate the process by requesting information, referral, or assistance in developing skills that will allow them to support the implementation of their child's IEP.

Service Delivery Models

Two generally recognized processes used by the school guidance counselor are counseling and consulting. Counseling is a complex helping process in which the counselor establishes a trusting and confidential working relationship. The focus is on problem-solving, decision-making, and discovering personal meaning related to learning and development. Consultation is a cooperative process in which the counselor assists the parents/family to think through problems and to develop skills that make them more effective in working with the student. Parent counseling services are provided under either an integrated or consultative services model.

Integrated services involve direct contact with the student, while consultation occurs with the parents. The provider may model and instruct with parents present, thus instructing parents in effective, positive, and proactive interaction, or may provide feedback to the parents retrospectively regarding the success of an intervention as it carries over between school and home. The integrated service may include interactions at school as well as in the home, with school guidance counselors typically providing most of the service in school, licensed mental health professionals, psychologists, and social workers more likely to provide the services at home.

Interventions might include such activities as parent effectiveness training, instruction and demonstration of behavioral support programs, or explanation of curriculum content or technologies that are for a home-based component.

Consultative services focus on providing input or information to parents regarding the child's needs, rather than providing services to both parents and child in tandem. Consultative services may not, however, obviate the need to work directly with the child in order to observe, baseline, identify needs, supply feedback, and problem-solve.

Interventions might include face-to-face or telephone contacts and will typically be brief and solutions oriented., the provider may facilitate

communication among school personnel, community professionals and the parents, particularly when the provider is also the case manager.

Education may be provided through general parenting, child development, or behavior analytic content, or may be addressed to specific diagnostic and situation issues. The provider may also make referrals for the family to community resources including support groups, experienced professionals, and relevant technologies. As part of the SAT/MDT team process or as a result of family requests

Whether integrated or consultative, the need for parent counseling, its nature and frequency, its duration and intensity, will be determined by the child's IEP team. The need for parent counseling may also become apparent to the student assistance team (SAT) prior to the referral to the MDT

Methods to Determine the Amount of Service Appropriate for Educational Benefit

The amount of parent counseling provided is dependent on numerous factors including the acute or chronic nature of the child's need, the recency of onset,

personal, financial, and educational resources already possessed by parents, the pattern of psychosocial stressors experienced by the child in school and the family at home, and the extent to which the child's needs are addressed by different providers. These, and others, are salient factors in helping parents to acquire the necessary skills that will allow them to support the implementation of their child's IEP. No specific guidelines to determine amount of service are available.

Examples of Parent Counseling Activities

Parent counseling as a related services can be either integrated or consultative services. "Medical" treatment is not a relevant issue in parent counseling, though specific referral and education services to parents may have a medical content. Long term counseling or intensive psychotherapy with parents does not fall within the parameters of educationally-related parent counseling.

Behavior Support/Modification:

Educational Counseling Examples

- The counselor assists the family in identifying appropriate reinforcers to be utilized in both school and home contexts.

- The counselor refers the family to community professionals who can assist the family in reducing at home behaviors that are interfering with the child's educational process.
- The counselor makes limited home visits with parent agreement to demonstrate effective running of a program, including contiguous reinforcement, where the behaviors of concern are relevant to educational progress.

Borderline Counseling Examples

- The counselor develops a behavioral support program for implementation by the parents, regarding behaviors occurring chiefly at home and whose relevance to educational progress is largely indirect, not addressed in IFSP/IEP.

Family Counseling:

Educational Counseling Examples

- The counselor meets with the parents, child, and siblings to advise them of community resources and support, subsequent to the diagnosis of a chronic condition that affects school attendance.
- The counselor meets with parents regarding stress management, required because of the nature of the demands imposed on them because of their child's disability, loans a set of audio tapes relevant to stress management, and follows up monthly with a phone call.

Borderline Counseling Examples

- The counselor meets with the family to address issues pertaining to long term family dynamics, one result of which is occasional school absence.
- The counselor schedules appointments with community professionals and arranges transportation to meetings on an ongoing basis, because parents have not consistently made and kept important appointments.

Anger Control Classes:

Educational Counseling Examples

- The counselor meets at school with parents whose child has a “behavior disorder” diagnosis, in order to explain the anger control classes being offered at school, and the frequency at which in-home relaxation sessions and parental feedback to the counselor are desired.
- The counselor conducts a home visit to help parents construct the optimal context and schedule in order for their child to practice self-soothing strategies to be utilized in high pressure situations at home and school.

Borderline Counseling Examples

- The counselor conducts anger control sessions for the family as part of a family preservation program that would help the child avoid an out-of-home residential placement.

Equipment and Space Needed

The most basic issues involve a space where the counselor can deliver service confidentially, and a secured area where files and records can be safely maintained. Dedicated phone lines and answering equipment can also be helpful.

Documentation

School guidance counselors providing parent counseling as a related service may document through lesson plans, if indicated, and through a “no progress”-“slow progress”-“satisfactory progress”-accomplished continuum on the IEP. Contracted providers maintain files in accord with the standard practice of their profession. Other school staff maintain documentation in accord with the policies and procedures of their school district.

Supervision and Evaluation of Services

Personnel functioning as employees of the school district will be evaluated according to policies of the district, often evaluated by principals or superintendents. In practice, most contracted professionals are evaluated by renewal or non-renewal of the contract. Observation and feedback from the classroom and resource teachers assist the counselor in assessing the effectiveness of delivered service.

References

- Carpenter, Stephanie L, King-Sears, Margaret E, & Keys, Susan G. (1968). Counselors + educators + families as a transdisciplinary team = more effective inclusion for students with disabilities. *Professional School Counseling*, 2, 1-9.
- Cline, Foster MD & Fay, Jim (1992). *Parenting with love and logic*. Colorado Springs, CO: Pinion Press.
- Dinkmeyer, Don. *Systematic training for effective parenting*. Circle Pines, MN: American Guidance Service.
- Federal Register, Vo. 64, No. 48/Friday, March 12, 1999/Rules & Regulations, P. 12424.
- Glenn, H. Stephen, & Nelsen, Jane. (1989). *Raising self-reliant children in a self-indulgent world: Seven building blocks for developing capable young people*. Prime Publishing. Rocklin, CA.
- Gorn, S. (1997). *The answer book in special education law, 2nd ed.* LRP Publicatoin.
- Lott, Lynn, & Nelsen, Jane. *Teaching discipline the positive parenting way*. Prime Publishing. Rocklin, CA.

Physical Therapy

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Physical Therapy Services as a Related Service

Federal Definition

Physical therapy as a related service means “services provided by a qualified physical therapist” (34 CFR ? 300.24(b)(8)). The definition of physical therapy as an early intervention service can be found in Part C of IDEA '97.

Nebraska Statute Information

The practice of physical therapy in the state of Nebraska is governed by Department of Health Statute, Neb. Rev. Stat. ? 71-2801 to 71-2822, and the regulations governing the practice of physical therapy (172 N.A.C. 137). According to statute, physical therapy is “the treatment of any bodily condition by the use of the physical, chemical, and other properties of heat, light, water, electricity, massage and active or passive exercise. It shall not include the use of roentgen rays and radium for diagnostic and therapeutic purposes” (Neb. Rev. Stat. ? 71-2801)

Professional Organization Information

The American Physical Therapy Association (APTA) has developed a technical assistance document for therapists working in the educational setting titled “Physical Therapy Practice in Educational Environments: Policies, Guidelines” American Physical Therapy Association and the Section on Pediatrics, 1111 North Fairfax Street, Alexandria, VA 22314 (APTA, 1990). While the legislative information is not updated to reflect IDEA '97, information is provided to assist the clinician with patient care and other administrative issues. While some state chapters of the APTA have pediatric special interest groups (SIG), at the time of this writing a SIG had not been developed in Nebraska. Further information on physical therapy in Nebraska schools can be obtained by contacting the chapter office of the Nebraska APTA in Omaha, the local ESUs or school district or the state’s University Affiliated Program (UAP), the Munroe-Meyer Institute for Genetics and Rehabilitation, University of Nebraska Medical Center in Omaha.

Case Law & Regulatory References

Case # 97-08SE filed against Adams Central, Jr.-Sr., High School District in December 1998 ruled that a student who “is able to attend

regular classrooms, move between the classrooms effectively, has consistently received passing grades, and has advanced to the point that they are on schedule to graduate” does not need direct physical therapy as part of a free, appropriate, public education as required under the Federal IDEA and Nebraska SEA. It was also ruled that “ if the student were to be removed from the regular education environment at school to receive direct physical therapy, he/she would not be receiving his/her education in the least restrictive environment required by the Federal IDEA, Nebraska Special Education Act (SEA), and their implementing regulations.”

Physical Therapy is Intended to Serve. . .

Physical therapy as a related service serves children ages 3-21 years with a verified disability. Areas to be

addressed may include the following: gross motor skills, orthopedic concerns, impaired mobility, and adaptive equipment/positioning needs that interfere with the student’s educational performance. The focus of educational services is to allow the student to benefit from their special education program by promoting functional independence or participation within the educational environment.

The focus and provision of physical therapy as an early intervention service for children ages birth to three years differs from physical therapy as a related service. Early intervention services have a focus to maximize a child’s development. The physical therapist may also be the sole provider in an early intervention program. These distinctions are important as there are differences between these two services as defined in federal law.

Educational therapy services are not intended to satisfy the medical needs of a student and therefore may not meet the student’s total therapy needs. Best practice in physical therapy focuses on helping the child achieve their optimum level of independence. Some students with disabilities may have a medical disability or sensorimotor impairment, identified by a medical facility, which does not interfere with educational performance. The multidisciplinary evaluation team (MDT) or IEP team may determine that the student does not require physical therapy through the educational program, however, the

student's family may wish to pursue therapy services outside the educational program.

Other students may have a medical diagnosis that significantly affects their educational performance. In this case, the student may require physical therapy services in both medical and educational settings. The school therapist's role in this situation would be to provide educational services and to communicate with medical personnel involved with the student to ensure as much coordination of services as allowed by the family's willingness to have disclosure.

**Physical Therapy
is Provided by . . .**

The physical therapist, physical therapist assistant and physical therapist aide provide physical therapy services. Physical therapists traditionally have been trained and employed in the medical setting to evaluate, treat, restore function, and prevent disability primarily with persons with diseases or disorders that impair mobility. Therapists in educational settings need background in human development, neuromotor development and treatment techniques, the design and use of adaptive equipment, parent-teacher-team training techniques, the rules and regulations of special education, and in writing Individual Education Programs (IEPs).

Qualifications of Providers

Physical Therapist

The physical therapist (PT) is a graduate of an accredited education program and must successfully pass a national examination to qualify for licensure in the state of Nebraska. In general, the PT receive a masters or doctorate degree from the academic institution they attend for their educational program. The Department of Health, through the Board of Examiners, licenses PTs in Nebraska.

Physical Therapist Assistant

The physical therapist assistant (PTA) is a graduate of an accredited education program and must successfully pass a national examination to become certified in the state. The PTA receives an associate degree upon completion of the educational program. The Department of Health, through the Board of Examiners, certifies PTAs to work under the supervision of a PT Neb. Rev. Stat. ? 71-2809(4). A physical therapist is allowed by statute to supervise two PTAs. A PTA cannot legally provide physical therapy services in the state unless they are certified and supervised by a PT.

Physical Therapist Aide

A physical therapist aide is an unlicensed and uncertified person who typically has received “on the job” training”. The PT aide assists the therapist in the practice of physical therapy and must have direct, on-site supervision by the therapist to provide therapy services Neb. Rev. Stat. ?71-2809(5). In certain settings the use of the term aide with paraprofessional is interchangeable. However, in this section the terms are kept separate to provide clarity in who employs the aide and who provides supervision, but more importantly perhaps when the service provided by an aide can be called physical therapy.

A PT aide shall mean a person employed by the physical therapist or agency contracted to provide the related service and who is supervised by the PT. A paraprofessional shall mean a person who is employed by the school district and who is directly supervised by either the classroom teacher or a PT who works for the school district. For example, in the Lincoln public schools a motor activity paraprofessional (MAP) is an aide who is employed by the school district, but supervision is provided by a

PT rather than a classroom teacher. In the Omaha public schools, paraprofessionals are employed by the district and supervised by the classroom teacher.

Role of Support Personnel

The paraprofessional's role varies greatly depending on whether their primary supervisor is a therapist, eg. MAP, or the classroom teacher. A MAP's primary activity is the provision of instructed activities by a therapist for students with special health care needs in conjunction with attainment of IEP objectives. As long as the activities being performed by the MAP are appropriate with respect to the scope of practice of a PT aide in state statute, the service provided by a MAP is physical therapy when a PT is on site¹. The paraprofessional's role also includes ongoing communication with the therapist regarding the student's performance.

In the case of a paraprofessional supervised by the classroom teacher, their primary role is in support of the teacher's educational program. The paraprofessional follows through with an activity program in fulfillment of the goals set by the teacher, parents and PT at the IEP meeting. The PT instructs the teacher and paraprofessionals in the activity program. The services provided by paraprofessionals in the classroom are not physical therapy, but rather an activity program for the student². The teacher supervises the paraprofessionals and maintains ongoing communication with the therapist regarding the student's performance.

Entrance Criteria

The student has a verified disability as defined by Rule 51, and the IEP team has identified:

- The problem relates to a delay in gross motor skill development such as delay in head control, sitting balance or walking;
- The problem appears to be motor (muscle weakness or lack of flexibility) or sensorimotor (lack of sensation, coordination or balance);

¹ These services are eligible for the medicaid in the public schools (MIPS) program as they meet state statute to be called physical therapy.

² These services do not meet state statute requirements to be called physical therapy.

- The problem relates to difficulty with equipment used for positioning or mobility in the educational environment such as orthotics (braces), standing equipment, special chairs including wheelchairs;
- The problem relates to difficulty in accessibility to the school or participation in activities that require gross motor skills, eg. Physical education or play time on the playground;
- Previous attempts to alleviate problems have not been successful; and/or
- The potential for change in the student's problem through physical therapy appears likely.

In addition to entrance criteria, the PT should perform a complete physical therapy assessment. This assessment could include functional motor skills, mobility, range of motion, strength, balance, and posture/positioning as they relate to the educational setting. Standardized testing may be done to determine the child's delay or functional skill level in the appropriate educational environment.

Physical therapy as a related service is planned and implemented through the student's IEP. Although medical information, including prescriptions from physicians, are to be considered by the educational team in determining the related service program, the school is only obligated to provide those services on the IEP. The district does, however, need a medical prescription for reimbursement under the regulations for Medicaid in Public Schools (MIPS).

Methods Used for Assessment:

Assessment for physical therapy services must be completed by a physical therapist. Many tests are available to assess impairments or disability in children. A few will be mentioned as examples, however, there is no single assessment instrument available to evaluate the need for or the outcomes of physical therapy as a related service. Assessment tests such as the Peabody Developmental Motor Scales (Folio & Fewell, 1983) and the Bruininks-Oseretsky Test of Motor Proficiency (Bruininks, 1978) are commonly used as norm referenced tests to determine delay in motor development. The School Function Assessment (Coster, et al., 1998) was developed to assess disability in the school environment or the Pediatric Evaluation of Disability Inventory (Haley, et al., 1992) provides a broader assessment test for disability in pediatrics. The Gross Motor Function Measure (Russell, et al., 1993) is an example of a test that can be used to assess impairments of motor

function or to evaluate the outcome of therapy activities to promote motor development.

Service Delivery Models:

Traditionally the continuum of service delivery for physical therapy has been labeled as direct service, integrated service, and consultative service as outlined in Table 1, page 146. It should be noted, however, that direct, integrated, and consultative services are not mutually exclusive. The need for consultation, i.e. sharing of information among team members and joint program planning and evaluation is an essential part of both direct and integrated service delivery. There is also a need for the therapist to provide some level of direct contact in all models for assessment and program planning so that the division is not based solely on the presence or absence of direct contact with the student.

In direct service the therapist works with a student individually (or in a small group) on a regularly scheduled basis to assist the student to develop skills relevant to the student's educational performance. The therapist is the primary provider of service for the student, however, the amount and frequency of service is a team decision as is true for all related services. Frequent program changes and adaptive equipment may be needed to meet the student's needs. The emphasis of direct therapy is to develop motor performance and skill acquisition to increase the student's benefit from instruction. Direct therapy may also be indicated to maintain newly acquired skills or to slow the rate of regression.

Intervention sessions may include the use of therapeutic techniques or specialized equipment, which require a therapist's expertise and cannot safely be used by others within the student's environment. Collaboration with parents, teachers, or paraprofessionals is necessary to achieve goals and for carryover of activities into the regular routine. Consultation is needed to maximize the educational benefit of the intervention and should always include others involved with the student who can carry over delegated activities.

Integrated therapy service combines direct hands on student contact and consultation with others directly involved with the student. There is an emphasis placed on the need for practice of motor skills and problem solving in the student's daily routine. The process of goal achievement is shared among those involved with the student. Those

involved may include therapists, teachers, parents, classroom paraprofessionals, and others.

Intervention typically includes adapting activities occurring in the student's routine; creating opportunities for the student to practice new motor skills, positioning, periodic monitoring of adaptive equipment, and problem solving with others. The services are provided within the student's daily environment, and should always include others involved with the student who can carry out the delegated activities.

The therapist's role in consultative service focuses on providing input to the teacher, staff, and parents regarding the student's specific needs rather than providing direct therapy. This does not preclude the need for the therapist to work directly with the student to identify needs or problem solve. The therapist supports the educational program, but is not the primary provider of service. The student's needs may not be rapidly changing or only minimal input is needed from the therapist. Consequently, only periodic direct contact by the therapist is necessary. The therapist's involvement includes providing suggestions to the teacher, staff and parents for modifications of educational materials and the environment as well as infrequent monitoring of the student's progress and any adaptive equipment that may be used.

Table 1: Continuum of Service Delivery

	Direct Service	Integrated Service	Consultative Service
Therapist's Primary Contact	Student	Student, teacher, parent, paraprofessional	Student, teacher, parent, paraprofessional
Environment for Service	Distraction free environment (may need to be separated from the learning environment) Specialized equipment needed	Learning environment with support of others within that setting	Learning environment with support of others within that setting
Methods of Intervention	May include: <ul style="list-style-type: none"> • Frequent instruction of others to implement carryover • Specific therapeutic techniques which cannot be safely delegated • Emphasis on acquisition of new motor patterns • Frequent equipment change 	<ul style="list-style-type: none"> • Educationally related functional activities • Positioning • Emphasis on practice of newly acquired motor skills in the daily routine • Periodic monitoring of adaptive equipment 	<ul style="list-style-type: none"> • Educationally related activities • Positioning • Adaptive materials emphasis on accommodations to the learning environment • Infrequent monitoring of adaptive equipment
Amount of Actual Service Time	Regularly scheduled sessions	<ul style="list-style-type: none"> • Routinely scheduled • Flexible amount of time depending on needs of staff or student 	Intermittent or as needed sessions depending on needs of staff or student
Primary Provider	PT or PTA	Teacher, parent, paraprofessional, school personnel Physical therapist	Teacher, parent, paraprofessional, other school personnel

Methods to Determine the Amount of Service for Educational Benefit

The amount of service depends on numerous factors, including the existence of changes in the student's physical status or environment, critical periods

for skill development, demonstrated progress toward achievement of IEP goals, and the amount of training needed by the person(s) carrying out the program. Monitoring of student performance is necessary to determine if the amount of service is appropriate to promote progress toward attainment of the student's IEP goals and objectives.

Although it has been a common practice in other state guidelines to indicate a frequency of greater than weekly to weekly for direct services, bimonthly to weekly for integrated services, and quarterly to bimonthly for consultative services; these guidelines were not found to have consensus with pediatric physical therapists. A consensus conference held in 1990 has provided some guidance to the frequency of service to improve the control of movement for children with cerebral palsy (Campbell, 1990). A service frequency of 1–2 times per week was needed which the PT or a combination of others including a PTA, paraprofessional or family member could provide. Specific recommendations need to be made by each individual team according to the needs of the individual. Intervention by the physical therapist(s) can consist of any of these models of service and at any time during the delivery. Intervention includes not only personal interactions with the student, family, and teaching staff, but also contact by phone, written correspondence, reports, and visits to agencies working with that student and family.

