AOTA Practice Advisory on Occupational Therapy in Response to Intervention

Scope of Practice

Occupational therapy practitioners[1] are highly qualified, licensed professionals who work in the school setting. They have expertise in promoting the function and engagement of all children in their everyday routines to support school participation. Addressing activities of daily living, rest and sleep, play, education, and social development are key components of occupational therapy practice.

The fundamental background of occupational therapy practitioners is rooted in concepts related to promoting meaningful participation, optimum development, and engagement within natural contexts or least restrictive environments. These are core principles of both the profession of occupational therapy as well as early childhood and school practice. As a primary service under Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), occupational therapy practitioners collaborate with early childhood and school teams to promote the physical, communication, cognitive, adaptive, and social-emotional domains of infants and toddlers. As a related service under Part B of IDEA and a pupil service under Elementary and Secondary Education Act (also known as No Child Left Behind), occupational therapy practitioners support children and youth by promoting participation in home, school, and community life.

Response to Intervention (RtI), an early intervening service, is a multi-tiered approach within general education that provides services early to struggling learners to facilitate school success. RtI addresses both the academic and behavioral health needs of all students, particularly those at risk. This approach, that requires collaboration from all school personnel, involves universal screenings; high-quality, evidence-based instructional methods and interventions; data collection and data-based decision-making; and progress monitoring. It is provided at increasing levels of intensity, or tiers, moving from school wide, to small group, and then to individual interventions as needed. The focus is on those students within general education who may not yet be identified for special education services but are struggling with behavior and/or academics that impact learning. Services may be directed toward systems (such as curricular modifications), classrooms, or students and may include such supports as universal screenings, positive behavioral supports, and professional development provided to educators and other school staff. There may be recommendations regarding classroom or assignment modifications or adaptations provided to the teachers, and group and/or individualized instruction based on progress monitoring and guided by the response to the instruction.

Successful implementation of this approach, which is beginning to be expanded into early childhood, middle, and high school environments, may increase student performance, decrease the number of referrals to special education, and reduce the number of students identified as

[1] When the term occupational therapy practitioner is used in this document, it refers to occupational therapists and occupational therapy assistants (AOTA, 2008).

having an educational disability, particularly the disproportionate number of minority and low income students (Blanchett, 2006; Guiberson, 2009). It may also facilitate a more seamless continuum between general and special education by providing supportive services to students who would traditionally not be found eligible for special education despite academic achievement difficulties. This could include students who struggle owing to transience, insufficient school experience, limited English proficiency, or social and economic disadvantages.

The domain of occupational therapy is to "support health and participation in life through engagement in occupation (American Occupational Therapy Association [AOTA], 2008, p.627)." The practice of occupational therapy is defined as "the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings (AOTA, 2011, p.1)." In serving their clients, occupational therapy practitioners can assume a leadership role in schools to support student participation in both academic and functional performance and social participation. In schools, the term *client* has a broad definition and includes persons, such as students, families, and educators; organizations, such as schools; and populations within a community, such as children with autism (AOTA, 2008). Occupational therapy practitioners have specific knowledge and skills that aid in facilitating successful learning environments for students. They are skilled in activity and environmental analysis and modifications that promote occupational performance. They have the expertise to offer assistive technology and universal design for learning strategies. During team decision making and data gathering in both general and special education, they can provide valuable information about underlying factors that influence school participation, such as neuromuscular factors, sensory processing, social participation, and mental health.

Occupational therapy practitioners use a variety of service delivery models, including direct and indirect approaches within school-based practice. One type of indirect service involves consultation. The consultative role is supported by language within IDEA Section 614(d)(1)(A)(i)(IV) that states that special education and related services can be provided "to the child, or on behalf of the child, and [as]…program modifications and supports for school personnel." Within school-based practice, AOTA endorses a paradigm shift from a medical model of *caseload* to an educational model of *workload* (AOTA, 2006). This shift expands the role of occupational therapy beyond direct service delivery to include such activities as participating in curriculum development committees and/or supporting the development of school-wide initiatives such as bullying prevention programs.