No matter which services or continuum of services is used, physical therapy intervention procedures should be specific to each student's needs. The techniques used should relate to the goals and objectives identified on the student's IEP. There are many different intervention philosophies and approaches, which the therapist may choose to use. It is the responsibility of the therapist to be aware of current evidenced-based practice procedures. It is also the therapist's responsibility to maintain documentation pertaining to the student's educational therapy program.

Exit Criteria

The IEP team should consider the following in discontinuing physical therapy as a related service:

- The goals pertaining to the delay in gross motor skill development have been attained or no further progress is expected following documentation of lack of progress;
- The motor or sensorimotor difficulty has been remediated or modifications have been made to the educational environment such as architectural modifications or use of adaptive equipment to allow the student access;
- Attempts to achieve goals or objectives on the IEP have not been successful; and/or
- Further change through physical therapy appears unlikely.

Examples of Related Service Activities

There are no nationally recognized guidelines for what comprises physical therapy as a related service as opposed

to physical therapy services that would be provided in a clinical (medical) setting. Therefore, using the following information is recommended to set specific policy within a school district on the procedure to be used to determine which therapy services are related services. The information on related services and medical services that follows was developed following two consensus conferences held in 1995 and 1996, and involved pediatric PT's from across the state of Nebraska. The need for collaboration is extremely important due to the lack of specificity in the federal and state regulations on defining an educationally related service.

The information in Table 2 on page 151 and the following questions should be addressed when determining the need for educational therapy services. They are provided as a guide to assist in the development of policies on educational therapy services:

- Does the student have a verified disability as per 92 NAC 51-006 (Rule 51), and are special education services required?
- Has PT been determined to be necessary through a documented assessment and implementation plan (IEP) process to enable the student to benefit from educational programming?
- Is the primary focus of PT to increase the student's access to education rather than medical rehabilitation? "Out-of-class" PT services may be indicated for school age students who have specific goals requiring one-on-one service, but should not be the predominate or only model of service provision. PT must be provided in the least restrictive environment,

typically in the school setting to provide consultative input to the educational staff.

- Who is the most appropriate provider who can safely and efficiently provide the service? For example, once the program is developed by a PT, a routine activity such as positioning or a goal-directed range of motion activity may be carried out by an PTA, aide, paraprofessional or parent.

The following bulleted list of services are services which should **NOT** be considered as educational. This list is not exhaustive. This list was developed by the participants of the PT and OT Consensus Conferences of 1995 & 1996.

- **Prior to or following a medical intervention which alters muscle length or the influence of muscle tone.** For example, a student who has surgery or botox injections may require a post intervention medical therapy program for a period of time. However, if upon return to the educational setting a change in his or her status is noted, then educational services or an increase in frequency of service may be appropriate to enable the student to benefit from his or her education program as determined by the IEP goals. A change in status typically requires providing additional information to team members and modifications to the program or IEP.
- **Acute rehabilitation for trauma as with burns, spinal cord injury or following a head injury.** A student may require both medical and educational services in this situation with coordination needed to assure that the educational program meets the IEP goals, and the medical team meets the medical needs.
- **Therapy deemed medically necessary, but does not pertain to IEP goals.**
- **Repetitive maintenance activities that are not demonstrated to have a direct effect on the student's ability to access or benefit from the educational program.**

In addition to the above list, the participants of the 1995 and 1996 PT and OT Consensus Conference supported the position that maintenance programs or therapy programs where the student is functionally independent in the educational setting should **NOT** be considered as an educational service.

**Table 2:
Clinical (Medical) Therapy and Related Service
Comparison**

	Clinical (Medical) Therapy	Related Service PT
Who	PT, PTA (Services tend to be discipline based)	PT, PTA, paraprofessional, educational personnel (Services are collaborative with carryover of multiple providers)
Focus of Therapy	To treat acute and chronic conditions where therapy goals are primary Therapy is provided in a medical setting where the attainment of developmental milestones and components of movement are primary Services are provided one-on-one with an emphasis on handling the child for therapeutic intervention	Assist a student with a disability in attaining educational goals so a student can benefit from his/her educational program Therapy is provided within the student's educational environment Services may be provided in groups or one-on-one with collaborative efforts focusing on the school schedule and routine to promote inclusion and accessibility
Delegation of Treatment	Parents	Parents, teachers, and paraprofessionals
Location	Hospital or clinic (Student comes in or home-based services)	Therapist goes to student's educational setting
Team Members	Medical team and family	MDT & IEP teams as required by 92 NAC 51

The following information provides further examples of interventions typically used by physical therapy to assist in the delineation of related versus medical services.

Intervention: Gross Motor Skill Development

Educational Therapy Example

- Activities to improve the infant's independence in the home or student's independence in the educational environment.
- Activities to facilitate the development of functional gross motor skills within the educational setting such as walking, sitting balance, transfers, head control, reaching, etc.
- Child has changed status following a medical intervention which alters muscle length or the influence of muscle tone, that requires a change in the educational program.

Medical Example

- Services prescribed by a physician that are beyond the scope or frequency of the IEP goals.
- Older student who after extensive programming for the development of a gross motor skill has demonstrated little capacity for improvement within the educational environment and for whom other accommodations have been made to provide accessibility.
- A student requires aggressive PT prior to or following a medical intervention that alters muscle length or the influence of muscle tone.

Intervention: Eye-Hand Coordination/ Environmental adaptation

Educational Therapy Example

- Student evidences decreased hand skills (weakness, high/low muscle tone and non-functional grasp). Therapy activities include, but are not limited to environmental adaptations, which enable student to manipulate essential tools to complete their educational requirements.

Medical Therapy Example

- A student with an injured hand or arm (i.e. tendon injuries, broken arm). The acute rehabilitation intervention should be coordinated and prescribed by the physician's order. Frequently the medical management includes a home program and follow-up for complications (stiff joints, reflex

sympathetic dystrophy). These are medical services, which must be coordinated through the primary care physician.

- A student who has a sensory motor involvement in one hand or arm, and is capable or uses that arm/hand as a functional stabilizing assist during two-handed activities.

Intervention: Splinting/Serial Casting

Educational Therapy Example

- Functional splinting: a splint is made to help the child perform an activity at school or home if in early intervention. As a result the child is able to participate in self-help tasks, vocational tasks, physical education exercises/games. The splint is worn to assist the child to function in the educational setting.

Borderline Therapy Example

- Static splinting to prevent contractures or hygiene problems.
- Monitor the static splints used following surgery.

Medical Therapy Example

- A student requires splints as a follow-up from a medical intervention that alters muscle length or the influence of muscle tone.
- Student requires a series of casts or plaster splints managed and coordinated by the primary care physician to treat contractures

Intervention: Range of Motion/Positioning

Educational Therapy Example

- Range of motion during or in preparation for a task that occurs in the normal school day.
- Use of adaptive equipment (e.g. floor sitter or stander) to maintain or improve range of motion during home based educational activities or school activities.
- Training the student to do self-range of motion which will help the student participate more fully in the school environment.
- Training of staff to provide a range of motion or positioning program for a wheelchair bound student, so that the student is not in one position for the entire school day.

Borderline Therapy Example

- Family or other caregivers have assumed responsibility for maintenance of range of motion and request assistance due to growth or other changes to maintain the program

Medical Therapy Example

- A student requires aggressive PT prior to or following a medical intervention that alters muscle length or the influence of muscle tone.
- A student has contractures, but the contractures are not worsening or interfering with the educational program.

Intervention: Environmental Adaptations/Accommodations

Educational Therapy Example

- Adaptive equipment modifications necessary for school tasks throughout the entire school day i.e. transfers, writing, positioning, communication, or other self-help activities.
- Input for architectural changes of the building
- Input for adjustment of equipment used at school such as chairs, standing equipment, orthoses.

Borderline Therapy Example

- Casting for orthoses

Medical Therapy Example

- Evaluation for environmental adaptations at home such as a ramp, bath chairs or equipment that is primarily utilized in the home.

Intervention: Gait (Walking) Training

Educational Therapy Example

- Student has difficulty but shows potential for mobility by walking to access bathroom, playground, cafeteria or other school areas.

Borderline Therapy Example

- Student requires only supervision of walking program by an individual without need for ongoing instruction or modification of the program by the therapist

Medical Therapy Example

- Using gait training for a student whom can access the educational environment through use of powered or manual wheelchair mobility and has limited potential for independence with walking.

- Prescription and fabrication of orthoses

Intervention: Standing Programs Using Adaptive Equipment

Educational Therapy Example

- Student has good potential for walking and standing is being used as an intermediate step or adjunct to the gait training program
- Student has increased risk of contractures or other deformity without positioning in standing during the school day.

Borderline Therapy Example

- Student has availability to equipment and a standing program at home that reduces need for a more comprehensive program at school

Medical Therapy Example

- Older student who has limited capacity for developing walking as a means of mobility or who's contractures can be managed with alternative positioning in prone or supine.

Workload Considerations

A therapist or assistant's caseload must allow time for the provision of quality educational services. Therefore caseload formulation should take into consideration the following factors: responsibility of therapist for record keeping; meetings or related administrative duties; the population of children to be served; the need for travel and program coordination; supervisory responsibilities for assistants or paraprofessional; and other factors related to providing quality services. Other factors include time for professional growth and training, program development, and the ratio of children requiring direct service versus integrated or consultation service.

The American Physical Therapy Association guidelines for therapy services in the schools recommend a caseload of approximately 40 to 45 students for a full-time therapist. The guide is only an approximation, however, and the number of children on a caseload needs to depend on the multiple factors that influence a therapist's ability to provide quality services.

Nebraska regulation for special education services (92 NAC 51) establishes the total number of school age students to be served by Level I personnel per school year per full-time professional staff member at 30 to 50 for special education services. Level I students are defined as students receiving less than 3 hours of Special Education instruction per

week. A guideline of 15-25 students per year per full-time professional staff has been set for Level II (students receiving more than 3 hours of special education services per week). No specific recommended caseload for PT is included in Rule 51 for early intervention services.

Based on information obtained from the 1995 Consensus Conference on PT and OT Services in the Schools, 50% to 65% of a therapist's time should be available for student contact with the remaining time needed for service related activities including equipment fabrication, meetings, consultation, documentation, and travel. However, the 50% to 65% figure for direct contact in a caseload is only an estimate to be used based on the responsibilities of the therapist and the composition of their caseload.

Needed Equipment or Space

Most therapy services will be provided in the classroom, lunchroom, or during the routine of a school day for school age children. However, students who are unable to benefit from large-group instruction or require small group or one-on-one services require allocated space to ensure optimal delivery of therapy services. This area should be relatively quiet and non-distracting with the following provisions recommended:

- Approximately 10' X 10' of uncluttered space for one-on-one therapeutic activities and 20' X 25' for testing, small group activities, locomotor or ball activities.
- Storage for equipment.
- Desk or table with adult and child sized chairs.
- Uncarpeted space and mats for treatment.

The therapy area may be a multiple use area with scheduling for therapy or other services.

Documentation

Other than the IEP, Rule 51 does not provide guidelines for the frequency or content of documentation for related service providers in the educational setting. The opinion from the Consensus Conference participants was that documentation should be provided every time a therapist provides an intervention which could include direct service, generation of required documentation, or services coordination activities. Documentation to parents regarding student's progress must occur at least as often as regular education students.

The types of written documentation may include:

- Initial assessment / reevaluation
- IEP progress reporting
- Transition report when student transitions from one placement to another, or from one therapist to another, or has significant change in health or IEP status
- MIPS forms
- Correspondence with practitioners in the medical community
- Justification for durable medical equipment
- End of year summary or discharge report

Suggested items that should be included in written

documentation include parental concerns; student information; date; provider; site of delivery; student's response; IEP/IFSP goal(s) addressed, intervention(s), and instructions.

Supervision and Evaluation of Services and Service Providers

Supervisors of physical therapists are responsible for the performance of the

physical therapists. Therapists should be evaluated on their performance on the job to determine their effectiveness in the educational setting by their supervisors. The therapy program should also be evaluated to determine if the quality and quantity of therapy services are appropriate and effective for various populations of students.

Evaluation is the process of gathering data which provides evidence of a therapist's performance. Competency criteria, performance objectives, and input from educational team members should be addressed. Observation of the therapist in a variety of settings as well as a review of student records will provide a means of rating competency criteria in the following areas: assessment, service delivery, consultation, education, communication (oral and written), professional ethics, program and student management, professional growth, and therapeutic intervention.

Supervision of PTs/Assistants/Aides

The policies and procedures of the hiring district or Educational Service Unit determine supervision of PTs.

Supervision of the PTA by the PT must be on-site with a frequency of at least every seven days or five treatments which ever comes first (172 NAC 137). Services provided by an aide, other than clerical, require direct, on-site supervision at all times by the PT (172 NAC 137). Only a

licensed physical therapist can evaluate the need for physical therapy services, establish or change IEP goals/programs or terminate services.

Glossary

Adaptive Equipment - Specialized equipment used with handicapped children to help them be more successful at a task. Examples include: braces, splints, positioning devices such as wheel chairs, standers, specialized chairs, specialized utensils, pencil grips, reachers, tray tables, etc.

Contraindicated - Any special symptom or circumstance that renders the use of the procedure or remedy as inadvisable.

Functional Motor Skills - Motor skills which serve a purpose or function. Examples include: rolling, sitting, crawling, standing, walking, running, carrying objects, opening doors, stairs etc.

Mobility - The ability to move about ones environment. Examples: walk, run propel a wheelchair, roll, scoot, ride a tricycle, etc.

Range of Motion - Degrees of movement in a joint.

References

- Campbell, Suzann K. Proceedings of the Consensus Conference on the Efficacy of Physical Therapy in the Management of Cerebral Palsy. *Pediatric Physical Therapy*. 1990;vol. 2, no. 3:175-176.
- Hanft, BE & Place, PA (1996). *The Consulting Therapist - A Guide for OT and PT in the Schools*. Therapy Skill Builders, San Antonio, TX.
- Handbook for Occupational & Physical Therapy Services in the Public Schools of Virginia*, Virginia Department of Education, March 1997.
- Physical Therapy Practice in Educational Environments - Policies and Guidelines*, (1990) American Physical Therapy Association and the Section on Pediatrics, 1111 North Fairfax Street, Alexandria, VA 22314
- Physical Therapy Practice in Educational Environments: Policies, Guidelines and Background Information - An Anthology*. American Physical Therapy Association, 1111 North Fairfax Street, Alexandria, VA 22314
- Rule 51 - Regulations and Standards for Special Education Programs* (Title 92, NE Administrative Code, Chapter 51), (1992), State of Nebraska, Department of Education 301 Centennial Mall South, Lincoln, NE 68509

Suggested Readings

- Gorn, S. (1997). *The answer book on special education law*, Second Edition. LRP Publications.
- Related Services for School-Aged Children with Disabilities*, Vol. 1 Number 2, 1991 News Digest, Washington DC.
- Schafer, L. (1998). *Special education related services, volume one: A guide for educators and parents in Nebraska public schools*, Nebraska Department of Education, Lincoln, NE.
- Smith, P. (1990). *Kentucky systems change project-integrating related services into programs for students with severe and multiple handicaps*. Kentucky Department of Education.
- The 18th National Institute on Legal Issues of Educating Individuals with Disabilities*, May 1997. San Diego, CA.

Psychological Services

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Psychology as a Related Service

School psychologists are professionals specially trained in education and psychology to serve all children from birth to age 21 and families within school districts. Psychological services include administering and interpreting assessments, consulting with other staff members, planning psychological services and counseling, assessing behavior, and developing positive behavioral intervention strategies. These services may be required as related services to assist a child with a disability to benefit from special education

Federal Definition

Psychological services include:

- Administering psychological and education tests, and other assessment procedures;
 - Interpreting assessment results;
 - Obtaining, integrating, and interpreting information about child behavior and conditions related to learning;
 - Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological test, interviews, and behavioral evaluations;
 - Planning and managing a program of psychological services, including psychological counseling for children and parents; and
 - Assisting in developing positive behavioral intervention strategies.
- [34CFR ?300.24(b)(9)]

Nebraska Statute Information

A license to provide psychological services in the school setting is not required in Nebraska. School psychologists are required to have valid certification through the Nebraska Department of Education. In addition to state certification, school psychologists may also be nationally certified by the National School Psychology Certification Board.

Professional Organization Information

A recent publication by the National Association of School Psychologists reported the following information on school psychological services.

Types of services delivered:

- Consultation – Collaborate with teachers, parents and school personnel about learning, social, emotional and behavior problems.
- Education – Provide educational programs on classroom management strategies, parenting skills, substance abuse, teaching and learning strategies, etc.
- Research – Evaluate the effectiveness of academic programs, behavior management procedures, and other services provided in the school setting.
- Assessment – Working closely with parents, teachers and IEP/IFSP teams, school psychologists use a wide variety of techniques to evaluate and re-evaluate: academic skills, social skills, self-help skills, personality and emotional development, etc.
- Intervention – Work closely with students, educational staff and families as well as help solve conflicts related to learning and adjustment. Provide psychological counseling, social skills training, behavior management, and other interventions.

Psychological Services are Intended to Serve...

School psychologists serve all children (birth to age 21) and families within school districts.

They help to coordinate appropriate services for students with learning, behavioral and/or emotional problems that inhibit their ability to benefit from a typical educational program. While other professionals in the school have knowledge of normal development among children and adolescents, school psychologists are in a unique position to contribute information that helps school staff and parents better understand issues related to those with certain handicapping conditions as defined by IDEA (e.g. a learning disability, a mental handicap or a behavior disorder). School psychologists also contribute significantly to the understanding of students who have learning and/or behavior patterns within the general school population (e.g. a slow learner, a student with attention deficit hyperactivity disorder or with a nonverbal learning disorder). School psychologists are often part of the initial problem-solving teams when school staff or parents suspect a disability, and essential team members in the Multidisciplinary Team process.

Psychological Services are Provided by...

School psychologists have specialized training in both psychology and education.

According to 92 NAC 24-007.03, the training requirements to become a school psychologist include a minimum of 60 graduate semester hours including a year-long supervised internship (at least 1,000 clock hours) in a school or clinic. A school psychologist must have taken courses in psychoeducational assessment; individual differences and/or exceptional children; learning and instructional techniques; intervention, behavior and classroom management; remediation and counseling techniques; child and adolescent development; organization and operation of schools; measurement, accountability, research and evaluation; consultation; and professional school psychology. The Nebraska Department of Education must certify a school psychologist. 92 NAC 24-00.03E states: Alternative Requirement for Endorsement: A license to practice psychology in Nebraska issued by the Nebraska Department of Health and Human Services

Role of Support Personnel

As a related service, school psychologists work closely with classroom teachers and paraprofessional providers on such issues as behavior management and instructional practices. In providing the full range of psychological services, school psychologists also work closely with school counselors and, when available, school social workers. The decision as to who specifically provides a particular service is usually made by the MDT or during the IEP meeting. A variety of factors are considered when making this decision. These include availability, expertise in the specific need area and previous experience with the individual student and/or the family.

Entrance Criteria

The IEP team has identified:

- The problem interferes with the child's ability to participate in his/her educational program and the problem is of a learning, social or behavioral nature.
- The team determines that positive change as a result of interventions would be likely.
- The student is in need of behavioral intervention strategies.

Methods Used for Assessment

Methods may include educational tests, intellectual tests, social/emotional evaluations, observations, behavioral checklists and interviews with school staff and parents. School psychologists are typically the only school personnel qualified to administer and interpret intellectual (IQ) tests as well as conduct a social/emotional evaluation.

Service Delivery Models

School psychologists work directly with students when administering tests as part of an educational assessment. These are administered one-on-one in a private, distraction-free environment. School psychologists may also provide services directly to students when involved in a counseling relationship. This can be done individually or as part of a group. Here, too, the setting needs to afford privacy.