Professional Preparation and Qualifications

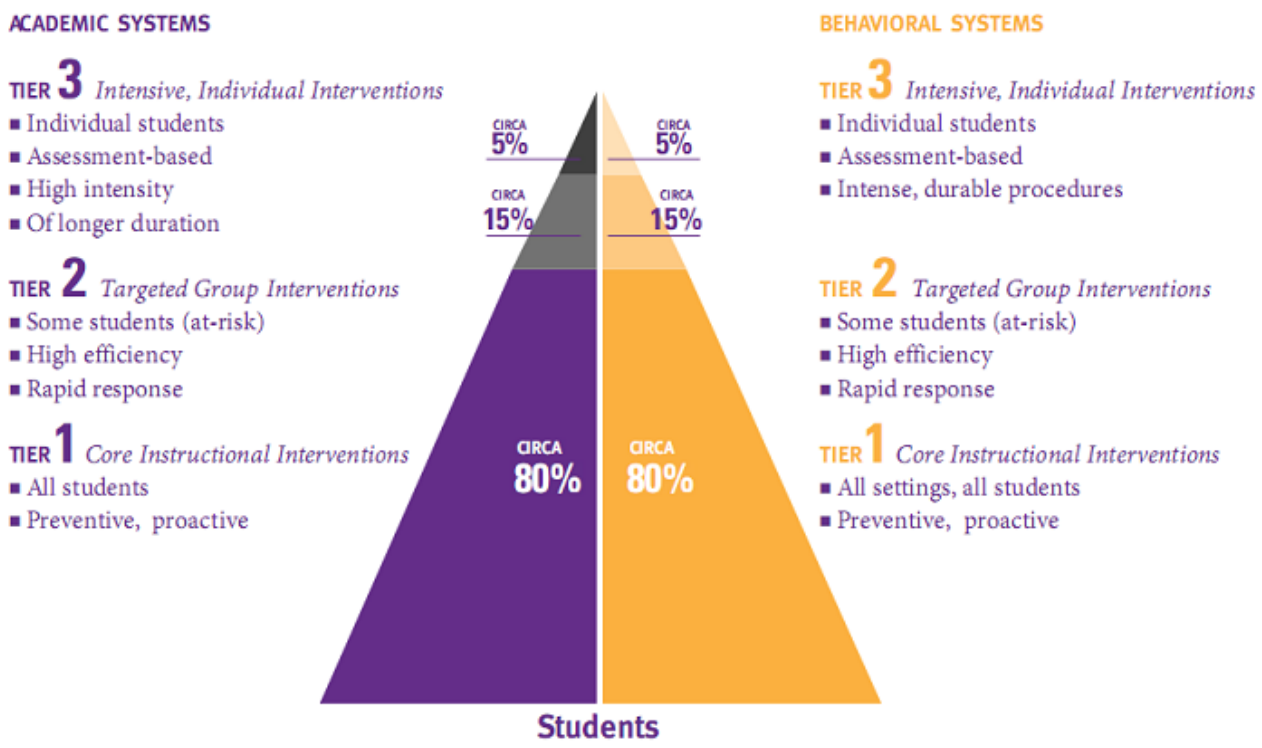
Occupational therapy practitioners complete an accredited educational program curriculum, supervised fieldwork, and a national certification examination. These processes form the basis for state credentialing (usually licensure) of practitioners. Their standards-based curriculum prepares them to analyze and understand occupational performance and behavior when considering the activity demands and the environmental context. Their background includes areas such as anatomy, neurophysiology, sensory processing, development, and mental health. School-based practice is a critical component within the occupational therapy curriculum.

More than 20% of the occupational therapy workforce in the United States provides services in America's public schools, and more than 60% of the occupational therapists who work in schools are employed directly by local education agencies or school districts (AOTA, 2010). Occupational therapy is designated as a related service under IDEA. According to IDEA, related services include "developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education." The role of occupational therapists prior to IDEA had been limited to screening and evaluating students who receive, or are being considered to receive, special education; providing direct services to students who were found eligible for occupational therapy services and special education; and consulting with general and special education teachers, as well as other personnel, to support students receiving special education (Dunn, 2000). The 2004 IDEA legislation also allowed for occupational therapy practitioners to act as providers of early intervening services for students in general education who do not receive special education or related services (U. S. Department of Education, 2007). Occupational therapy practitioners are expanding their roles from primarily direct service delivery models to address the more complex demands in the school setting. Data collected through the 2010 Occupational Therapy Compensation and Workforce Study found that school-based practitioners spent 62% of their time providing direct client intervention and 34.4% of their time on indirect intervention, administrative work, and/or consultation (AOTA, 2010).

The RtI Model

Many states and local districts use a three-tiered RtI framework. In the three-tiered model, the first tier typically includes scientifically driven, high-quality instructional, behavioral, and social-emotional instruction and supports for all students in general education. Core curricula and universal interventions (e.g., a school-wide positive behavior support program) are typically included in this tier. Universal screenings, both school wide and classroom specific, are often used to determine whether students are learning the curriculum content and/or whether behavioral performance is commensurate with the expectations established for the age and/or grade of the students. Research has demonstrated that for both learning and behavior, 80% or more of students should be performing at expectations established for this first tier of instruction and support. If the number is less than 80%, general education leadership examines the scope and sequence of the curriculum, its alignment with established national and state academic standards, and the instructional practices typically used by the faculty. In some cases, specific teachers, or the entire faculty, will be provided with additional mentoring or coaching regarding instructional methodologies or behavioral management.