School psychologists work collaboratively with school counselors, school social workers, teachers and families on how to intervene effectively with a student's behavior (e.g. in a one-to-one consultation, a parenting class, or IEP team meeting). School psychologists may continue to collaborate with them to help monitor the effectiveness of these interventions. School psychologists may also work with school nurses as well as other health professionals when the effectiveness of a medical intervention is being monitored.

School psychologists consult with members of the IEP team regarding how to work most effectively with students demonstrating a variety of learning, behavioral or emotional problems. As a result of team concerns, a school psychologist observes the student in the school environment (e.g. classroom, playground, resource room, etc.), and assists in the problem-solving process to help the student be more successful.

Methods to Determine the Amount of Service Appropriate for Educational Benefit

The amount of psychological services appropriate for educational benefit would be monitored through assessment techniques mentioned previously. Progress must be measurable. The child's performance as a result of the intervention would be compared with baseline performance to determine if goals and benchmarks are met. Progress as a result of special education and related services may also be

measured in the child's increased participation in the regular curriculum and participation and evidence of improvement in district wide testing programs. Parents must be informed regularly of the progress and if the progress is sufficient to enable the child to reach goals previously agreed upon by the end of the year.

Examples of Psychological Services

School psychologists provide a variety of interventions that help meet the educational, social, emotional and behavioral needs of children. Interventions that qualify as a related service include:

Educational Assessment:

- A school psychologist administers educational tests (e.g. IQ and achievement) that help provide a student, his/her parent(s) and teacher(s) with information regarding learning style, cognitive strengths and weaknesses as well as achievement levels
- A school psychologist is involved in conducting a student's special education re-evaluation to help determine the effectiveness of his/her educational plan and offers suggestions when necessary on how to improve it.
- A school psychologist may use curriculum based measurement techniques to monitor academic progress.

Psychological Counseling

- A school psychologist provides individual counseling services to help a student learn better ways of coping with a personal, social, or family issue that is impacting educational performance.

Behavior Management

- A school psychologist may teach a special education student self-monitoring techniques to improve on-task behavior.
- A school psychologist as part of a team conducts functional behavioral analysis with a special education student to determine why a certain behavior occurs and offers intervention strategies.
- A school psychologist assists in the development of a behavior intervention strategy.

Consultation

- A school psychologist consults with a Student Assistance Team to provide learning alternatives or behavior modifications.
- A school psychologist consults with other agencies and professionals (i.e. physician, therapist, caseworker, etc.) to coordinate services for a student.

Workload Considerations

The National Association of School Psychologists (NASP) recommends one school psychologist for every 1,000 students. School psychologists working in a setting that adheres to these standards should be able to provide a full range of psychological services. Increasing this ratio can be expected to limit the availability of direct services to students.

Equipment Needs

School psychologists require a quiet, well-lit room that affords them privacy when working with students. A desk, locked file cabinet and medium-size table with comfortable chairs are necessary furnishings. A phone for use in making contact with parents and collaborating with other professionals is important. Storage space for test kits and other materials is helpful.

Documentation

School psychologists maintain confidential test protocol information. Though forms may vary from district to district, a school psychologist is typically to participate in the completion of a Multidisciplinary Team Report following an educational evaluation.

Supervision and Evaluation of Services and Providers

School psychologists are typically supervised by the district's Director of Special Education and administrators in the buildings they serve. Evaluations of school psychological services usually are similar to those of other staff and follow established district procedures.

Glossary of Terms

- Achievement test** – a test designed for the purpose of assessing prior learning in academic areas.
- Consultation** – a process of interaction between two professional persons – the consultant who is a specialist, and the person who is seeking counseling, who invokes the consultant’s help in regard to a current work (school) problem with which he/she is having some difficulty and which he/she has decided is within the others area of specialized competence.
- Counseling** – a process that involves a relationship between two people who meet so one person can help the other to resolve a problem.
- Curriculum-based Measurement (CBM)** – a simple set of procedures for frequent and repeated measurement of a student’s performance in classroom curriculum.
- Functional Behavioral Assessment** – observation of environmental events that serve to maintain severe behavior problems.
- Intelligence Quotient** – an index of rate of development in certain aspects of intelligence.
- Intelligence Test** – a psychological test designed to measure cognitive functions, such as reasoning, comprehension, and judgement.
- Intervention Strategy** – the rationale, methods and materials upon which instruction, treatment or rehabilitation are based.

References

- National Association of School Psychologists. *What is a school psychologist?* (Brochure).
- 92 NAC 24, February 16, 1997. Nebraska Department of Education Certificate Endorsements Rule.
- 92 NAC 51, Hearing Draft, May 6, 1999. Nebraska Department of Education Special Education Rule.
- Federal Register, Vol. 64, No. 48/Friday, March 12, 1999/ Rules and Regulations, P. 12424.
- Best Practices in School Psychology III.

Recreation

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Recreation As A Related Service

Many of the first skills learned are learned during play. The possession of this advanced activity of daily living skills can play an important role in the successful community adjustment of individuals with disabilities (Schleien & Rynders, 1989). Children with disabilities should learn to appreciate and effectively utilize leisure time. Recreation and leisure services for children with disabilities can play a significant role in assisting children in achieving their potential.

Recreation and physical education are not the same from a legislative or programmatic perspective. Unlike physical education, recreation is by definition, an addition to regular special and physical education. Recreation and leisure are important parts of a total education.

Recreational therapy assists augments and enhances the education and learning process. As an educational tool, recreational therapy can be used to achieve cognitive, social, emotional and physical objectives identified as learning needs.

Recreational therapy as a related service not only provides assistance, instruction and strategies to facilitate the short-term objectives of special education, it is also important to the long-range life goals of the students with disabilities. It facilitates social involvement and friendships and encourages and provides skills associated with opportunities for community integration.

Currently, few state and local education agencies include recreation as a related service in their Comprehensive System of Personnel Development administrative codes or training objectives, or on a student's IEP. Without the need for recreation services being addressed through these processes, it can be difficult for children with disabilities to receive appropriate and necessary recreation services as part of their education.

Federal Definition

Recreation includes:

- assessment of leisure function;
- therapeutic recreation services;
- recreation programs in schools and community agencies; and
- leisure education.” [(34 CFR ? 300.24(b)(10)]

(NOTE: In Nebraska recreation specialists are not licensed.)

Attempts to provide children with disabilities with an appropriate education often means training in self-help skills, prevocational tasks, transitional skills, leisure skills, community living, and other domains of adaptive behavior. The Therapeutic Recreation Specialist's (TRS) activities should be in harmony with these broader program domains with a focus on increasing the child's overall leisure and social independence and appropriateness of behavior. The "need" and opportunity for increased independence should work hand in hand with the need for concurrent changes in recreation and leisure behavior. Ideally, all staff should be working towards common objectives, each reinforcing one another's inter-related program components.

**Recreation is
Intended to Serve...**

Traditionally, recreational therapy services have been delivered in schools to persons with mental retardation. Fewer programs have been developed for students with emotional and behavioral disorders, autism, severe and profound disabilities, students transitioning from clinical settings back into schools and students who are being included in regular classrooms.

Through recreation, students with disabilities explore their own attitudes and values toward leisure and recreational involvement and plan ways to utilize recreation to assist them in their adjustment to school, community and, ultimately, independent living. Recreation activities and experiences are an important aspect of community adjustment and have an impact on total adjustment, especially in the transition from school to work and/or independent living.

For most children, recreation and the skills required for participation in recreation are taken for granted because they are a natural part of growing up. Unfortunately, children with disabilities often do not have the same opportunities to explore and learn about recreation and leisure as a direct result of their disabilities.

Typically little academic or other formal training is provided for children with disabilities to develop their leisure awareness, clarify their leisure values, learn recreation skills, utilize leisure resources and participate in inclusive environments. This training is particularly important for children with disabilities, for whom recreation and leisure may be the primary context for social learning and integration.

**Recreation is
Provided by...**

A trained Certified Therapeutic Recreation Specialist (CTRS) should provide recreation.

The actual role of the CTRS varies dependent on the actual school in which he/she is employed. Generally, the CTRS serves as a direct service deliverer and/or as a consultant depending on the needs of the students.

The recreational therapist is not a teacher, but rather is a supportive member of the educational team who works and consults with other education personnel. The recreational therapist works cooperatively with other related service personnel, the adapted physical educator, the special educator and other educators to extend and enhance the students' total education.

Professional preparation is usually accomplished in an undergraduate or a master's degree program. Personnel that are prepared in a program that has a recreational therapy option are typically eligible to sit for the certification examination through the National Council on Therapeutic Recreation Certification (NCTRC). Recreational therapists do not have teaching credentials. Recreational therapists support teachers and educational goals by providing a related service. In order to function in school settings, professional recreational therapists must be recognized and certified as related service personnel by state education credentialing bodies.

The following job skills and responsibilities were identified as essential for Therapeutic Recreation Specialists working within inclusionary school systems:

- Conduct comprehensive, developmental assessment of skills and needs relative to student's leisure functioning together with team members and family.
- Provide training, consultation services, and assistance to extracurricular activity leaders, teachers and teacher aids to facilitate inclusion of children with disabilities into leisure and recreation experiences in the classroom and on going after school programs.
- Identify and evaluate community recreation and leisure programs, which hold the greatest potential for the realization of recreation, leisure and social (community transition) needs, and objectives in the student's IEP.
- Provide leisure education for individual students and their parents/caregivers relative to a) leisure and recreation needs, and b) approaches to meeting those needs at home and in the community.
- Provide consultation and assistance to teachers, parents and students in the identification of assistive technology and

adapted equipment essential to successful leisure participation and competence.

- Cooperate and collaborate with a multidisciplinary educational team to assist students in meeting educational objectives focusing upon social, recreation and leisure needs.
- Evaluate the total recreation and leisure service component and process within the educational program.

In addition to knowledge areas in therapeutic recreation, the Therapeutic Recreation Specialist will require specific knowledge such as:

- Familiarity with consultation models
- Knowledge of trans-disciplinary team approaches
- Familiarity with services offered by team members
- Understanding of syndromes/conditions resulting in handicapping conditions
- Techniques related to parent consultation and counseling
- Familiarity with the format and writing of Individual Education Plans
- Experience (practicum) in applying these skills, prior to beginning their jobs

Role of Support Personnel

Although it is recommended that a Certified Therapeutic Recreation Specialist deliver the service, teachers and

paraprofessionals can assist the CTRS to expand the effectiveness of this service. With assistance of the CTRS the teacher may be involved in the following:

- Identify the leisure needs of the students.
 - Does each student understand the concept of free time?
 - Does each student have basic leisure activity skills (ability to play table games, interact with others)?
 - Can each student choose age appropriate activities in which to participate during free time? Can each student locate leisure/recreation resources in their community and describe activities available at each?
 - Does each student have the ability and skills (planning, assertiveness, use of resources, etc.) to participate independently in their community during their leisure time?

- Considering ways to infuse the teaching of recreation and leisure skills and attitudes into the existing curriculum.
 - encourage student initiation (of activities or conversation) with others during break time at school.
 - provide opportunities for students to call leisure resources to get information about fun things to do in their community.
 - while discussing current events, include leisure and recreation opportunities available in the community.
 - gather leisure resources to read in the classroom (movie section of the newspaper, weekly magazines and newspapers that include leisure events in the area, recreation and parks brochures, and museum brochures).
 - further develop students' math skills by teaching them how to keep score for a bowling game. This is an excellent way to keep their attention.
 - while teaching time-telling skills, use leisure situations for problem solving. For example, "If it takes 10 minutes to walk to the movie theater and the movie starts at 7:00, what time do Sally and her friends need to leave her house?"
 - to enhance money skills, role play leisure situations that students may encounter: paying at the bowling alley for shoe rental and for bowling two games; asking for change for video games- and checking for correct change.
- If students lack physical skills in activities they want to participate in during their free time. Talking with the school's adapted physical education or physical education teacher, music or art instructor. They can address the physical needs of students while the teacher helps students develop leisure skills they need to carry out these activities on their own at home, without the assistance of school personnel and equipment. If teachers address not only the physical skills but also the leisure skills required (planning, dealing with barriers, etc.), students will be prepared to carry out their own ideas more independently in their own communities.
- Talking with other special educators to find out how they address recreation and leisure skill development for their students.

- Using a checklist to acquire leisure information about students from parents. Communicate effectively with the family to help bridge the gap between the school and the student's actual leisure hours.

Entrance Criteria

Recreation as a related service must be administered in a manner to assist children to benefit from their special education

program. The need for recreation as a related service should focus on recreation and leisure skill deficits and attitudes, which are learning, classroom performance, and present and future life style.

At all levels, emphasis is upon the assessment and subsequent remediation of recreation and play skills. Following assessment, remediation is accomplished through (1) treatment-oriented recreation services, (2) leisure education, and (3) School/Community Recreation Participation in the least restrictive environment. Emphasis should be placed on exploration of recreation and leisure skills, values, and attitudes and on participation in activities consistent with their peers without disabilities.

Service Delivery Models

The role of a recreational therapist in a school system is dependent on a variety of circumstances including: the size of the

school system, the staffing pattern of recreational therapists, the organization of special education services and the experience of the school system in utilizing recreational therapy services.

- A recreational therapist may provide assessment services to a school system. This is often handled on a contractual basis for assessments as requested by teachers and/or parents.
- Contractual assessments are more likely to occur when a school system does not employ a recreational therapist. This role is critical to the expansion of recreational therapy services in schools because the assessment may lead to the recognition of the need for this related service that may not have been provided previously.
- The recreational therapist can provide related services to students as designated on their IEP. This may be on an individual or group basis providing therapeutic intervention, leisure education or facilitating inclusive recreation.

- The recreational therapist may also serve as a consultant to teachers, parents, community and other agencies on strategies for providing appropriate recreation services and programs for persons with disabilities. This most often occurs in regular school environments, particularly in inclusive settings, but may occur in myriad settings.
- Another area of consultation for the recreational therapist may be specifically with classroom teachers on the inclusion of leisure in their curriculum. Specifically, this may mean working with the teacher on how to conduct large group leisure education sessions for their class from standardized leisure education curricula. The recreational therapist may also consult with classroom teachers concerning the use of leisure activities as learning tools.
- The recreational therapist in a school system may also provide referral services for the students and their families. Often students with disabilities have difficulty connecting to their community and finding accessible programs, both physically and socially. Recreational therapists can become experts on community recreation connections and provide a valuable referral and information service.

Methods to Determine the Amount of Service Appropriate for Special Education Benefit

Following a thorough assessment of leisure functioning, any or all of the following goals may be established for the student.

1. Leisure awareness: To increase the student's awareness and understanding of the concept of leisure, its place in life, its benefits and to explore ones personal leisure interests.
2. Leisure resources: To gain knowledge of the variety of leisure opportunities available at home and in the community and identify resources required for participation.
3. Leisure communication skills: To develop communication skills necessary for participation in a wide variety of leisure activities.
4. Making Decisions: To provide the student with a model for making independent decisions in leisure.
5. Leisure Planning: To foster planning and independent participation in leisure activities.

6. Activity skill instruction: To enable the student to acquire the skills needed to participate in age appropriate recreational activities in ones home and community.

Exit Criteria

Other than continuation of services until the goals are met, no other criteria have been developed.

Workload Considerations

In most instances, services are best provided one-to-one, however, it is not uncommon for recreation therapy to be conducted in small group interventions. It is necessary to consider the independence level of the children involved in a group in determining the ration of students to providers. It is recommended that there be no more than three students to one therapist in a given session.

Needed Equipment and Space

A classroom and typical school recreation play area will be needed. Transportation to enable community transition training will also be needed. Access to a swimming pool is recommended.

Documentation

Formal assessments should be completed, discussed in the IEP meeting, and objectives should be established to meet the student's needs. Progress notes and transition plans should follow district guidelines.

Supervision and Evaluation of Services and Providers

The district administrator or their designee should provide supervision of the recreation therapy services. Since recreation therapy is a new related service, no specific evaluation guidelines have been developed to date.

Example of Recreation Activities

Jane is a 14 year old girl with Downs Syndrome. During her most recent IEP team meeting, the team suggested a certified therapeutic recreation specialist (CTRS) to assess the need for recreation services. Although Jane found some acceptance among her peers in earlier grades, lately her friends no longer want to hang out with her. Her interest in school has diminished. The teacher believed, and the team agreed, that if Jane receives recreation services it would help her to better focus on school and she could begin to transition into community

life. A therapeutic recreation assessment revealed that Jane would benefit from the following recreation related services:

Leisure awareness: Jane has little understanding of the difference between work and leisure. Through leisure awareness she will learn to differentiate leisure time from work time at home and at school. This will also help her to work more efficiently when she enters paid employment. Additionally, through leisure awareness Jane will learn to identify leisure activities in which she participates, and to identify the feelings associated with leisure participation. She will learn the benefits of leisure participation, and be able to identify negative aspects of having unstructured time.

Leisure resources: Jane will benefit from learning what she needs to participate in leisure. For example, during the assessment she stated that she likes to watch movies. She did not know that she needed money to buy a ticket, transportation to get to the theater, information about what is playing and the time it starts, how much time was needed to go and see the entire movie, and friends to accompany her. The assessment also revealed that she needed to identify available resources for leisure participation both inside the home and in the community. Jane also needs to learn the concept of barriers to leisure, to identify personal barriers, and develop strategies for overcoming them.

Leisure communication skills: Jane needs to learn to cooperate with others if she is going to successfully participate in leisure. To communicate in an assertive manner will help her gain independence and be more successful in group activities.

Decision-making: For Jane to be successful in the community, she needs to understand the importance of having choices and making independent decisions for leisure. She needs to learn to set goals, explore her different options and the consequences of them, and then make a decision based upon this information.

Leisure planning: To facilitate her independence, Jane would benefit from developing a leisure action plan. This includes creating the leisure action plan, engaging in the planned activity, and self-monitoring her participation.

Activity skill instruction: Once Jane chooses the leisure activities in which she wants to become involved, she will need to acquire the specific leisure activity skills. These skills will need to use these skills in the real environment, whether that be the classroom, the home, or in the community. Methods to determine the amount of related service appropriate for the educational benefit.

Glossary

Assessment of leisure functioning is a procedure to determine the current functional strengths and needs of students with disabilities in terms of skills, abilities, and attitudes relative to recreation and leisure.

Therapeutic recreation services are the use of recreation activities to habilitate or rehabilitate functional abilities, which contribute to behavioral change. Therapeutic recreation is a process involving assessment, development of goals and objectives, and the implementation, documentation, and evaluation of intervention strategies.

Recreation programs in schools and community agencies involve the provision of recreation services that facilitate the full participation of children and youths with disabilities in school and community programs. Activities are used to promote health, growth, development, and independence through self-rewarding leisure pursuits.

Leisure education provides students with recreational and educational instruction. The instruction is intended to promote positive attitudes toward leisure, recognition of the benefits of recreation involvement, the development of skills necessary for recreation participation (such as social, decision-making, and planning skills), knowledge of recreation resources, and attitudes and skills that facilitate independent, satisfying leisure experiences.

Suggested Readings

- Bullock, C., & Johnson, D. (1988). Recreation Therapy in Special Education. In F. Brasile, T. Skalko & j. Burlingame (Eds.) Perspectives in recreational therapy: Issue of a dynamic profession. Ravensdale, WA: Idyll Arbor, Inc.
- Bullock, C., Johnson, D. & Shelton, M. (1999). Kids in context. Boston: Hampton Press
- Bullock, C., Mahon, M. J., Morris, L., Jones, B. (1991). The comprehensive leisure education program: A model for a school based leisure education program for children with disabilities Unpublished manuscript. University of North Carolina at Chapel Hill, Center for Recreation and Disability Studies in the Curriculum in Leisure Studies and Recreation Administration, Chapel Hill, North Carolina.
- Center for Recreation and Disabilities Studies. (1992), Model program guidelines for school-community leisure link. Chapel Hill, NC: Center for Recreation and Disability Studies.
- Hambrecht, G., Forlifer, N., Peters, J. & Wilson, B. (1989). Leisure education curriculum for adolescents. Silver Spring, MD: Montgomery County Government Recreation Department.
- Linder, T. W. (1990). Transdisciplinary play-based assessment. Baltimore: Paul H. Brookes Publishing Co.
- Mahon, M. J. & Bullock. C.C. (1991). Teaching adolescents with mild mental retardation to make decisions in leisure through the use of self-control techniques. Therapeutic Recreation Journal, 12(6), 9-26.
- Rainforth, B. York, J. & Macdonald, C. (1992). Collaborative teams for students with severe disabilities: Integrating therapy and educational services. Baltimore: Paul H. Brookes Publishing Co.
- Sable, J., Powell, L., & Aldrich, L. (1994). Transdisciplinary principles in the provision of therapeutic recreation services in inclusionary school settings. Annual in Therapeutic Recreation, (4), 69-81.
- Schleien, S. (1984). The development of cooperative play skills in children with severe learning disabilities: A school-based leisure education program. Journal of Leisurability, 11(3), 29-34.
- Witt, P. A., & Ellis, G. (1987). The leisure diagnostic battery users manual. State College, PA: Venture Publishing.

Additional Resources

The following are recommended resources that are available for purchase. If you as a CTRS are interested in working in the schools under IDEA, you should consider purchasing the items listed below.

Center for Recreation and Disability Studies

Leisure Studies & Recreation Administration

CB# 3185 Evergreen House

UNC at Chapel Hill, NC 27599-3185

Fax: 919.962.1223

Telephone: 919.962.1222

Call for price, tax and shipping fee.

LIFE, Leisure is for Everyone, is a training program for community recreation professionals that sensitizes them to the needs and abilities of persons with disabilities and provides them with the skills required to offer access to all programs and facilities. LIFE was originally funded through a grant from the Department of Education from 1985 to 1988. LIFE is designed as a workshop learning opportunity, and the materials have also been used for college and university classes and as resources for persons interested in promoting access in community recreation programming.

LIFE: A New Direction, a training project funded by the Department of Education from 1988-1991, provided parents and teachers with information about the values and benefits of recreation and recreation's role in the education process. A major goal of the project was to increase the inclusion of recreation as a related service on the Individual Education Plans of students with handicapping conditions. Training materials developed through the project are described below.

LIFE Resources: The LIFE Resource Manual has information on interacting with people who have disabilities, details about specific disabling conditions, a list of companies that distribute adaptive devices and equipment, and a checklist of accessibility design factors.

The Parent Training Guide to Recreation is a four-section compilation of resources designed for professionals who train parents of children with disabilities. College or university faculty in recreation administration, leisure services, or special education may also find this manual useful. Section I describes the importance of play and recreation to all persons. Section 2 provides information on recreation service

delivery. The twenty-three minute videotape, "Can Molly Come out. . .and Play?" describes the benefits of recreation and illustrates three structured options for recreation service delivery. Section 3 offers suggestions for identifying recreation and leisure opportunities in the community and for gaining access to them. Section 4 includes resources for family recreation participation and provides information about adapted play and recreation equipment, camps, sports, and so forth.

The Community Reintegration Program, funded from 1987 to 1991 by the Rehabilitation Services Administration, US Department of Education, was implemented to enhance the quality of life for persons with disabilities. CRP provided transitional therapeutic recreation services to help recently hospitalized and other individuals with disabilities to attain independence in their home communities. Through the project, a leisure education program was developed and delivered by transitional therapeutic recreation specialists at two sites in North Carolina. Due to the effectiveness of the project, the Community Reintegration Program has been continued in North Carolina through the NC Independent Living Programs. Leisure education materials and a Model Program that describes the operation of the Community Reintegration Program are outlined below.

Recreation - The Time of Your Life is a leisure education manual designed for participants in the Community Reintegration Program. The manual contains twelve units of instructions and exercises and is in loose-leaf notebook form so it can be easily edited, resequenced, or supplemented to fit specific needs.

The Community Reintegration Facilitator's Guide is for therapeutic recreation specialists conducting leisure education programs for clients. This loose-leaf manual contains learning objectives and strategies and exercises to help clients accomplish each objective. It contains a suggested approach, a camera-ready brochure master to start the program, and a copy of Recreation - The Time of your Life.

The Wake Leisure Education Program: An Integral Part of Special Education. The effects of Leisure Education on the Transition of Youth with disabilities from Secondary Schools to Adult Life was a projected funded by the Office of Special Education and Rehabilitation Services, US Department of Education from 1988 to 1991. The grant involved both research and demonstration in cooperation with the Wake County School System in Raleigh, North Carolina. Through the project, a therapeutic recreation specialist provided leisure education sessions for high school seniors in classes for students with educable and trainable mental

handicaps to determine the effects of leisure education on selected social and attitudinal dimensions of student's leisure awareness and participation. The model leisure education program, Wake Leisure Education Program: An Integral Part of Special Education is designed for teachers and recreation specialists. The resource contains introductory information on the need for leisure education in the schools, and suggestions and strategies for establishing a leisure education program. The "Leisure Education Curriculum" is organized into ten units, each with a goal, objectives, session outline, and suggestions for successful teaching. This resource also contains tolls and forms for students, sample assessment guides, IEPs (including leisure education objectives) and a summary of the results.

Learning to Play, Playing to Learn: Recreation as a Related Service. Offers information about the education of students with disabilities, as well as background information on recreation as a related service from P.L. 94-142 to I.D.E.A. The video provides you with experiential learning activities, discussion questions, and a handout prototype for your class. The education activities are fun and educational, and can be done in class or given as outside assignments. They are intended to help students become more aware of the importance of leisure in their lives as well as in the lives of their future students.

School-Community Leisure Link. The School-Community Leisure Link was a research and demonstration project funded by the office of Education from 1989-1992. The model program provides a comprehensive leisure education program within the school system, which includes structured training for students with disabilities and working with families and community agencies. The program enables students with disabilities to increase their independent leisure functioning at school, at home, and in the community, and eases their transition to adult life. A Therapeutic Recreation Specialist facilitates the leisure education in the classroom, conducts teacher training, designs and distributes newsletters and a summer leisure guide, consults with families, and works with community agencies to increase integrated opportunities. The project materials include a comprehensive overview of the program and the process of delivering leisure education within the school system. The leisure education curriculum includes individual curriculum based measures tested by classroom teachers and the Decision-Making in Leisure Model.

Rehabilitation Counseling

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Rehabilitation Counseling as a Related Service

Research has shown that in order to improve post-school outcomes of students with disabilities, education can no longer view, plan, or implement students' educational programs in isolation from the students' community living, working, continued education and social environments. (Wagner, 1991; Wagner, 1993; DeStefano & Wagner, 1991; Fairweather, Stearns & Wagner, 1991).

Preparation for employment with full community participation is the goal of the transition services in the IEP. The intent of rehabilitation counseling as a related service is to provide an additional service that will ensure this goal is accomplished. Rehabilitation counseling empowers students and families with the knowledge, skills and attitudes necessary to ensure that students with disabilities have the following; 1) the ability to assess themselves, including their skills and abilities, and the needs associated with their disability, 2) awareness of the accommodations they need because of their disability, 3) knowledge of their civil rights to these accommodations through legislation such as the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973, and 4) the self-advocacy skills necessary to express their needs in the work place, and educational institutions, and in the community setting. (National Information Center for Children and Youth with Disabilities Washington DC. Vol. 3 #1 March 1993).

Federal Definition

Rehabilitation counseling services means, "services provided by qualified personnel in individual or group sessions that focus specifically on:

- career development;
- employment preparation;
- achieving independence, and
- integration in the workplace and community of a student with a disability."

The term also includes vocational rehabilitation services provided to a student with disabilities by vocational rehabilitation programs funded under the Rehabilitation Act of 1973, as amended." [34 CFR §300.24(b)(11)]

Nebraska Statute Information

Currently, rehabilitation counselors are not licensed in Nebraska.

Professional Organization Information

The role of rehabilitation counseling as a related service

area in the education setting may include:

- Increasing students, families, educators, community, and adult service providers awareness and knowledge about what each system/agency and person does and is responsible to do.
- Facilitating communication between school, families and community and adult service providers.
- Effectively coordinating services between the school and other agencies based on student outcomes and needs leading to effective transition.
- Developing a planning process that identifies a clear path for students to follow from school to adult living.
- Utilizing assessment information across agencies, reducing duplication and streamlining the referral and eligibility process.
- Establishing a referral system so students can more easily access agency supports.
- Collaborating with regular education teachers to refocus the school curriculum to include functional academics, career development and daily living skills.
- Providing a support system for families and students.
- Assessing individual vocational needs, preferences, interests and skills to be used in the development of an effective transition services in the IEP.
- Providing job specific skills and generic vocational skills training, including social skills necessary to participate in the work force.

Case Law and Regulatory Interpretations

Nebraska State Statutes and Case law has provided clarification to the scope of rehabilitation

counseling in the educational setting. Nebraska Revised Statutes-- Annotated Chapter 83, State Institutions Article 12, Developmental Disabilities Services states that; "... all persons with developmental disabilities shall receive services and assistance which present

opportunities to increase their independence, productivity, and integration into the community; have access to a full array of services appropriate for them as individuals and to the maximum extent possible to live, work, and recreate with people who are not disabled.” The Individuals with Disabilities Education Law Report identifies several transition case examples.

- A hearing officer criticized the school’s use of anecdotal IEP notes in lieu of formalized transition planning, and especially the school’s failure to invite the student to the IEP.
- In *Yankton School District v. Schramm*, the court stated that “simply telling the student and her family about other community agencies and leaving it up to the family to follow through is inadequate.”
- Mason City Community School District transition efforts were deemed inadequate by an impartial hearing officer. A 19-year-old with mild MR was slated to graduate because he had met the requisite number of credit hours. There were no formal transition plans the two years prior to graduation, and the IEP simply indicated Vocational Rehabilitation would be contacted at the time of graduation. The IEP did not consider the 4 transition areas.
- In the case of *Clarion v. Goldfield Community School District*, an impartial hearing officer confirmed that each IEP team must at least whether recreation/leisure needs are priority areas for that student. If they are, recreation/leisure services must be provided.

Rehabilitation Counseling is Intended to Serve...

Rehabilitation counseling is intended to serve those students ages 14-21 years with a verified disability and a current IEP with transition plan in place as mandated by 92 NAC 51. The need for transition services on the IEP and rehabilitation counseling as a related service is evidenced in the results of the U. S. Department of Education survey on post-secondary outcomes and community adjustment. A National Longitudinal Transition Study was commissioned by the federal Office of Special Education Programs of the U.S. Department of Education. This study began in 1985 and was completed in 1993 and included more than 8,000 former special education students in 300 school districts. The study asked the question: “How well do students with disabilities fare following high school?”

Researchers acquired the following facts:

- “Thirty-six percent of all youth with disabilities served in publicly mandated special education programs dropped out of school prior to graduation. On average nationally, this percentage represented a higher dropout rate than any other group of young people.”
- “Approximately 43 percent of youth with disabilities remained unemployed three to five years after high school. Of those who were employed, many worked only part time and received low wages. The vast majority were not receiving medical insurance coverage or other fringe benefits through their employers.”

When the IEP team determines the need for rehabilitation counseling as a related service, consideration will be given to: extent of employment/vocational needs; daily living needs; ability to access community services; ability to access recreation and leisure activities; ability to develop and maintain social relationships, and need for post secondary planning and agency linkages.

Rehabilitation Counseling is Provided by...

According to 92 NAC 51, rehabilitation counseling can be provided by, “Any special education endorsement, guidance and counseling, vocational special needs a or diversified occupations endorsement, or special services certificate for school rehabilitation counselor.”

Nebraska has no licensure for persons who are qualified to provide rehabilitation counseling. It is recommended rehabilitation service providers be knowledgeable about career development, employment options, independent living needs, and have the ability to coordinate the work place and the community into the educational setting.

Qualifications of Providers

Nebraska Department of Education Regulations and Standards for Special Education Programs, 92 NAC 51, defines “Qualified Personnel” as any “personnel who have met Nebraska Department of Education approval or Nebraska Department of Education recognized certification, licensing, registration, or other comparable requirements that apply to the area in which the individuals are providing special education or related services.” (92 NAC 51) Any

person specifically assigned as a school rehabilitation counselor must meet the NDE Approved Endorsements as stated in 92 NAC 51-010.

One of the primary roles of the rehabilitation counseling provider is to work with the IEP team to determine the time line, type of service, goals and objectives, and funding agencies needed by the individual student. Responsibilities of the person providing rehabilitation counseling would include, but not be limited to; exposing students to a broad array of career opportunities and facilitate selection of career options based on individual interests, preferences, strengths and abilities, providing consultation and support to school personnel, employers, and families regarding the student's transition needs, providing information about adult service agencies and build effective linkages to those services, establishing work experience programs within the community, assisting/evaluating students' transitional needs, participating in IEPs, and facilitating the transfer of students between high school and post-secondary programs. Resource teachers, job coaches, educational assistants, interpreters and classroom teachers can all provide rehabilitation counseling services and be part of the transition plan according to the IEP goals and objectives.

Entrance Criteria

Rehabilitation counseling service delivery is generated through the IEP process. Schools are ultimately responsible for provision of rehabilitation counseling however, the IEP team may identify an outside agency as the service provider. These services must be identified in the IEP. Present levels of performance and parent/student vision statements direct the team's decision whether rehabilitation counseling should be included as a related service and the amount of the involvement with the student. Transition needs for work experience, academic/vocational instruction, adult/daily living skills, and community linkages are all factors that determine rehabilitation counseling goals, objectives and activities. Duration of services is determined by the extent to which the student progresses to achieve the goals established.

Methods Used for Assessment

Assessment is imperative for career planning, establishing work placements, determining course of study, course selection, and creating post-secondary plans. In addition to the formal tests, and informal assessments typically used to determine the needs of students with

disabilities, it is necessary to include assessments directly related to transition services. Although no specific test can be recommended, it is suggested that in the process of rehabilitation counseling, formal or informal assessment in learning styles, interests, vocation skills, employability skills, academic achievement, and daily living skills be considered as important components of a rehabilitation counseling transition service delivery plan.

Exit Criteria

Exit criteria from school rehabilitation counseling services can be completed in any of the following ways: 1) student no longer verifies for special education and receives a change of placement to regular education; 2) the IEP team determines school rehabilitation services are no longer needed; 3) student completes rehabilitation counseling objectives; 4) student receives a high school diploma, and/or reaches the maximum age (21 years) and transitions to adult service agencies; or employment.

Examples of Rehabilitation Counseling Activities

Rehabilitation counseling services would include any activities that assist the student in achieving independence and self-reliance through employment opportunities, educational opportunities, appropriate housing and transportation, and appropriate community service linkages. The person responsible for rehabilitation counseling with the student should have a firm understanding of the student's abilities, preferences, and interests, as well as the family's vision for the student in order to facilitate cooperative planning among the student/family and local agencies.

Rehabilitation counseling focuses on activities that help the student become employable and to live independently in the community to the maximum extent possible through instruction, community experiences, vocational/employment objectives, daily living skills, and evaluation. Specifically, rehabilitation counseling can provide guidance in instructional education and course of study. Community experiences are generally provided outside of the school building, in the community setting. Job site training, banking, shopping, transportation, recreational services, independent living centers, and familiarity with adult service providers are all activities important to rehabilitation counseling. Vocational/employment services provided by rehabilitation counseling lead to a job or career. They also include assistance and guidance in registering to vote, doing taxes, renting an apartment, accessing medical

services, Social Security need, filing for insurance, etc. Activities for acquiring daily living skills include preparing meals, budgeting, maintaining an apartment, paying bills, caring for clothes, and grooming needs. Assessment and evaluation activities provide information about job or career interest, aptitudes and basic skills. This information can be gathered through informal situational assessment, observations, or formal measures.

Workload Considerations

Guidelines have not been developed for staff providing rehabilitation counseling as a related service.

Documentation

Documentation of the service is to be included in the IEP under transition services.

Supervision and Evaluation of Services and Providers

Supervision of the service and provider is provided by the assigned district's administrator(s).

Administrative Issues

A state-wide group of School Transition Specialists (Nebraska's state term for School Rehabilitation Counselor) is currently revising the Nebraska Department of Education (NDE) Transition Technical Assistance Document. It includes sample forms, programs, agency addresses and phone numbers and may be a helpful resource. To obtain further information on transition services contact Jack Shepard, NDE.

References

Federal Regulations/Federal Register, Volume 64, No. 48/Friday, March 12, 1999/Rules & Regulation, pg. 12424.

92 NAC 51, Hearing Draft, May 6, 1999. Nebraska Department of Education Rule on Special Education.

Transition Technical Assistance Document Nebraska Department of Education.

School-to-Work Home page (www.stw.ed.gov), May 1997, Products and Resources.

Gorn, S.: The Answer Book on the Special Education Law, Second Edition, LRP Productions, 1997.

Individuals with Disabilities Education Law Review (IDELR)

Neb. Rev. Stat. 83 Article 12

Suggested Reading

“Transition from School to Adult Life for Students with Disabilities”
(available from the Nebraska Department of Education)

School Health Services

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School Health as a Related Services

Federal Definition

School health services mean, “services provided by a qualified school nurse or other qualified person.” [(34 CFR ?300.24(b)(12)]

Nebraska Statute Information

The school nurse (RN) is a licensed health care provider whose actions are governed by the Nurse Practice Act [Neb. Rev. Stat. ?71-1,132.04 to 132.53]. This Act defines the qualifications of a nurse, the practice of nursing and the standards for the practice of nursing in Nebraska. The practice or attempted practice of professional or practical nursing, or the use of any title to indicate that such a person is practicing professional or practical nursing without a license is unlawful. The practice of nursing by a registered nurse means assuming responsibility and accountability for nursing actions which include, but are not limited to:

- Assessing human responses to actual or potential health conditions;
- Establishing nursing diagnosis;
- Establishing goals and outcomes to meet identified health care needs;
- Establishing and maintaining a plan of care;
- Prescribing nursing interventions to implement the plan of care;
- Implementing the plan of care;
- Teaching health care practices;
- Delegating, directing, or assigning nursing interventions that may be performed by others and that do not conflict with the Act;
- Maintaining safe and effective nursing care rendered directly or indirectly;
- Evaluating responses to interventions;
- Teaching theory and practice of nursing;
- Conducting, evaluating, and utilizing nursing research;
- Administering, managing, and supervising the practice of nursing; and
- Collaborating with other health professionals in the management of health care.

Professional Organization Information

The National Association of School Nurses (NASN) supports the principle of inclusion of children with special health conditions in the educational setting, with appropriate professional and support staff (including school nurses), inservice education, adequate training for all staff, appropriate facilities, supplies and equipment to assure the success and safety of the student in the educational setting (National Association of School Nurses, 1995).

School health services are those health services provided by a registered nurse that are designed to help a student protect, improve and maintain physical, emotional, and social well-being. Students with special health conditions may require special health care services provided by a registered nurse. Such health care services may include, but not be limited to, ensuring the provision of a safe and healthy environment, emergency health care procedures, communicable disease prevention and control, administration of medication, administration of invasive nursing procedures, individualized health assessment and care planning, and health care record keeping.

Case Law and Regulatory Interpretations

Although it is not clear whether Congress ever intended or perceived that students with extensive special health care needs would seek the public education to which they have been entitled through federal statutes for approximately the past 20 years, currently IDEA regulations contain several provisions related to the delivery of services to students with health care needs. Interpretation of these regulations was provided by the Supreme Court in its decision of *Tatro* in 1984. That decision clearly obligated school districts to provide any health services that met the Court's tripartite standard: (a) the student has a disability that requires special education; (b) the procedure is required during the school day, such that without the procedure, the student could not participate in the educational program; and (c) the procedure can be performed by someone other than a licensed physician (Rapport, 1996).