Figure 1: Three-Tier Model of School Supports

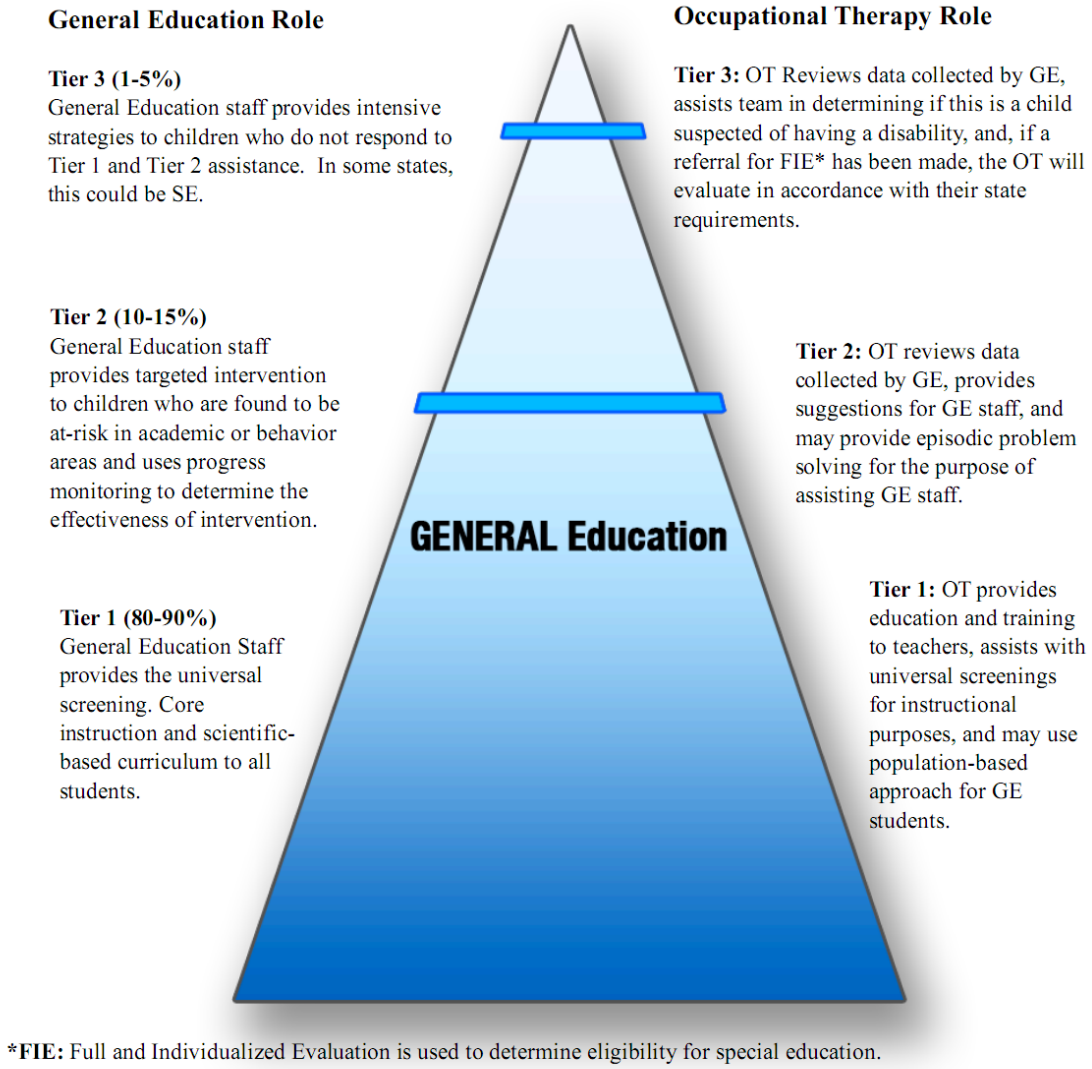


Source: National Association of State Directors of Special Education, 2010.