Until March 3, 1999, the tripartite standard decided in the *Tatro* case provided important legal direction over the delivery of health and medical services to students with disabilities in schools today. But on March 3, 1999, the Supreme Court ruled in the case of an Iowa teen, who is a ventilator-dependent quadriplegic, that the public school must finance one-on-one nursing care needed for this student to attend school.

The case stated that the student's situation did not constitute a medical services exclusion because medical services apply only when a physician's services are required (Associated Press, 1999). Exactly how this case will effect previously litigated cases and future situations is yet to be seen.

Health Services are Intended to Serve...

Education and health care professionals use a variety of terms to describe students with chronic or special health conditions. These students may be referred to as students who are chronically ill, medically fragile, technologically dependent or other health impaired. As stated in Nebraska School Health Services as Special Education Related Services (Schafer, L. 1996), each of these terms have overlapping features.

"Chronically ill" typically means a student whose condition is not temporary and results in decreased strength, vitality and alertness. Examples of chronic conditions often seen in students are asthma, diabetes, rheumatoid arthritis, cancer or epilepsy. Students who have a chronic illness often present fluctuating states of health care needs. The condition may adversely affect the student's educational performance and require supervision or intervention to maintain or to manage their health care status .

In Nebraska, the term "other health impaired" is used in the educational setting to identify a student who requires special education because of a health condition which results in limited strength, vitality, or alertness due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle-cell anemia, hemophilia, epilepsy, lead poisoning, leukemia or diabetes which adversely affects a student's educational performance.

A "technologically dependent" student is a student who requires a medical device to compensate for the loss of a vital function and substantial and ongoing nursing care to avert death or further disability. The Office of Technology Assessment in Washington D.C. has identified four separate populations, distinguished from one another by their clinical characteristics, that could be used to describe technology dependent students:

- Group I Students dependent at least part of each day on mechanical ventilators;
- Group II Students requiring prolonged intravenous administration of nutritional substances or drugs;

- Group III: Students with daily dependence on other device-based respiratory or nutritional support, including tracheotomy tube care, suctioning, oxygen support or tube feeding; and
- Group IV: Students with prolonged dependence on other medical devices that compensate for vital functions who require daily or near daily nursing care. This group includes:
- Students requiring cardio-respiratory monitors
 - Students requiring renal dialysis as a consequence of chronic renal failure, and
 - Students requiring other medical devices such as urinary catheters or colostomy bags as well as substantial nursing care in connection with their disabilities.

"Medically fragile" typically means a student who has a life-threatening physical condition. A medically fragile technology dependent student is a student who requires a medical device to compensate for the loss of a vital body function.

The terminology "student with special health care needs" is used to be inclusive of all students with special health care needs regardless of their educational placement. Students with special health care needs may or may not require special education. The decision as to whether a student qualifies for special education is made by a multidisciplinary evaluation team in accordance with eligibility requirements identified in Section 006 of 92 NAC 51 (Rule 51), the special education rule.

Students with special health care needs are students who require individualized health care intervention during the school day to enable participation in the education program. This population includes students:

- Who may require administration of medication
- Whose medical condition is currently stable but may require routine or emergency medical procedures; or
- Who use a particular medical device which compensates for the loss of the vital body functions.

School Health is Provided by...

The school nurse is a licensed, registered nurse whose practice focuses on the health

care needs of students in the larger school-community. (American Nurses Association, 1983). It is the opinion of the National Association of School Nurses (NASN) that the school nurse must be included and work collaboratively with the interdisciplinary or multidisciplinary team. This is vital for effective planning and service provision for the inclusion of students with special health conditions in the educational setting. It is believed that the school nurse is the most effective case manager for the student with severe health conditions. The school nurse develops the individualized health care plan and implements or directs and supervises the delivery of all nursing care procedures in the school, and when appropriate, to and from school and on field trips. The school nurse may decide to delegate nursing services, but must provide training, direction and supervision to licensed practical nurses and unlicensed assistive personnel.

Minimum standards for nursing practice, as defined by the state Nurse Practice Act, and professional standards of nursing practice established by professional organizations, exist to guide registered nurses in the provision of nursing services in the school setting. It is the combination of the legal and professional regulation of practice that provides the framework for clinical practice. Nebraska state laws, rules, regulations, and professional standards of clinical nursing practice and school nursing practice should be consulted, when determining which interventions, duties, and responsibilities are professional in nature and which are appropriate for licensed practical nurses and unlicensed assistive personnel to perform.

The school nurse has the sole responsibility and authority within the educational setting to delegate nursing services that promote the health and safety of school age children (NASN 1994). Delegation, as defined by the American Nurses Association (ANA), is the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome (National Association of School Nurses, 1994). Nursing tasks and nursing procedures may be delegated by the supervising school nurse based upon professional judgment; however, the professional nursing judgments of assessment, evaluation, and care planning may not be delegated. Delegation of nursing services by a non-nurse and /or performance of nursing services without nurse supervision may constitute the practice of nursing without a license, according to the National Council of State Boards of Nursing (NCSBN) (NASN, 1994).

While school administrators have certain responsibilities

regarding the student's educational placement, they cannot legally be responsible for deciding the level of nursing care required by an individual student with special health care needs. The school nurse (RN), based on the state's nurse practice act and related state rules and regulations, determines whether care should be provided by a licensed nurse or delegated to trained and supervised unlicensed assistive personnel, as stated by the National Association of State School Nurse Consultants (NASSNC) (Schafer, L. 1996).

The NASSNC states that the school nurse determines whether delegation of nursing care is appropriate in each individual situation even if a physician or other health professional states or "orders" that such care should be provided by a licensed practical nurse or an unlicensed assistive personnel (unless that physician or other professional takes full responsibility for the training and supervision of the unlicensed assistive personnel). Furthermore, it must be both legally and professionally appropriate for that professional to engage in delegating the specific care activity to a licensed practical nurse or to unlicensed individuals. It is essential that the family, school nurse, school team and health care providers work in collaboration to plan and provide the student with high-quality care in an environment that is not only least restrictive, but also safe for all students and staff (Schafer, L. 1996).

School board policies governing the provision of health related services to students must assure that services are provided in a manner consistent with law and standards of professional practice. Prior to the development of policies, districts would be well advised to read and discuss the Appendices of the document *Nebraska School Health Services as Special Education Related Services* (Schafer, L. 1996). Policies should include:

- Guidelines to determine whether the service needed is one which the district is required to provide.
- Procedures to assure that health-related activities performed in school settings are provided by qualified and properly trained individuals, including those services provided on school transportation vehicles.
- Procedures to provide for the appropriate training and supervision for any individual asked to provide health-related services.
- Delineation of the duties to include that a school nurse (RN) is:
 - Responsible for determining whether the health related activity needed by a student may only be performed by a

registered nurse or is one which may be safely delegated by the licensed registered nurse to a licensed practical nurse or a specific unlicensed individual whom the (RN) trains and monitors;

- Responsible for selecting and training who will be performing what health related activities, ensuring delegation is consistent within the delegates job description, does not interfere with their ability to perform other job duties and does not interfere with the instructional program provided to other students in the classroom;
- Responsible for training, monitoring and supervising the delegate on a regular basis; and
- Responsible for the supervision and monitoring of all legally required nursing interventions.

Role of Support Personnel

The Nebraska Legislature passed LB 594 in May 1999. Neb. Rev. Stat. §71-1,132.30 states that the nurse practice act does not prohibit performance of health maintenance activities by a designated care aide for a competent adult at the direction of such adult or at the direction of a caretaker for a minor child or incompetent adult. Health maintenance activities are those activities which enable the minor child or adult to live in his or her home and community. Such activities are those specialized procedures, beyond activities of daily living, which the minor child or adult is unable to perform for himself or herself and which the attending physician or registered nurse determines can be safely performed in the home and community by a designated care aide as directed by a competent adult or caretaker. (LB 594, 1999)

Questions concerning the provision of health services in the school setting may be directed to the state School and Adolescent Health Coordinator at the Nebraska Department of Health and Human Services, (402) 471-0160.

Entrance Criteria

To qualify for special education health related services: (1) the child must be qualified under IDEA and in Nebraska under 92 NAC 51, (2) the service must be necessary to aid a child with a disability to benefit from special education; and (3) the service must only be provided if it can be

performed by a nurse or other qualified person, but not a physician. Schools are required to pay for medical services only when the services are necessary to determine the need for special education and related services. The health related service must be necessary during the school day and required for an appropriate education. (Mehfoud,1997).

Methods Used for Assessment

A key component of this multidisciplinary evaluation for a child with a health related condition is a health assessment that may be conducted by the school nurse. Based on this assessment, the school nurse identifies those health issues that are relevant to the child's educational progress. If a child with health related disabilities is determined eligible for special education and related services under 92 NAC 51, an individualized health care plan (IHCP) with specific behavioral objectives, interventions and evaluation criteria should be initiated by the school nurse as part of the child's individual education program (IEP) team process, and incorporated into the IEP.

Health assessment refers to the collection and analysis of information or data about the child's state of health, patterns of functioning, and need and management for health services in the school setting. The health assessment is conducted by the nurse and consists of data collection, data analysis and nursing diagnosis. The extent of information (health assessment) gathered by the nurse will be determined by the child's health care needs. The assessment of resources and needs should be based on information gained from the medical records, school records, and concerns of the parents, child, and school personnel. The assessment process must consider needs for training, equipment, and accessibility with each setting the child will be in during the school day as well as during transitions between these settings. (Parette & Bartlett, 1996)

The completed referral form and the child's school health information should be reviewed by the nurse. The nurse should also check the child's record to determine if the child has a verified special education disability, or if the child has been referred for a special education multidisciplinary team evaluation. If either is the case, it is recommended that the nurse consult with special education personnel and the building administrator prior to contacting the parent. This will assist in coordination of communication between school and home and help ensure that evaluations conducted are comprehensive and address all areas of the child's suspected disability.

After completing the above review, it is recommended the nurse (RN) do the following:

- Schedule a meeting with the parent for completion of pertinent background information
- Obtain written parent permission to complete a special health care evaluation. For a child with a verified disability or in the process of a special education multidisciplinary team evaluation, the request for a special health care evaluation may be part of the written parent notice for special education evaluation.
- Obtain written release of information consent from the parent.
- Contact the child's primary physician to discuss the child's special health care needs
- Obtain a copy of the physician's order and parent authorization for potential special health care services to be performed at school
- Complete a written summary of the child's specialized health care needs. For a potential child with a disability this summary should become part of the multidisciplinary evaluation team report.

Service Delivery Models

School health related services may be delivered directly by the school nurse or by an appropriate person as delegated by the registered nurse. A statement of the special education and related services, the supplementary aids and services and a statement of the program modifications or supports for school personnel that will be provided for the child are to be included in the IEP (92 NDE 51; 007.05B3)

If a child with special health care needs has been referred to special education or has already been identified according to 92NDE 51 as a child in need of special education, it is recommended the school nurse be part of the multidisciplinary evaluation team and provide a written report for the multidisciplinary evaluation team report.

The school nurse, may be included when appropriate as a participant on the individual education program (IEP) team for children age three to age twenty-one. The child's health care needs should be addressed as part of the IEP meeting. The child's IEP must have the following information documented:

- Identify "school health care" as a related service;

- Identify the dates when the school health care service will begin and when it will end; and
- Include in the current level of performance a summary of the child’s current health status as it relates to the child’s special education program.

It is recommended each child receiving school health related services as part of the special education program have an individual health care plan, which is student specific. The plan identifies the student’s health needs and the health care actions which will take place during the school day to address those health needs. Detailed information on formulation and implementation of a health care plan can be found in the Nebraska Department of Education document, *Nebraska School Health Services as Special Education Related Services* (Schafer, L. 1996).

The individual health care plan for students with disabilities should be reviewed at least annually, as part of the student’s IEP meeting. Any changes in the student’s health care status would require more frequent review of the individual health care plan.

Method(s) to Determine the Amount of Service Appropriate for Educational Benefit

The amount of school health related services appropriate for educational benefit can be

determined by the multidisciplinary evaluation team (MDT) as the MDT addresses the following questions:

- Is the service requested similar to those services provided by the school nurse to students without disabilities?
- Is the service a “supportive service” required to assist the student to benefit from special education?

Exit Criteria

The IEP team would determine if the school health related service or special health care was no longer needed during the school day or that it was no longer needed due to a change in the student’s health care status as provided by documentation from the health care provider.

Examples of School Health Activities

Medication Administration

Educational: Medication necessary to function during the day e.g. ritalin at noon, seizure control medication necessary to be given on a regular schedule, or medication to be given with food e.g. at lunch.

Borderline: Medication to be given three times a day and parent requests it be given at school due to extenuating circumstance.

Intermittent Catheterization

Educational: Student requires intermittent catheterization to prevent bladder infections and to prevent accidents at school.

Gastrostomy tube feedings/medication administration

Educational: Intermittent tube feedings are needed for nutritional needs and normal growth and development. Intermittent feeding is needed to maintain normal gastrointestinal functioning.

Borderline: Tube feeding at beginning of day and end of day is done for convenience of family.

Tracheostomy Suctioning/Care

Educational: Intermittent suctioning is done to assist student to clear secretions. There is routine checking of tracheostomy tube placement and placement of ties.

Workload Considerations

The number of students with special health care needs must be considered when making staffing decisions. The recommended caseload for school nurses is 750 students per nurse. For special education students the ratio is 250 per school nurse. When the special education population includes students with frequent special procedures, the need for frequent supervision of unlicensed assistive personnel, review of IHCP's, attendance at IEP team meetings, and other consultative and administrative duties, the ratio would need to be less. The school nurse with a mixed student population in a number of sites would need to include time for travel as well as time for planning and coordination.

When nursing procedures are delegated to unlicensed assistive personnel the procedure is client specific and requires training and

periodic review and supervision. Documentation of training, supervision, and evaluation is required.

The school nurse must have time for regular re-evaluation of the status and effectiveness of the service delivery of the health-related procedures for the student who is medically fragile.

Needed Equipment and Space

The special equipment needed to provide school health related services is generally provided by the parents of the student.

An example would include catheters for intermittent catheterization. Equipment generally provided for all students would be provided for students with special health care needs, such as drinking cups for taking medication. Space would be needed for storage of equipment, and for providing privacy when carrying out nursing procedures. Adaptations may be needed to provide privacy and the space necessary for certain activities, such as diapering or tube feedings. Space is needed where there is access to sinks for washing hands and setting up supplies which can be kept clean or sterile as needed.

Documentation

Precise documentation of the delivery of special health care procedures is an essential part of safe provision of school health services. All special health care services delivered to the student during the school day should be documented in writing on a per-incident basis.

Examples of documentation include:

- individualized health care plan,
- assessment,
- training of personnel,
- documentation of procedures,
- medication administration,
- parent permission,
- parent contacts,
- evaluation/outcome, and
- supervision/review.

Supervision and Evaluation of Services and Providers

The school nurse is responsible for the supervision and evaluation of the health care given. The amount of supervision required is determined by the type of

care being provided and the level of training of the person providing the care. The plan for supervision and evaluation is a part of the individual health care plan (IHCP) and the IEP. The documented, periodic supervision, includes an emergency plan and referral to the supervising school nurse when there is a problem or concern between planned evaluations or observations.

The school nurse evaluates the care being given and the need for ongoing training and supervision of the caregiver. The school nurse reports to the school administrator who has the responsibility to:

- Oversee the student's educational program to ensure that the health needs of the student in the school setting are appropriate.
- Provide adequate personnel to meet the student's education, transportation, and health care needs.
- Assure that adequate provisions are provided to assume the liability involved when students with special health care needs are served in the education environments.
- Maintaining overall responsibility for the administration, coordination, and evaluation by appropriate personnel of the effectiveness of the special health care needs provided to students.

Glossary

Delegation (Nursing). The process of the transferring of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome.

Health Assessment. As used in these guidelines, the collection and analysis of information or data about a child's health condition to determine the child's state of health, patterns of functioning and needs for health services, counseling and education. Health assessment is the licensed function of physicians and nurses.

Individualized Health. A plan of action to be developed and used by the registered school nurse Care Plan and other members of the school team, as appropriate, to meet the child's health needs.

Licensed Practical Nurse (LPN). An individual who is licensed as a practical nurse by the state of Nebraska, and who functions dependently at the direction of registered nurses or licensed practitioners. [In the school setting, an LPN must be supervised by a registered nurse (RN) or physician.]

Nurse Practice Act. A statute enacted by the legislature of any state or by the appropriate officers of the districts or possessions. The act delineates the legal scope of the practice of nursing within the geographical boundaries of its jurisdiction.

Nursing. The American Nurses Association (ANA) has defined nursing as the diagnosis and treatment of human responses to actual or potential health problems. Nursing views the patient from an holistic health perspective whereby the individual's mind, body and spirit are seen as interdependent and functioning as a whole within the environment. Nursing is differentiated from medicine in that the whole person and his/her response to health problems is the focus as opposed to the specific illness itself.

Nursing Supervision. Provision of guidance by a registered nurse for the accomplishment of a nursing task or intervention with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or intervention. Total nursing care of an individual remains the responsibility and accountability of the nurse.

Registered Nurse (RN). An individual who is licensed in Nebraska by the Nebraska Department of Health to practice nursing. The professional nurse has responsibility for the care of individuals and groups through a colleague relationship with other health care providers, to function in making self-directed judgments, and

to act independently in the practice of the profession.

School Health Service. Services provided by a qualified school nurse or other qualified person.[34 CFR §300.16(b)(11)]

School Nurse. A registered nurse or advanced registered nurse practitioner (ARNP) who meets the Nebraska licensing requirements.

Technology Dependent Child. A child who has a long-term chronic disability; requires a medical device to sustain life; requires skilled care or monitoring on a routine daily basis; and is 21 years or younger.

Unlicensed Assistive Personnel (UAP). Staff members who are not authorized (by licensure) to provide health care services or perform health care acts or tasks that are regulated by the Nebraska Department of Health. Authorization to provide health related services for students is received from the parent or delegated by the registered nurse.

References

- American Nurses Association. (1983). Standards of School Nursing Practice. Kansas City: American Nurses Association.
- Associated Press. (1999, March 4). Ruling Could Handicap Schools. Grand Island Independent, pp. 1, 2A.
- Federal Register/Vol. 64, No. 48/Friday, March 12, 1999, Rules & Regulations, pg. 12424.
- Mehfoud, K. (1997, May). Distinguishing Between Educationally and Medically Related Services: The New Case Law. Paper presented at The 18th National Institute on Legal. Issues of Educating Individuals with Disabilities, San Diego, CA National Association of School Nurses. (1994). Delegation of Care Issue Brief.
- National Association of School Nurses. (1995). Inclusion Issue Brief.
- Parette, H.P., & Bartlett, C.H. (1996). Collaboration and Ecological Assessment: Bridging the Gap Between Medical and Educational Environments for Students Who Are Medically Fragile. Physical Disabilities: Education and Related Services, 15 (1), 33-47.
- Rapport, M J.D. (1996). Legal Guidelines for the Delivery of Special Services in Schools. Exceptional Children, 62, 537-549.
- Schafer, L. (ed.) (1996). Nebraska School Health Services as Special Education Related Services. Lincoln, NE: Nebraska Department of Education Special Populations Office.

Social Work Services in Schools

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Social Work Services in Schools as a Related Service

Social workers have worked in school settings throughout the twentieth century. School social workers always have been concerned with the learning needs and adjustment of all children and youth. With the enactment of P.L. 94-142, the Education for All Handicapped Children Act in 1975, school social work was identified as a related service and social workers were given the additional specific role of assisting pupils with disabilities.