Based on time frames established and adopted by local education agencies, students are screened again. It would be expected that 20% or less of the students would still be having difficulty (NASDSE, 2010). Targeted intensive prevention or remediation for some students may be initiated if their performance or rate of progress is determined to be less than adequate based on the typical expectations for their grade level and educational program. Once these students are identified, school-based problem-solving teams, composed of professionals from a variety of different professional disciplines, including occupational therapy, may convene to develop strategies for addressing the needs of these students. Often, the problem-solving team will engage in a four-step process to (1) identify the problem, (2) generate hypotheses that account for the cause of the problem, (3) develop and implement a plan to address the problem that is conceptually congruent with the proposed hypotheses, and (4) evaluate the effectiveness of the plan to diminish the problem (Fuchs, Mock, Morgan, & Young, 2003; Telzrow, McNamara, & Hollinger, 2000). Interventions recommended by the team as the result of problem solving may include implementing alternative instructional methodologies or providing more intensive instruction, such as tutoring sessions for the problematic content area. Once these interventions are implemented, the students are screened again. Based on evidence in the education literature (Reschly, 2005), it would be expected that Tier 2 interventions would be effective for another

15%, leaving no more than 5% of the students needing more specialized general education services (e.g., Title 1), or a special education referral. Tier 3 is intensive 1:1 interventions for students who did not respond sufficiently to Tier 1 and Tier 2. Interventions at Tier 3 are based on an individual student's needs, often provided to students individually or in pairs, and data is collected, at a minimum, on a weekly basis (VanDerHeyden & Burns, 2011). In many cases, Tier 3 interventions are designed to provide the team with information related to the cause of a specific student's learning difficulty. In some cases, a student in Tier 3 may participate in a comprehensive evaluation to determine eligibility for special education and related services (Brown-Chidsey & Steege, 2005). It is important to note that RtI is not to be used in lieu of special education when needed.

Occupational Therapy Within the RtI Model



***FIE:** Full and Individualized Evaluation is used to determine eligibility for special education.

Copyright © 2010 by Gloria Frolek Clark. Used with permission.

Under an RtI model, occupational therapy can offer valuable strategies and interventions along the tiered continuum of intensity. For example, in Tier 1, the therapist may conduct a workshop for educators for professional development on sensory processing, conduct handwriting screenings for all kindergarten students, make recommendations associated with classroom management, or provide new teachers with support when developing their classrooms' routines. In Tier 2, the therapist may recommend seating modifications to benefit small groups of struggling students in general education to promote better student outcomes or collaborate with a teacher to develop an intervention to support a small group of students who are struggling with the transition between printing and cursive. In Tier 3, the therapist may recommend sensory strategies for a specific child as needed or make recommendations related to organizational strategies to a team that is concerned with a student's ability to complete and turn homework assignments in on time. The occupational therapy practitioner could also be involved in collecting progress monitoring data related to these interventions to determine their efficacy and support the team to make adjustments to the interventions as needed. In addition to collecting progress monitoring data, the therapist can work with school teams to analyze the data and make recommendations related to when a student or group of students would benefit from receiving more intensive intervention in a different RtI tier.

Practice Considerations

Not all states have adopted an RtI approach. The requirements for delivering RtI services vary between states. State language or terminology related to RtI and the state requirements for providing occupational therapy services in general may also differ. Occupational therapy practitioners should review their state practice acts before providing these services to be sure that the language in their licensure laws aligns with providing prevention and pre-referral activities. State practice act referral and evaluation procedures should be carefully reviewed to ensure compliance with the RtI model before occupational therapy practitioners provide care. Practitioners may also consider contacting their state boards of education for further information regarding RtI in specific school districts. Other state-specific practice considerations include billing procedures, progress monitoring, and the structure of tiered interventions.

Resources

Membership in a national professional organization such as AOTA provides access to quality resources and constituent support specific to working in school-based practice. AOTA resources include:

- FAQ on Response to Intervention
- Fact Sheet on School Mental Health
- FAQ on School Mental Health
- SPCC on Mental Health Promotion, Prevention, and Intervention With Children and Youth
- AOTA CEonCD™ on RtI
- Consumer Brochure on RtI
- Role of Occupational Therapy in School-Based Practice
- Fact Sheet on Role of Occupational Therapy in Schools
- Fact Sheet on Role of Occupational Therapy in Universal Design for Learning
- Transforming *Caseload* to *Workload* in School-Based and Early Intervention Occupational Therapy Services

- FAQ for Educators: Help All Students Achieve Greater Success in Academic Performance and Social Participation
- Official Document: Occupational Therapy Services in Early Intervention and School-Based Practice
- *Collaborating for Student Success: A Guide for School-Based Occupational Therapy*
- *Occupational Therapy Services for Children and Youth Under IDEA, 3rd Edition*