As stated in 1991 by the National Information Center for Children and Youth with Disabilities, “Social Work Services are provided in order to address the whole welfare of the student with a disability– his or her life at home, in school, and in the community.” (NICHCY, 1991)

The compatibility of social work and special education services is summarized in the following statement:

“The principles of special education legislation complement the basic philosophy and code of ethics of the social work profession. The social work profession is founded on democratic and humanitarian ideals. It is committed to protecting the right of individuality, self-respect, and the opportunity for development, without discrimination. Legislation that grants infants and youths the right to an appropriate education in the least restrictive environment is consistent with these ideals.” (Allen-Mears, 1996 p. 167)

Federal Definition

Social work service in schools includes:

- Preparing a social or developmental history on a child with a disability:
- Group and individual counseling with the child and family:
- Working with those problems in a child’s living situation (home, school, and community) that affect the child’s adjustment in school;
- Mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program; and

- Assisting in developing positive behavior intervention strategies. [34CFR§300.24(b)(13)]

Nebraska Statute Information

The Nebraska Regulations Governing the Licensure of Mental Health Practitioners and the Certification of Marriage and Family

Therapists, Professional Counselors, and Social Workers describe the practice of social work as follows:

- Social work practice or the practice of social work means the professional activity of helping individuals, groups, and families or larger systems such as organizations and communities to improve, restore, or enhance their capacities for personal and social functioning and the professional application of social work values, knowledge principles, and methods in the following areas of practice:
- Information, resource identification and development, and/or referral services;
- Preparation and evaluation of psychosocial assessments and development of social work service plans;
- Case management, coordination and monitoring of social work service plans in the areas of personal, social or economic resources, conditions, or problems.
- Development, implementation, evaluation, and/or administration of social work programs and policies;
- Supportive contacts to assist individuals and groups with personal adjustment to crisis, transition, economic changes, or a personal or family member's health condition, especially in the area of services given in hospitals, health clinics, home health agencies, schools, shelters for the homeless, shelters for the urgent care of victims of sexual assault, child abuse, elder abuse, or domestic violence nursing homes, and correctional facilities;
- Social casework for the prevention of psychosocial dysfunction, disability, or impairment; and
- Social work research, consultation, and education. (172 NAC 94)

Professional Organization Information

The professional organization of social workers is the National Association of Social Workers,

(NASW). NASW has developed school social work standards, which address many aspects of the field. These standards were initially developed in 1978 and revised in 1992. The most recent revision was developed to reflect and promote professionally sound practice.

For more information refer to the NASW (1992) Standards of Competence and Professional Practice for school social workers.

Social Work Services in Schools is Intended to Serve...

Factors that may contribute to the need for Social work as a Related service may include; behavioral problems, attendance concerns, lack of provision of basic needs, evidence of emotional disturbance, abuse or neglect of the child, and other issues present in the home and community.

Social Work Services in the Schools is Provided by...

Anyone identifying themselves as a social worker in the state of Nebraska must comply with the state regulations.

“Any person who wishes to represent himself/herself as a social worker must be certified as a master social worker or social worker.” (172 NAC 94) In order to be a certified social worker in the state of Nebraska an individual must “Have a baccalaureate or master’s degree in social work from an approved education program”. In addition that individual must meet the other criteria as outlined in the state regulations for certification which include reaching the age of majority and being of good character. In order to be certified as a master social worker the individual must have a master’s or doctorate degree in social work, have completed 3,000 hours of supervised experience, and passed the American Association of State Social Work Boards Advanced or Clinical test.

“School social workers shall develop skills for effective service to children, families, personnel of the local education agency, and the community” (NASW Standard 18, 1992).

Role of the Providers

In its Standards for School Social Work Services, NASW (1992) states the following regarding the qualifications of school social workers.

“Standard 26. The local education agency should employ school social workers with the highest level of qualification for entry-level practitioners. A master of social work (MSW) degree from an CSWE-

accredited program is the recommended entry-level qualification for school social work and is required for the NASW School Social Work Specialist credential. When the school social work staff includes some persons whose highest degree is a bachelor of social work (BSW) degree and others who have an MSW, tasks shall be assigned differentially in a manner that takes into account the staff's levels of education and demonstrated competence." (NASW Standards, p. 15)

Entrance Criteria

Referral to the school social worker may be because of student behaviors, attendance issues, or when school personnel, special education staff or the family express needs related to issues that interfere with the child's special education experience. The need for the services of the school social worker to be provided to the child or family will then be determined by the MDT/IEP team. In this instance, it is recommended that the social worker be part of the team making the recommendation.

Methods Used for Assessment

The school social worker in collaboration with the family and others who have knowledge of the child and family in question should assess the need for social work services. This process may be initiated prior to the Student Assistance Team (SAT) or Multidisciplinary Team (MDT), with the resulting findings included in the IEP.

Social workers have specific expertise and interest in "... assessing the needs, characteristics and interactions of children, families, personnel in the local education agency, and individuals and groups in the neighborhood and community." (NASW Standards p. 12, 1992). Some tools that may be used in this process include genograms, eco-maps, and various self-assessment instruments.

Service Delivery Models

Models of school social work practice should be developmental, not static and should use an ecological perspective. Standard 18 also provides information on the skills required to implement the model. (NASW Standard 18, 1992) A listing of skills required to implement the model can also be found in standard 18.

With the development of the skills stated in NASW's Standard 18, the school social worker would be able to provide a variety of methods of related service delivery which could be effectively stated on an IEP.

Method(s) to Determine the Amount of Related Service Appropriate for Educational Benefit

The amount of service to be delivered to the child and family is likely to be determined by considering issues such as appropriate

family functioning in relation to the child’s special education needs and child’s adjustment in school. Problems in the child’s living situation such as substance abuse, lack of basic needs, mental illness, medical needs, which have not been addressed, transportation issues, truancy, and unemployment, may prevent the family from full participation in the IEP process. Social Workers may be addressing these issues prior to the SAT and may be involved with the MDT in formulating eligibility for services. In this case, the service is not a related service as it is not part of the IEP. The amount of services provided by the social worker should be based on professional judgment, assessment of the child and family situation, and in collaboration with the IEP.

Exit Criteria

If the IEP goals specific to social work services have been achieved, the service is discontinued.

Examples of Social Work Services in the School Activities

The interviewing and assessment skills of the social worker can be used

to help determine the needs and concerns of the student and the student’s family. These factors could be significant in implementing an effective educational plan for the child. Such factors may include a family history that reveals beliefs about schools and systems that impede the family’s full participation in the special education process.

As a liaison between the student, family and the school system, the social worker can pave the way by first addressing the needs that are salient to the education of the student. For example, one reason a student might be withdrawing or acting out in the classroom could be that the family has no stable place to live. In addressing the needs of the family, appropriate referrals and resources may be identified. With the social worker’s knowledge of community resources the family’s living situation could be stabilized, after which a more valid assessment of the child’s classroom behavior could be made.

Frequently the evaluation for special education services is complex. The social worker may assume the roles of liaison between the school and family. The social worker may also assist the family in understanding the school's expectations and the family's rights to due process. The school social worker may ensure the family understands the process step by step and see that their questions are answered. The social worker may need to assist the location of an interpreter so that the family can fully participate in the special education process.

Social workers have knowledge of the various agencies, resources, and programs in the community. It may become necessary for the social worker, with the permission of the family, to provide communication and coordination with other agencies such as mental health facilities or the juvenile justice system in the community so that the child can access an appropriate education.

Workload Considerations

Appropriate ratios for school social work staff to students depends on the characteristics of the student population to be served. Each educational agency, state or local must determine what is adequate for its particular circumstances. The National Council of State Consultants for School Social Work Services recommends the following (NASW Standard 18, 1992):

- Total school population with no special concentration – 1 worker to 2,000 students;
- Total school population with poverty concentration – 1 worker to 1,500 students;
- Total school population with special education concentration – 1 worker to 1,000 students;
- Total school population with special education and poverty concentrations – 1 worker to 800 students;
- Total school population with special education poverty, and minority concentrations – 1 worker to 500 students;
- Total school population with special education, poverty, and minority concentrations and federal impact issues – 1 worker to 350 students;
- Special education assignment only – 1 worker to 50 students.

Needed Equipment and Space

The NASW Standards for School Social Work Services provider guidance on equipment and space considerations:

“Standard 28. The local education agency should provide a work setting that permits social workers to use their competencies effectively. School social workers need basic work resources to ensure privacy and confidentiality to children and families and to be most effective in their work. These basic resources include an office with a telephone; clerical support; an adequate budget for professional materials, supplies, and activities; and adequate private facilities in each school site for meeting (individually and in small groups) with children, families and personnel of the local education agency. (NASW Standards, p. 15, 1992)

Documentation

Documentation of services should be determined by each local education agency. In keeping with social work ethics documentation may be limited to identifying data, resources offered, and issues addressed with family, school personnel and other professionals. (NASW, 1996)

Supervision and Evaluation of Services and Providers

It is not unusual for social workers who work in schools to be supervised by a non-social worker. This issue is addressed in the NASW Standards for School Social Work Services.

“Standard 25. The administrative structure established by the local education agency should provide for appropriate school social work supervision. The local education agency has the responsibility for administrative and technical supervision to ensure high-quality services. Special provisions for social work supervision are indicated for inexperienced school social workers in certain areas in which one or few such social workers serve an entire local education agency.” (NASW Standards, p. 15, 1992)

Glossary of Terms

- Advocate Role** “A basic function of social workers, speaking out on behalf of the client to achieve changes in the conditions that contribute to the client’s problems and securing and protecting a client’s existing right or entitlement.” (Barker, 1999, p. 12)
- Broker Role** “A function of social workers and community organizers in which clients (individuals, groups, organizations, or communities) are helped to identify, locate and link available community resources, and various segments of the community are put in touch with one another to enhance their mutual interests.” (Barker, 1999, p. 55)
- Client System** “The client and those in the client’s environment who are potentially influential in contributing to a resolution of the client’s problems. For example, a social worker may see a nuclear family as the client and the extended family and neighbors, teachers, and employers as making up part of the client system.” (Barker, 1999, p. 81)
- Eco-map** “A diagram of family relationship created by Ann Hartman and used by social workers, family therapists, and other professionals to depict a variety of reciprocal influences between the client and those people related to the client, relevant social institutions, and environmental influences.” (Barker, 1999, p. 146)
- Genogram** “A diagram used in family therapy to depict family relations extended over at least three generations. The diagram uses circles to represent females and squares for males, with horizontal lines indicting marriages. Vertical lines are drawn from the marriage lines to other circles and squares to depict the children. The diagram may contain other symbols or written explanations to indicate critical events, such as death, divorce, and remarriage, and to reveal recurrent patterns of behavior.” (Barker, 1999, p. 193)
- School Social Work** “The specialty in social work oriented toward helping students make satisfactory school adjustments and coordinating and influencing the efforts of the school, the family, and the community to help achieve this goal. School social workers are often called on to help students, families, and teachers deal with such problems as truancy; social withdrawal, overaggressive behavior, rebelliousness, and the effects of special

physical, emotional or economic problems. They also interpret the methods and philosophy of the school to the parents and community. In many states, school social workers are certified or licensed with the statues often following the National Association of Social Workers standards for School Social Work Services.” (Barker, 1999, p. 426)

Specialist (SSWS) credential -- “A program established by the National Association of Social Workers (NASW) to identify school social workers who have met rigorous national standards for education and experience in school social work practice.” (Barker, 1999, p. 427)

Self-determination “An ethical principle in social work that recognizes the rights and needs of clients to be free to make their own choices and decisions. Inherent in the principle is the requirement for the social worker to help the client know what the resources and choices are and what the consequences of selecting any one of them will be. Usually self-determination also includes helping the client implement the decision made. Self-determination is one of the major factors in the helping relationship.” (Barker, 1999, p. 431-432)

Systems Theories “Those concepts that emphasize reciprocal relationships between the elements that constitute a whole. These concepts also emphasize the relationships among individuals, groups, organizations or communities and mutual influencing factors in the environment.” (Barker, 1999, p. 477)

References

- 172 NAC 94 Nebraska Department of Health Professional and Occupational Licenses Regulations, Title 172. Regulations Governing the Licensure of Mental Health Practitioners and the Certification of Marriage and Family Therapists, Professional Counselors, and Social Workers. Chapter 94. 1996.
- Federal Register, Vol. 64, No. 48/Friday, March 12, 1999/Rules and Regulations, P. 12424.
- Allen-Mears, Paula, Washington, Robert, & Welsh, Betty (1996) Social Work Services in Schools 2nd Ed., Boston: Allyn and Bacon.
- Barker, R. L. (1999) The Social Work Dictionary 4th Ed., Washington D.C: NASW Press.
- Clark, James P., (1998), The School Social Work Association of American and The National Association of Social Workers– School Social Work Section, Functional Behavior Assessment and Behavioral Intervention Plans: Implementing the Student Discipline Provisions of IDEA '97, A Technical Assistance Guide for School Social Workers.
- Federal Register, Vol. 64, No. 48/Friday, March 12, 1999/Rules and Regulations, P. 12424.
- National Association of Social Workers, (1996), Code of Ethics.
- National Association of Social Workers, (1992), NASW Standards for School Social Work Services.
- NICHCY:** Related Services for School-Aged Children with Disabilities, (Vol. 1, No 2. 1991). News Digest, NICHCY.
- Pueschel, S. M., Scola, P. S., Weidenman, L. E., & Bernier, J. C. (1995). The Special Child: A Source Book for Parents of Children with Developmental Disabilities. (2nd ed.) Baltimore: Paul H. Brookes Publishing Co.

Suggested Readings

Compton, B. R., & Galaway, B. (1989) Social Work Processes (4th ed.)
Belmont, California: Wadsworth Publishing Company.

Constable, R., Flynn, J. P., & McDonald, Shirley. (1991). School Social
Work, Practice and Research Perspectives. (2nd ed.). Chicago:
Lyceum Books, Inc.

Freeman, E. M., Franklin, C.G., Fong, R., Shaffer, G. L., & Timberlake,
E.M. (1998). Multisystem Skills and Interventions in School Social
Work Practice. Washington DC: NASW Press.

Social Work in Education: A Journal for Social Workers in Schools
Published in January, April, July and October. Washington DC:
NASW Press.

Speech Language Pathology

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Speech Language Pathology as a Related Service

In the state of Nebraska speech-language pathology may be provided as a special education service or a special education related service. This section will focus only on speech-language pathology as a related service.

Federal Definition

Speech-language pathology services include:

- Identification of children with speech or language impairments;
- Diagnosis and appraisal of specific speech or language impairments;
- Referral for medical or other professional attention necessary for the habilitation of speech or language impairments;
- Provision of speech and language services for the habilitation or prevention of communicative impairments, and
- Counseling and guidance of parents, children, and teachers regarding speech and language impairments.” [34 CFR ?300.26(b)(14)ii]

Nebraska Statute Information

The practice of speech-language pathology shall mean the application of principles, methods, and procedures for the evaluation, monitoring, instruction,

habilitation, or rehabilitation related to the development and disorders of speech, voice, or language for the purpose of preventing, identifying, evaluation, and minimizing the effects of such disorders and conditions but shall not include the practice of medical diagnosis, medical treatment, or surgery. Speech-language pathologist shall mean an individual who presents himself or herself to the public by any title or description of services incorporating the words speech-language pathologist, speech therapist, speech correctionist, speech clinician, language pathologist, language therapist, language clinician, logopedist, communicologist, aphasiologist, aphasia therapist, voice pathologist, voice therapist, voice clinician, phoniatrist, or any similar title, term or description of services; and

Communication assistant shall mean any person who, following specified training and receiving specified supervision, provides specified limited structured communication services, which are developed and supervised by a licensed audiologist or speech-language pathologist, in the areas in which the supervisor holds licenses. Source: Laws 1978, LB406, S13; Laws 1985, LB129, S14; Laws 1988, LB1100, S66. Operative date April 8, 1988.

The practice of speech-language pathology includes:

- Providing screening, identification, assessment, diagnosis, treatment, intervention (i.e., prevention, restoration, amelioration, compensation) and follow-up services for disorders of:
 - speech: articulation, fluency, voice (including respiration, phonation, and resonance)
 - language (involving the parameters of phonology, morphology, syntax, semantics, and pragmatics; and including disorders of receptive and expressive communication in oral, written, graphic, and manual modalities)
 - oral, pharyngeal, cervical esophageal, and related functions (e.g., dysphagia, including disorders of swallowing and oral function for feeding; orofacial myofunctional disorders)
 - cognitive aspects of communication (including communication disability and other functional disabilities associated with cognitive impairment)
 - social aspects of communication (including challenging behavior, ineffective social skills, lack of communication opportunities)
- Providing consultation and counseling, and making referrals when appropriate;
- Training and supporting family members and other communication partners of individuals with speech, voice, language, communication, and swallowing disabilities;
- Developing and establishing effective augmentative and alternative communication techniques and strategies, including selecting, prescribing, and dispensing of aids and devices and training individuals, their families, and other communication partners in their use;

- Selecting, fitting, and establishing effective use of appropriate prosthetic/adaptive devices for speaking and swallowing (e.g., tracheoesophageal valves, electrolarynges, speaking valves);
- Using instrumental technology to diagnose and treat disorders of communication and swallowing (e.g., videofluoroscopy, nasendoscopy, ultrasound ography, stroboscopy);
- Providing aural rehabilitation and related counseling services to individuals with hearing loss and to their families;
- Collaborating in the assessment of central auditory processing disorders in cases in which there is evidence of speech, language, and/or other cognitive-communication disorders; providing intervention for individuals with central auditory processing disorders.
- Conducting pure-tone air conduction hearing screening and screening tympanometry for the purpose of the initial identification and/or referral of individuals with other communication disorders or possible middle ear pathology.
- Enhancing speech and language proficiency and communication effectiveness, including but not limited to accent reduction, collaboration with teachers of English as a second language, and improvement of voice, performance, and singing;
- Training and supervising support personnel;
- Developing and managing academic and clinical programs in communication sciences and disorders;
- Conducting, disseminating, and applying research in communication sciences and disorders;
- Measuring outcomes of treatment and conducting continuous evaluation of the effectiveness of practices and programs to improve and maintain quality of services.

Professional Organization Information

Speech-language professionals work to prevent speech, voice, language, communication,

swallowing, and related disabilities. They screen, identify, assess, diagnose, refer, and provide treatment and intervention, including consultation and follow-up services, to persons of all ages with, or at risk for, speech, voice, language, communication, swallowing, and related disabilities. They counsel individuals with these disorders, as well as

their families, caregivers, and other service providers, related to the disorders and their management. Speech-language pathologists select, prescribe, dispense, and provide services supporting the effective use of augmentative and alternative communication devices and other communication prostheses and assistive devices.

Case Law and Regulatory Interpretations

Speech-language therapy typically is a related service for students whose speech impairments adversely affect their educational performance. However, in a hearing officer decision in a Massachusetts due process action found that a student who stuttered could receive speech therapy as a related service, despite the fact that the effect of his stuttering on his current educational performance was minimal.” In re Gregory, L., 1985-86 EHLR 507:157 (SEA Mass., 1985)

Speech-Language Pathology is Intended to Serve...

Speech-language pathologists serve children with speech, voice, language, communication, swallowing, and related disabilities.

In Nebraska speech-language pathologists are approved to serve children with the following categorical assignments: autism, diagnostic programs, early childhood special education in-home and center-based programs, home and hospital services, home-school liaison, other health impairments, speech-language impairments, traumatic brain injury, and any student whose IEP team has determined shall receive speech and language services as a related service (mild/moderately/severely mental handicap, specific learning disabled, etc.) (92 NAC 010.01D)

Speech-Language Pathology is Provided by...

Neb. Rev. Stat. §71-1,187 states, "The practice of audiology or speech/language pathology or the use of the official title of such practice by a person who holds a valid and current credential as a speech or hearing specialist, issued by the State Department of Education, if such person performs speech-language pathology or audiology services solely as part of his or her duties within an agency, institution, or organization for which no fee is paid directly or indirectly by the recipient of such service and under the

jurisdiction of the State Department of Education, but such person may elect to be within the jurisdiction of sections 71-1,186 to 71-1,196.” [Neb. Rev. Stat. §711,187]

Qualifications of Providers

Every applicant for a license to pathology shall (1) present proof of a master’s degree or its equivalent in audiology or speech-language pathology from an academic program approved by the board, (2) present proof of at least nine calendar months of full-time speech-language pathology or audiology, supervised in the area in which licensure is sought, and (3) successfully complete and examination approved by the department on recommendations of the board. Presentation of official documentation of certification by a nationwide professional accrediting organization approved by the board shall be deemed equivalent to subdivisions (1), (2), and (3) of this section. [Neb. Rev. Stat. 71-1,190]

Speech-language pathologist certification in Nebraska requires a master’s degree, which is also required by ASHA. Speech-language pathologists are also required by ASHA to obtain the ASHA Certificate of Clinical Competence (CCC) which involves the completion of a master’s degree, a supervised Clinical Fellowship (CF), and a passing score on a national examination. In some areas, such as college teaching, research, and private practice, a Ph.D. degree is desirable. Only a speech-language pathologist may assess the need for speech-language therapy intervention.

A speech-language pathology assistant (communication assistant) may be utilized to aid a speech-language pathologist. Speech-language pathology assistants are to be used only to supplement, not supplant, the services provided by speech-language pathologists.

Role of Support Personnel

Speech-language pathology assistants are one category of support personnel in speech-language pathology. Support personnel are people who, following academic and/or on-the-job training, perform tasks as prescribed, directed, and supervised by ASHA-certified speech-language pathologists. There are different levels of support personnel based on training and scope of responsibilities. Aides, for example, have a different, usually narrower, training base and a more limited scope of responsibility relative to speech-language pathology assistants. States may use different terminology to refer to support personnel in speech-

language pathology (e.g., communication aides, paraprofessionals, service extenders).

Nebraska's State Statutes, (1998) states specific guidelines regarding what a communication assistant can and cannot perform. According to the State of Nebraska, a communication assistant may:

- Implement programs and procedures designed by a licensed audiologist or speech-language pathologist which develop or refine receptive and expressive verbal and nonverbal communication skills;
- Maintain records of implemented procedures which document a patient's response to treatment;
- Provide input for interdisciplinary treatment planning, inservice training, and other activities directed by a licensed audiologist or speech-language pathologist;
- Prepare instructional material to facilitate program implementation as directed by a licensed audiologist or speech-language pathologist;
- Recommend speech, language, and hearing referrals for evaluation by a licensed audiologist or speech-language pathologist;
- Follow plans, developed by the licensed audiologist or speech-language pathologist, that provide specific sequences of treatment to individuals with communicative disorders;
- Chart or log patient responses to treatment.

According to ASHA's *1995 Guidelines for the Training, Credentialing, Use, and Supervision of Speech-Language Pathology Assistants*, which apply across all practice settings, a speech-language pathology assistant may conduct the following tasks under the supervision of a speech-language pathologist.

- Conduct speech-language screenings.
- Follow documented treatment plans or protocols.
- Document patient/client progress.
- Assist during assessment.
- Assist with informal documentation, prepare materials, and other clerical duties.
- Schedule activities, prepare charts, records, graphs, or otherwise display data.
- Perform checks and maintenance of equipment.
- Participate in research projects, in-service training, and public relations programs.

Note: For a definitive list of services or tasks a speech-language pathology assistant may not perform refer to ASHA's 1995 *Guidelines for the Training, Credentialing, Use, and Supervision of Speech-Language Pathology Assistants*. For a list of duties and activities prohibited by communication assistants refer to Neb. Rev. Stat. §71-1,195.07.

Entrance Criteria

In order for a student to receive speech-language pathology as a related service from their resident public school district, the child must have a verified disability as determined by a multidisciplinary evaluation team as per 92 NAC 51-006 (Nebraska Rule 51). It should be noted, however, that a verification of a speech-language impairment is not required to receive speech-language therapy as a related service to support the student's special education program plan. According to 92 NAC 51, speech-language impairments shall mean: "... a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment, which adversely affects a child's development or educational performance." This means designing special educational instruction to address the unique needs of the student, that result from their disability, and ensure the student has access to the general curriculum, so that he or she can meet the educational standards which apply to all students in the school district. [34 CFR §300.26(3)(I) and (ii)]

The receipt of speech-language pathology as a related service is based on the documented and assessed needs of the student for the service. The result of the service allows the student to benefit from his or her special education program. In determining whether or not assessed educational needs should be met by speech-language pathology services the multidisciplinary evaluation team (MDT) or the individual education plan team (IEP) needs to document that

According to the *Special Education Related Services Guide, Volume One*, in determining whether or not assessed educational needs should be met by speech or language services, the following should be apparent:

- A problem(s) exists related to the use of speech or language. The expertise of a speech-language pathologist for intervention services is required.
- The problem interferes with the child's ability to participate in his/her educational program.
- Previous attempts to alleviate the problem have not been successful.

- There is potential for positive, progressive, developmental, or functional change.
- It appears that without speech-language services, negative change could occur. Change as a result of the intervention should be in addition to change due to increasing age or maturation of the student. (Schafer, 199

Methods Used for Assessment

There are four guidelines to help determine whether a student is receiving educationally relevant therapy (ibid.):

- Identify how specific therapeutic domains and areas (speech production, expressive/receptive language) contribute to and /or challenge a student's performance of his or her IEP.
- Assess and describe a *student's performance* in specific areas of the school such as the classroom, lunchroom, halls, rather than solely on the basis of formal test.
- Discuss how any suggested intervention *will improve* the student's ability to meet the goals and objectives of the IEP.
- Communicate, both verbally and through written reports in common language that all team members can understand.

Only a fully credentialed speech-language pathologist (i.e., one who holds a professional level teaching certificate from the State of Nebraska) can perform assessments and assist in the verification process of the multidisciplinary team.

Service Delivery Models

Service delivery may include direct, integrated, and consultative services. The service delivery site may include the speech-language resource room, classroom, home, or community.

During the course of intervention, a student might participate in several service delivery models before dismissal. Service delivery is a dynamic concept and changes as the needs of the students change. No one service delivery model is to be used exclusively during intervention. For all service delivery models, it is essential that time be made available in the weekly schedule for collaboration and consultation with parents, general educators, special educators and other service providers.

Methods to Determine Amount of Service Appropriate for Education Benefit

The following need to be present and addressed when determining the need for educational therapy services, and are

provided as a guide to develop policy on speech language pathology as a related service:

- Does the student have a verified disability as per 92 NAC 51-006 (Rule 51), and are special education services required?
- Has therapy been determined to be necessary through a documented assessment and implementation plan (IEP) process to enable the student to benefit from educational programming?
- Is the primary focus of the therapy to increase the student's access to education rather than medical rehabilitation? "Out-of-class" therapy services may be indicated for school-age students who have specific goals requiring one-on-one service, but should not be the predominate or only model of service provision. Therapy must be provided in the least restrictive environment, usually the student home (if early intervention) or school setting to provide consultative input to the educational staff.
- Who is the most appropriate provider who can safely and efficiently provide the service? For example, with the student meeting specific goals for articulation/language the classroom teacher or special education teacher provides carry-over within their classroom setting.

Exit Criteria

Dismissal occurs when a student no longer needs special education or related services to take advantage of educational opportunities. One of the following three criteria should be documented to justify dismissal:

- Speech-language pathology goals have been met or the unique expertise of the related service provider are no longer needed and no additional goals or objectives that require the resources of the related service are indicated.
- Potential for further change as a result of the related service intervention is unlikely based on previous documentation or programming has been developed that can continue without the related service.

- The team determines that the service is no longer indicated due to a change in the child's status.

Examples of Related Service Activities

Educational therapy services are those services developed by educational personnel and the family and documented in the student's IEP. Although medical information, including prescriptions from physicians, are to be considered by the educational team in determining the student's education program, the school is only obligated to provide those services deemed to be necessary for the student to benefit from his or her special education program.

There are no nationally recognized guidelines for what comprises educational therapy services as opposed to services that would be provided in a clinical (medical) setting. Services which should not be considered as education include:

- Acute rehabilitation for trauma as in laryngeal trauma, burns inhalation, or following a traumatic or closed head injury. A child or student may require both medical and educational services in this situation with coordination needed to assure that the educational program meets the IEP goals of the individual and that the medical program follows coordination from the medical team.
- Any therapy that is medically necessary, but does not pertain to the IEP goals.
- Any maintenance activities that do not have a direct affect on the student's ability to access or benefit from the educational program.

Traumatic/Closed Head Injury

Educational Therapy Example: Therapy could focus on one or more of the following areas which has been determined to produce an adverse affect on the child's educational or developmental performance: includes but is not limited to attention, memory/learning, organization, problem solving, abstract reasoning, communication, judgment, visual and/or auditory perception, social communication skills i.e. agitation, irritability, aggression, apathy, lack of insight, impulsivity, poor emotional control, secondary depression, withdrawal and difficulties with social relationships).

Borderline Therapy Example: Transition from acute therapy to the educational setting. Community re-entry skills are being developed.

Medical Therapy Example: Patient is identified by the Los Amigos Rancho Scale (an evaluation tool utilized by rehabilitation therapists to determine where the patient is progressing through the coma stages) to be below a level VIII. Therapy is focused on moving to different levels of the Los Amigos Rancho scale. Evaluating and developing an augmentative system for communication.

Dysphagia

Educational Therapy Example: It should be noted that dysphagia is not identified in Rule 51. It is believed that it could be an educational need in certain situations. This would be dependent on the student's developmental stages. Oral motor strengthening (mouth, lips, and tongue) is needed to enhance the ability to communicate and to swallow. Young children learn through various senses, such as, tasting and touching. By strengthening the oral motor region, one enhances the future ability to use these senses, and strengthen the swallowing mechanism to prevent any aspiration.

Borderline Therapy Example: Student has completed a modified barium swallow evaluation (x-ray study of the swallow) and it was determined that the patient can swallow safely during school lunch utilizing speech language therapy techniques. The speech/language pathologist in the educational setting could place the student on a short-term program, training staff to monitor the appropriate techniques to prevent aspiration (food/liquid going into the lungs vs. stomach).

Medical Therapy Example: Speech/language pathologist in medical setting would evaluate the modified barium swallow, develop a safe oral intake program or supplemental program, train the student in appropriate techniques until monitoring can be achieved with limited risk of aspiration (food/liquids going into the lungs vs. stomach).

Hearing Impaired

Educational Therapy Example: Therapy for the student's participation in the educational process. This could include speech and language acquisition within the educational curriculum and IEP goals. Treatment should focus on comprehension, and production of language in spoken, signed, or written forms; speech and voice production; auditory training (an amplification system where the user has a receiver and the speaker has a microphone/transmitter), speech reading, multimodal (e.g., visual, auditory-visual, and tactile) training; and overall communication strategies. (ASHA, 1997, Preferred Practice Patterns).

Voice

Educational Therapy Example: Provide treatment that encourages and teaches the appropriate use of the vocal mechanism within the educational setting. This could include teaching the student abusive vs. non-abusive vocal behavior.

Borderline Therapy Example: Coordinating therapy within the educational setting to help carry-over the medical speech/language pathologist's goals. Educational speech/language pathologist places goals into an educational aspect.

Medical Therapy Example: Assessment of laryngeal function via videostroboscopy (test where the vocal cords are visualized through a nasal tube or rigid scope through the mouth which projects the image on a television screen.) Therapeutic intervention of organic and functional voice disorders through coordination of care with an ENT physician.

Workload Considerations

According to 92 NAC 51 005.03A, the total number for school age student served by Level I (less than 3 hours of special education service per week) personnel per school year per full time professional staff member shall be between 40-60 students with speech-language impairments. 92 NAC 51 005.04A specifies that if the total number of students served in Level II (more than 3 hours of special education service per week) classrooms per full time professional staff member shall be between 12-20 students with speech-language impairments. The caseload for a combination of Levels I and II shall range from 15-25 students per school year per full time professional staff member.

The Guidelines for Caseload Size and Speech-Language Service Delivery in the Schools (ASHA, 1993) delineate many considerations to be observed in determining caseload size, including roles and responsibilities of the speech-language pathologist, age and severity of students, and service delivery models. The following statement from that ASHA document provided recommendations for caseload size in 1993, however, changes in student population and IDEA requirements should also be considered in determining appropriate caseload size today. "Caseload size must reflect a balance between how many hours are available in the school day for services to students, and how many hours are needed to complete paperwork, staffing, and other required activities. The recommended maximum caseload for appropriate services is 40

students, regardless of the type or number of service delivery models selected. Special populations may dictate fewer students on the caseload. A recommended maximum caseload composed entirely of preschoolers is 25. Other populations that may require additional time, and therefore fewer students on the caseload, include students who are technologically dependent, medically fragile, multilingual or limited-English proficient. Some states limit the number of students in self-contained classrooms. Eight students without a support person, or 12 students with a support person, are the recommendations for this type of setting." (ASHA, 1993).

Needed Equipment and Space

The amount of space and equipment needed varies from student to student, depending on the needs being addressed in the IEP and the service delivery

model utilized. If the speech-language pathologist is providing services within a location separate from the general classroom, a quiet, well-lit room that provides adequate workspace for students to work toward IEP goals is necessary. A desk locked file cabinet for student file information, a telephone for parental and professional contact, and storage space for materials are also useful.

Documentation

As per 92 NAC 51 007.05B7a, the IEP must include a statement regarding how often the child's parents will be informed of their child's progress, and must be at least as often as parents are informed of their nondisabled children's progress. This includes:

- Their child's progress toward the annual goals
- The extent to which that progress is sufficient to enable the child to achieve the goals by the end of the school year

Documentation and accountability are required for each of the core roles of the school speech-language pathologist. Documentation is needed for federal and state requirements. Clear and comprehensive records are necessary to justify the need for intervention, to document the effectiveness of that intervention, and for legal purposes. Professionals in all positions and settings must be concerned with documentation. ASHA requires that "accurate and complete records [be] maintained for each client and [be] protected with respect to confidentiality" (ASHA, 1995).

Each school district and/or educational service unit has required forms for documentation as outlined by the State Department of Education, and are designed to conform with the regulations as stated in IDEA.

Supervision and Evaluation of Services and Providers

Documentation is an important task of the supervisor in schools. Supervisors are responsible for conducting performance appraisals of those being supervised. Performance appraisal is the practice of evaluating job-related behaviors. Professional performance appraisal is an important factor in facilitating a growth process that should continue throughout an individual's professional career (ASHA, 1993). According to ASHA, 1985, performance appraisal is conducted to:

- assist the person being supervised in the development of skills as outlined in the core roles
- assist the person being supervised in the description and measurement of his/her progress and achievement
- assist the person being supervised in developing skills of self-evaluation
- evaluate skills with the person being supervised for purposes of grade assignment, completion of the clinical fellowship requirements, and/or professional advancement

Periodically, the speech-language pathologist should evaluate the individual therapy programs to determine if the quality and quantity of therapy services are appropriate and effective for each population of student. The speech-language pathologist should be actively learning new skills and procedures in which to improve service delivery.

A licensed audiologist or speech-language pathologist who supervises communication assistants must:

- Provide direct onsite supervision for the first treatment session;
- Provide direct onsite supervision of at least twenty percent of all subsequent treatment sessions per quarter;
- Provide at least ten hours of inservice training each year, either formal or informal, which is directly related to the particular services provided by the communication assistant (this is in addition to the initial training consisting of at least 12 hours);
- Prepare semi-annual performance evaluations of the communication assistant;

- Be responsible for all aspects of patient treatment (Neb. Rev. Stat. §71-1,195.08 & 09).

Utilization of special education paraeducators in instructional settings, per 92 NAC 51 005.05, shall include: “... *the development and maintenance by the district of written procedures regarding special education paraeducators that reflect their: job description, preservice and inservice training, supervision, and evaluation. A paraeducator shall not teach, as defined in Neb. Rev. Stat 79-802.*”

The fully qualified, ASHA-certified speech-language pathologist is responsible for the services provided by assistants. In states that regulate speech-language pathology assistants, speech-language pathologists who hold full, unrestricted licenses assume these responsibilities for persons working under their direction. ASHA's 1995 guidelines define a supervisor as a speech-language pathologist certified by ASHA and licensed by the state (where applicable), who has been practicing for at least 2 years following ASHA certification and has completed at least one preservice course or continuing education unit in supervision. The amount and type of supervision required should be based on the skills and experience of the speech-language pathology assistant, the needs of the child served, the service setting, the tasks assigned, and other factors. ASHA's Code of Ethics requires certificate holders to provide "appropriate supervision." In ASHA's 1995 speech-language pathology assistant guidelines, the minimum amount of supervision suggested is 30% weekly (at least 20% direct) for the first 90 workdays and 20% (at least 10% direct) after the initial work period. Direct supervision means on-site, in-view, observation, and guidance by a speech-language pathologist while support personnel perform an assigned activity. The guidelines also recommend that a speech-language pathologist supervise no more than three speech-language pathology assistants.

Glossary of Terms

Abusive vocal behaviors: includes but not limited to chronic throat clearing, yelling, talking sharply or loudly, making strange noises, talking above or below the normal pitch, etc.

Aspiration: food or liquid goes into the trachea leading to the lungs, instead of the esophagus leading to the stomach

Auditory trainer: an amplification system where the user has a receiver and the speaker has a microphone.

Augmentative System: people who are unable to communicate verbally may utilize another communication device, such as a computer device, a communication board with pictures, sign language etc.

Dysphagia: swallowing problems due to weakness or discoordination of the muscles of the mouth and/or throat.

ENT : otolaryngologist or Ear, Nose and Throat Physician.

Functional voice disorders: The larynx does not have any lesions, nodules (bumps on the vocal cords) or other problems that would cause the voice problem.

Laryngeal function: how the larynx (voice box) moves to make sound

Los Amigos Rancho Scale: a scale from one to seven, with one being the lowest coma level, used in the hospital setting to determine what coma stage the person's behaviors exhibit. This tool is utilized by the rehabilitation team and has seven distinct descriptions for each level.

Modified barium swallow: X-ray of the person while swallowing varied consistencies of food mixed with radiographic material (barium) to view the swallow mechanism. This helps the speech/language pathologist determine the safest foods for the person or techniques to use to help safe swallowing.

Oral motor: muscle movement of the mouth, such as the tongue, lips, etc.

Organic pathologies: Includes but is not limited to, cancer or noncancerous lesions, nodules (bumps), cysts or other visible problems of the vocal cords. which would prevent the appropriate voice from occurring.

Videostroboscopy: A diagnostic test completed by the E.N.T. and speech/language pathologist to view the larynx and rule out any lesions and observe the movements of the larynx while the patient talks. This is obtained by placing a flexible tube through the patient's nose or a rigid tube to the back of the throat for viewing. The image is projected onto a television screen.

References

- American Speech-Language and Hearing Association. (1994). *Code of Ethics*. Rockville, MD: Author.
- American Speech-Language and Hearing Association. (1999). *Guidelines for the roles and responsibilities for the school-based speech-language pathologist*. Rockville, MD: Author.
- American Speech-Language and Hearing Association. (1995). *Position statement and guidelines for training, using, and supervising speech-language pathology assistants*. Rockville, MD: Author.
- American Speech-Language and Hearing Association. (1997). *Preferred Practice Patterns for the Profession of Speech-Language Pathology*. Rockville, MD: Author.
- American Speech-Language and Hearing Association. (1995). *Scope of practice in speech language pathology*. Rockville, MD: Author.
- Department of Health and Human Services Regulation and Licensure Credentialing Division. *Statutes, Rules and Regulations relating to: Audiology and Speech-Language Pathology*. (1998) Nebraska State Office Building, 301 Centennial Mall South, Third Floor, P.O. Box 94986, Lincoln, NE 68509-4986.
- Department of Health and Human Services Regulation and Licensure Credentialing Division. *Statutes Relating to Licenses, Professional and Occupational (Uniform Licensing Law)*. (1997) Nebraska State Office Building, 301 Centennial Mall South, Third Floor, P.O. Box 94986, Lincoln, NE 68509-4986.
- Gorn, S (1997). *The answer book on special education law, 2nd edition*. Horsham, PA: LRP Publications.
- Nebraska Department of Education. (1998), *Nebraska IEP technical assistance guide*. Lincoln, NE: Author.
- Nebraska Department of Education. *Rule 51-Regulations and standards for special education programs (Title 92, NE Administrative Code, Chapter 51)*. (1998, September, working draft). Lincoln, NE: Author.
- U.S. Congress. (1999, March, final regulations). *Individuals with Disabilities Education Act of 1997 (IDEA)*. Washington, DC: U.S. Government Printing Office.
- U.S. Department of Education. (1996). *18th annual report to Congress on the implementation of individuals with disabilities education act of 1992 (IDEA)*. Washington, DC: U.S. Government Printing Office.