AOTA participates in national discussions about RtI with various organizations, including the IDEA Partnership, RtI Action Network, and RtI Center. Links to these coalitions, along with RtI tools such as collections of articles and continuing education resources, can be found on the AOTA Web site, at http://www.aota.org/Practitioners-Section/Children-and-Youth/Browse/School/RtI.aspx
Other AOTA resources for professional development include the Early Intervention & School System Special Interest Section, Pediatric Board Certification, professional newsletters and journals, and OT Connections forums. For more information, visit http://www.aota.org/Practitioners-Section/Children-and-Youth/Browse/School.aspx and http://www.aota.org/Practitioners/PracticeAreas/Pediatrics.aspx

References

American Occupational Therapy Association. (2010). *AOTA 2010 occupational therapy compensation and workforce study*. Bethesda, MD: Author.

American Occupational Therapy Association. (2011). *Definition of occupational therapy practice for the AOTA Model Practice Act*. Bethesda, MD. Retrieved May 8, 2012, from http://www.aota.org/Practitioners/Advocacy/State/Resources/PracticeAct/36437.aspx?FT=.pdf

American Occupational Therapy Association. (2008). Occupational therapy practice framework: Domain and process (2nd ed.). *American Journal of Occupational Therapy*, 62, 625–683. doi:10.5014/ajot.62.6.625

American Occupational Therapy Association. (2006). *Transforming caseload to workload in school-based and early intervention occupational therapy services*. Retrieved from http://www.aota.org/Consumers/Professionals/WhatIsOT/CY/Fact-Sheets/38519.aspx?FT=.pdf

Blanchett, W. (2006). Disproportionate representation of African American students in special education: Acknowledging the role of white privilege and racism. *Educational Researcher, 35*(6), 24–28.

Brown-Chidsey, R., & Steege, M. (2010). *Response to Intervention: Principles and effective strategies*. New York: Guilford Press.

Dunn, W. (2000). *Best practice occupational therapy: In community service with children and families*. Thorofare, NJ: Slack.

Frolek Clark, G., & Polichino, J. (2010). *Response to Intervention (RtI) for at-risk learners: Advancing occupational therapy's role in general education*. Bethesda, MD: American Occupational Therapy Association.

Fuchs, D., Mock, D., Morgan, P., & Young, C. (2003). Responsiveness-to-intervention: Definitions, evidence, and implications for the learning disability construct. *Learning Disabilities Research & Practice, 18*, 157–171.

Guiberson, M. (2009). Hispanic representation in special education: Patterns and implications. *Preventing School Failure, 53*, 167–176.

National Association of State Directors of Special Education. (2010). Response to Intervention: Policy considerations and implementation. Alexandria, VA: Author.

National Association of State Directors of Special Education. (2006). IDEA Partnership Project. Retrieved from http://www.ideapartnership.org/

Individuals with Disabilities Education Improvement Act of 2004. Pub. L. 108-446.
Reschly, D. J. (2005, December). *Response to Intervention (RtI) in general remedial and special education*. Paper presented at the 2005 IDEA and NCLB Collaboration Conference, Arlington, VA.

Telzrow, C., McNamara, K., & Hollinger, C. (2000). Fidelity of problem-solving implementation and relationship to student performance. *School Psychology Review, 29*, 443–461.

U.S. Department of Education. (2007). *Questions and answers on response to intervention (RTI) and early intervening services (EIS)—Question E-3*. Retrieved from http://idea.ed.gov/explore/view/p/%2Croot%2Cdynamic%2CQaCorner%2C8%2C

VanDerHeyden, A., & Burns, M. (2011). *Essential of Response to Intervention*. Hoboken, NJ: Wiley.

Authors

The AOTA Response to Intervention Workgroup (2012):

Sue Bazyk, PhD, OTR/L, FAOTA
Michael Berthelette, MSM, OT/L
Susan Cahill, PhD, OTR/L
Gloria Frolek Clark, PhD, OTR/L, BCP, FAOTA
Cathy Csanyi, MA, OT
Sharon McCloskey, OTR/L
Beatriz McGuire, OTR/L
Carole Ivey, PhD, OTR/L
Leslie Jackson, MEd, OT, FAOTA
Ellen Harrington Kane, OT, MS
Laurie Olson, PhD, OTR/L, FAOTA
Jean Polichino, MS, OTR, FAOTA

Sharon Ray, ScD, OTR/L
Suzanne Sanchez, OT
Judie Schoonover, MEd, OTR/L, ATP
Tim Nanof, MSW, AOTA Staff
Sandy Schefkind, MS, OTR/L, AOTA Staff