Transportation

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Transportation As A Related Service

Students who are verified for special education services who also need special transportation services may present some unique challenges for the school district. Transportation personnel have not only the typical transportation tasks, but also need to handle the physical and behavioral needs of children needing special transportation services. The transportation personnel will, with training provided by the district, be responsible for taking appropriate safety precautions and care of children with a wide range of ages and disabilities.

Federal Definition

Transportation includes:

- ? “Travel to and from school and between schools;
- ? Travel in and around school buildings; and
- ? Specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for child with a disability.” [34 CFR? 300.24(b)(15)]

Nebraska Statute Information

“It is the intent of the Legislature that transportation services for children with disabilities be provided in the most cost-efficient manner consistent with the goal of providing free appropriate special education. The Legislature finds that educational service units and special education cooperatives created by school districts and recognized by Nebraska Department of Education (NDE) are in a unique position to improve the coordination and efficiency of transportation services in all areas of the state. It is the intent of the Legislature to authorize and encourage school districts, educational service units, and special, education cooperatives to jointly plan, coordinate, and, where feasible, provide transportation services for children with disabilities.”
[Neb. Rev. Stat. §79-1,130]

Case Law and Regulatory Information

According to 92 NAC 51, the board of education of each school district is required to furnish one of the following types of services to the children with disabilities who are residents of the school district.

- Provide transportation for any child with a disability who is forced to leave the school district temporarily because of lack of educational services,
- Provide transportation within the school district for any child with a disability who is enrolled in a special educational program of the district when either:
 - The child is required to attend a facility other than what would be the normal school of attendance of the child to receive appropriate special education services; or
 - The nature of the child’s disability is such that special education transportation is required.
- Except when a parent is transporting only his or her child, the school district shall require that the driver and vehicle meet the standards required by 92 NAC 91,92, 93, and 94, the Nebraska Department of Education *Transportation Rules*.
- The board of education shall provide transportation for all children with disabilities birth to age five including children birth to age five who are wards of the court. [92 NAC 51-014 October 3, 1999]

For children with disabilities who attend nonpublic schools, transportation is provided by the public school if it is necessary for the child to benefit from or participate in the services provided as per 92 NAC 51-015.05. A nonpublic school child with a disability must be provided transportation:

- From the child’s school or the child’s home to a site other than the nonpublic school; and
- From the service site to the nonpublic school, or to the child’s home, depending on the timing of the services. [92 NAC 51-015.05A1 and A2, October 3, 1999]

Public school districts are not required to provide transportation from the child’s home to the nonpublic school. [92 NAC 51-015.05 October 3, 1999]

Periodically the U.S. Department of Education issues “letters of clarification.” The following excerpts are five issues that need to be understood by school transportation planners. (Snyder, *School Bus Fleet*, March 1997)

- “There are two circumstances under which a school district must provide free transportation to students with disabilities. First, a district must provide the same transportation services for students for disabilities that it provides to the general

student population. Thus, if a district transports all students who live more than a mile from school, they must provide the same level of service to a student with disabilities, even if such service requires special equipment. Second, a district must provide free transportation for all students who need it in order to benefit from special education. In the latter case, transportation is considered a related service and should be included in a student's IEP."

- "The regulations for IDEA provide examples of specialized equipment that might be required to transport students with disabilities, such as special or adapted buses, lifts or ramps. But these examples ? do not constitute an exhaustive list. [Districts are] responsible for providing the equipment that is necessary to provide special transportation for a disabled student as designated in the student's IEP."
- "The goals and objectives for transportation don't always have to be spelled out in a special education student's IEP, as they do for other related services. If transportation is being provided solely to enable the student to travel to and from school, in and around school, and between schools, no goals or objectives are needed. If, however, instruction will be provided to enable the student to increase his or her independence or improve his or her behavior or socialization during travel, then goals and objectives must be included in the student's IEP."
- "IDEA regulations do not specify when a student is or isn't entitled to transportation. That determination is left up to the discretion of the student's IEP team, which includes school officials and the student's parents. In general, however, students may be entitled to special transportation if their disabilities create unique needs that make it especially problematic to get the child to school in the same manner that a non-disabled child would get to school in the same circumstances."
- School districts can offer to reimburse parents for mileage to transport their children to and from school - but they cannot require parents to provide transportation. "While it is not unreasonable for the school district to request that the parent provide the transportation on the condition of reimbursement from the public agency, it would be inconsistent with [the

regulations] to condition the provision of transportation ... on the parent's willingness to provide the service." (Hehir, 1995)

Linda Bluth, Assistant Superintendent for Compliance at Baltimore City Schools and a noted expert on special education transportation identified two additional items. First, students with disabilities who need specialized transportation as a related service should not be assigned to bus routes that require them to ride for significantly longer than children without disabilities. This, in Dr. Bluth's opinion, is a procedural violation. Second, according to Dr. Bluth, the school day should not be shortened for special education students to facilitate transportation schedules. "Sometimes the IEP committee reduces the length of a student's school day solely for the purpose of transportation, and that's a violation too," states Dr. Bluth. (Snyder, *School Bus Fleet*, March 1997)

Transportation is Intended to Serve...

Some children, as a result of their disabilities, are unable to ride on the regular school bus and sit securely on the bus seat while the bus is in motion without specialized or adapted equipment. Preschool children are usually too small and too young to climb up on the bus seat and sit still by themselves for the entire ride. Infants need special containment and are at high risk for injury if carried on others' laps. Some children with disabilities need the support of a positioning seat to keep them comfortable on the bus. Others use wheelchairs or other mobility devices at home and school. Still others have behavioral problems and need help to stay seated and quiet on the bus.

Transportation is Provided By...

According to Nebraska's school transportation rule, "A *student transportation vehicle operator's permit* is required for the driver of all vehicles used to transport one or more school children; provided that such transportation service is sponsored and approved by a school's governing board. A permit is also required for those drivers independently contracted by a military base to transport one or more children to school. This regulation is not intended to include: legally licensed operators of common carrier coach style buses which operate under the jurisdiction of the Surface Transportation Board or Nebraska Public Services Commission when used for activity trips as described in section 002.01 of this chapter; private motor vehicles used exclusively to

carry members of the vehicle owners household; small vehicles (cars and vans) used for activity purposes only; or the operation of small vehicles (cars and vans) in emergency situations, when approved by the school administrator or person designated by the governing school board. Drivers of small vehicles (cars and vans) on activity trips only shall be given instruction in emergency evacuation procedures; first aid and other instruction applicable to the group of students being transported by the appropriate local school, agency or contractor prior to such transportation activity. [92 NAC 92-003.01A]

Role of Support Personnel

It is recommended that the school clarify the roles and responsibilities of bus drivers and transportation aides. Parents need to be informed about what the driver or transportation aide can or cannot do for their child, regarding such issues as:

- buckling the child in the restraint system;
- evacuating passengers in a traffic or vehicular emergency;
- caring for a medically fragile child or acting in a medical emergency;
- controlling the transmission of communicable diseases;
- alternative courses of action if no adult is at home to receive his or her child
- managing a child's disturbing behavior. (Stewart, 1993)

Drivers and transportation aides should be given adequate training in the proper use of special equipment; the various disabilities and their effect on children's capabilities and behavior; how to respond to medical emergencies; how to manage the behavior of children with disabilities if necessary; and how to conduct emergency evacuations with wheelchairs and other specialized devices.

Entrance Criteria

The determination of whether or not a school-age child qualifies for transportation services is made by the child's IEP team based on the specific criterion found in 92 NAC 51-014. All children below age five are eligible for transportation services.

Transportation must be provided when either:

- The child is required to attend a facility other than what would be the normal school of attendance of the child to receive appropriate special education services; or

- The nature of the child's disability is such that special education transportation is required. [92 NAC 51-014, October 3, 1999]

Methods Used for Assessment

Transportation staff and other appropriate school personnel should take time to discuss each school age child's

transportation needs with the parents before school begins each year and during the annual IEP meeting. This will help assure that the related service plan can be carried out in a way that "works" for all involved. For transportation decisions, the objectives of the IEP team should include:

- Making sure that the child's restraint equipment is suitable;
- Conveying to the bus driver accurate information about the child's condition and ability, as well as any care that might be required in transit;
- Assuring that the parents understand the transportation decisions and their role in the daily routine; and
- Fostering a sense of teamwork and communication. (Stewart, 1993)

One advantage of discussing the child's transportation needs during the IEP meeting is that transportation safety issues can be discussed by the same people, and can be seen as part of the overall care and education of the child. Equally important, the selection of seating devices for use by a child at school and home can be made with transportation in mind possibly avoiding the purchase of an expensive device that cannot be used on the school bus. (Stewart, 1993)

The IEP team should resolve the following transportation issues:

- Can the student be safely transported without undue risk to the child or others?
- Will the length of the trip and/or other aspects of transportation put the child at unreasonable risk?
- Can the child's adaptive equipment be accommodated? What is an appropriate restraint system? Can the child be transferred to a bus seat from the mobility device?
- Are there specialized care or intervention concerns? What level of supervision and expertise might be required?
- How will any auxiliary equipment be transported? (Stewart, 1993)

Method to Determine Amount of Service Appropriate for Educational Benefit

Transportation is primarily an accessibility to education issue. However, other educational benefit

issues may be appropriate for a particular child. One common issue would be that of self-control and behavior management. Another is independence. Both are integrally involved in the success of the child in the general curriculum. The IEP team should discuss learning opportunities including self-control, behavior management, and independence. If it is determined that the time involved in transportation is an appropriate learning time for such issues as these, goals and objectives should be included on the child's IEP.

Exit Criteria

During the child's annual (minimum requirement) IEP review, the child's transportation needs should be reevaluated using the same criteria used for entrance into transportation services.

Workload Considerations

Of primary concern is the determination of supervision of the child during transportation. Does the child need more supervision than a driver alone can provide? If there are transportation goals and objectives on the child's IEP, who will be responsible for assuring that they are met? Will a paraeducator be needed? Is safety of the child or others in question?

Needed Equipment or Space

Which Restraint is Best for a Child with Special Needs?

There are many special conditions and a number of different options for restraint devices. Most small children with disabilities can be comfortably and securely restrained in conventional car seats. These seats are easily obtained and relatively inexpensive. Families often own them already, but in some cases they may not be suitable for accommodating the child's positioning needs.

Many larger children with disabilities that do not affect their ability to sit without support can use regular safety belts installed in school buses. Others may require special positioning or mobility devices.

Considerations for Selecting Child Safety Seats

- The child:
 - Child's height and weight;
 - Degree of support needed for trunk and/or head;
 - Control of extremities, if needed;
 - Medical need to lie flat or in a semi-reclined position;
 - Need for supervision;
 - Behavioral characteristics;
- The child safety seat (CSS) and school bus:
 - CSS must meet federal standard (213), if intended for children under 50 pounds (all safety seats meet this standard, some special positioning seats do, also);
 - CSS must fit within the confines of the school bus seat when oriented forward or rearward according to the weight of the child;
 - CSS must be able to be reclined if the child's condition requires it;
 - The school bus must be able to accommodate an additional tether, if required by the device.

Parents, bus drivers, and other members of the transportation and school staff who may need to help secure the child properly must understand the correct use of any restraint system. It is recommended that one copy of the manufacturer's instructions for the seat be kept with the seat, and another on file for reference.

Checklist for Safety Seats, Vests

- Is the infant under 20 pounds facing the rear of the bus?
- Is the angle of recline appropriate for the child's size, orientation, and condition?
- Is the safety belt in the correct place and pulled tight?
- Are the additional anchors required by the manufacturer secured?
- Is the harness over the shoulders and snug?
- Are shoulder straps in the correct harness slots at the shoulders?
- Is the harness doubled back through the adjuster slide, if this adjustment mechanism is used?
- Is the safety seat or vest under recall?

Checklist for Wheelchairs

- Is the wheelchair suitable for securement in a motor vehicle?
- Can the child be moved to a vehicle seat and be secured with a restraint system?
- If the child is to be carried in the wheelchair, has it been secured facing forward, with four tie-downs attached to the frame and adjusted to be tight?
- Has the child in the wheelchair been restrained with a separate lap and shoulder belt system that fits correctly?

Considerations for District-Provided Child Safety Seats

Should the transportation provider make available the conventional safety seats should the parents supply them? Here are some of the considerations:

- One factor is the cost. Conventional safety seats and vests that can be used by children with many disabilities can be purchased at fairly low cost. Some models provide considerable flexibility, being easy to adjust to fit different size children under about 40 to 50 pounds.
- A benefit is the ease of use for drivers, who can become very familiar with the correct use and adjustment of one or two types of devices. This makes operation smooth and can reduce hassles on the route.
- A disadvantage is that the operator must be responsible for the care and cleaning of the devices. However, this is also a benefit. The operator can control the condition of devices used on their buses, to be sure that they are in operating condition and have all their parts. Restraints owned by families may not always be complete or properly cared for.

Personal Safety Issues

Some bus drivers, aides and/or parents may have concerns regarding the type of physical contact that could occur when the harness of restraint devices is buckled and adjusted around a child. Shoulder and crotch straps are located in sensitive areas. Many child restraints have buckles located on crotch straps; others have the buckle on a stiff post under a shield, which fastens to the shell between the legs. Many have shoulder straps that are adjusted in front of the child's chest.

The district may wish to encourage parents to buckle their children into their restraints themselves whenever possible. The groin strap can be made easy to reach by laying out the harness straps, so they are ready to be put on before the child is placed in the safety seat.

Parents may want to choose a restraint with a harness that does not buckle directly in the groin area and that has a harness adjustment mechanism that is not at the chest. (Some standard safety seats have such designs.) However, there is no child restraint designed to completely avoid physical contact in either buckling, or removing the harness. If a child requires a very specialized type of equipment, parents may not have a choice of harness types.

Which children should be transferred to the bus seat?

Each district will need to determine who is to decide when it is reasonable to transfer a child from a mobility device to the bus seat. In addition, criteria and considerations need to be established to make the determination. For the busy bus driver, one consideration is the extra time a transfer may take. Other criteria and considerations are:

- Will the child's condition and weight permit the transfer?
- Has physician and parental approval been obtained to assure that a child can be moved safely?
- Who is to actually accomplish the transfer?
- Can one person do the transfer?
- Has that person or persons been trained in transfer techniques?
- In the case of a child whose mobility or positioning device does not meet the criteria for use on board the bus, the answer is clear - the child must be transferred, or an approved device used.

Attachment of Tie-downs

Tie-downs hold the wheelchair at four points, securing it in frontal and rear impacts. They must be attached to the frame of the wheelchair, not to the wheels or other weaker parts. Wheelchair manufacturers generally do not specify the best locations for these tie-downs in their instructions, since they do not want to promote the use of their equipment in motor vehicles.

Wheelchair Positions

Forward-facing wheelchairs do take up more space in the vehicle than those that face sideways do. The protective value of the forward orientation was accepted by The Eleventh National Conference on School Transportation, 1990, but has not been completely adopted in all districts or states. In many districts, older buses outfitted for side-facing orientation are slowly being replaced with new ones configured for forward-facing wheelchairs.

The placement of wheelchairs at the back of the vehicle allows for an additional wheelchair to be placed in the row, but raises concerns about the distance from the driver of those students. The possibility that the driver might not be able to monitor them adequately needs to be considered before adopting this seating arrangement.

Additional Student Equipment

The IEP team should deal with the types of protective or medical equipment that the child must use during transportation. Here are the common types that the driver may have to handle.

- **Helmets:** Passengers carrying helmets should wear them while on board the bus. Helmets are protective for people who are likely to have seizures or who have had head injuries.
- **Respirators, Tracheal Tubes:** A respirator, which breathes for a person may be attached to the battery of the wheelchair or to an additional battery. Separate batteries must be secured to prevent possible spills of battery acid. Hoses and fittings must be protected from being dislodged or broken.
- **Oxygen Bottles:** Any oxygen bottle must be secured in an upright position away from the aisle area.
- **Braces and Head Straps:** These supportive devices for arms, legs, back or neck must be used during transportation, unless otherwise specified in the IEP/IFSP or documented in some other way. It is important to avoid sudden movements or bumping people using this equipment. Their fragile condition is such that they may feel no pain in the supported areas.

Documentation

Documentation of transportation services include recommended transportation logs maintained by the driver and /or the transportation aide (if applicable); written review information maintained on the IEP; observation of driver or aide; driver or aide interviews; and parent interview. A sample form is

included at the end of this section as a suggested format to document transportation service information.

**Supervision and
Evaluation of Services
and Service Providers**

In most instances, drivers are supervised by transportation staff or in smaller districts by an assigned administrator. It is imperative that the driver also work with the appropriate IEP teams for any special transportation needs. Transportation aides are typically supervised by the special education teacher(s) of the children they work with. Evaluation of transportation aides in most cases is completed by building administrators and /or transportation supervisors.

References

- 92 NAC 51, October 3, 1999. Nebraska Dept of Education Special Education Rule.
- 92 NAC 92, September 13, 1998. Nebraska Dept of Education Transportation Rule.
- Federal Register, Vol. 64, No. 48. Friday, March 12, 1999. Rules and Regulations, page 12424.
- Heihr, Thomas. (May 1995). OSEP Letters of Clarification. Written to: Dr. Franklin L. Smith, Superintendent of Schools, District of Columbia. Office of Special Education Programs, U.S. Department of Education.
- Individuals with Disabilities Education Act. 20 U.S.C. Chapter 33. As amended by P.L. 105-17 (1997).
- Stewart, Deborah Davis (1993). Special Care for Transporting Special Kids: Getting Children with Special Needs to and From School Safely, A Manual for School Transportation Professionals. Automotive Safety for Children Program, Riley Hospital for Children. Indianapolis, Indiana.
- Snyder, William (March 1997). Overcoming the challenges of special needs transportation. School Bus Fleet.

Resources

National Organizations

National Highway Traffic
Safety Administration
(NHTSA)
Office of Occupant
Protection
400 Seventh St. SW
Washington, DC 20590

**NHTSA Auto Safety
Hotline: (800)424-9393
(for child restraint recall
lists)**

National Association for Pupil Transportation

P.O. Box 745
East Moline, IL 61244
(800)541-1519

The National Clearinghouse on School Transportation

Serif Press, Inc.
1331 H Street NW
Washington, DC 20005
(202)737-4650

Confidential Student Information
(Sample Form)

The following information must be provided by the parent/guardian of children requiring special transportation. A copy will be given to the appropriate transportation provider who has been trained in the use of confidential information. A copy will also be attached to the child's IEP and reviewed at each IEP review.

Child's Name: _____ Date of Birth: _____

School: _____ School Year: _____

Home Address: _____ Zip Code: _____

Parent/Guardian: _____ Hm Phone: _____

Mother's Wk Phone: _____ Father's Wk Phone: _____

A.M. Pickup Location: _____ Phone: _____

P.M. Drop-off Location: _____ Phone: _____

Emergency Contacts:

Name: _____ Phone: _____

Name: _____ Phone: _____

Emergency Medical Information:

Child's Doctor: _____ Phone: _____

Hospital Preference: _____ Address: _____

Allergies: _____

Current Medication: _____ Dosage: _____

Special Instructions for Attending Physician: _____

Check All That Apply:

- ? Verbal ? NonVerbal? Ambulatory ? Nonambulatory
? Epileptic ? Hemophiliac ? Mental Retardation ? Visually Impaired
? Hearing Impaired ? Diabetic ? Medically Fragile

Special Bus Equipment:

- ? Wheelchair ? Safety Vest ? Car Seat ? Lap Belt
? Other:

Special Instructions for Managing Child:

(Place Photo Here)

Signature: Parent/Guardian:

Date
