Province of British Columbia
Ministry of Health and
Ministry Responsible for Seniors

CHILD DEVELOPMENT AND REHABILITATION SECTION

PROGRAM GUIDELINES:

SCHOOL-AGED THERAPY PROGRAM - OCCUPATIONAL THERAPY AND PHYSIOTHERAPY

First Edition: April 1992
Revised: January 1995
Reprint: April 1995

Province of British Columbia
Ministry of Health and
Ministry Responsible for Seniors

CHILD DEVELOPMENT AND REHABILITATION SECTION

PROGRAM GUIDELINES:

SCHOOL-AGED THERAPY PROGRAM - OCCUPATIONAL THERAPY AND PHYSIOTHERAPY

First Edition: April 1992
Revised: January 1995
Reprint: April 1995

Copies of this Handbook can be acquired from:
Child Development and Rehabilitation Section
Ministry of Health and Ministry Responsible for Seniors,
Province of British Columbia,
Courtyard Level
1520 Blanshard Street,
Victoria, British Columbia
V8W 3C8

TABLE OF CONTENTS

I. INTRODUCTION

It is now widely believed that access to a continuum of occupational therapy and physiotherapy services is required to assist individuals who need extra support to achieve their goals at various stages throughout their lives. Occupational therapy and physiotherapy service delivery has been well established in Early Intervention Programs in many communities in British Columbia and has now been extended to school-aged children and their families. The School-Aged Therapy Program has been designed to focus upon the developmental tasks and roles of children of school age. In this program, occupational therapists and physiotherapists collaborate with families, with educators and with other service providers to provide services to school-aged children.

Ministerial Order 150/89 (M150/89) of the *School Act* maintains that "unless the educational needs of a handicapped student indicate that the student's educational program should be provided otherwise, a board shall provide that student with an educational program in classrooms where that student is integrated with other students who do not have handicaps". This statement indicates a commitment to providing educational programs, whenever possible, in ordinary settings, which facilitate the learning and enhance the self-concept of children who need extra support. Individual differences and particular needs must always be considered when planning educational programs for any child. Students are persons with distinct characteristics and with diverse skills and abilities which are influenced by a learning environment. Most children benefit from education in a regular classroom in their own neighbourhoods.

Ideally, educational programs should be capable of meeting the learning needs of all students. In many classrooms in British Columbia learning experiences and teaching methods are characterized by flexibility so that individual learning needs can be accommodated. Teachers fulfil a wide variety of needs by adapting teaching materials and equipment, by altering the pace of instruction and by utilizing specialized support services. The principle of individualized learning implies that learning is continuous and that students work towards learning outcomes at their own rates depending on individual differences. By understanding that students learn in diverse ways and at different rates, educators utilize their ingenuity and call upon their teaching skills to meet the needs of a wide variety of learners.

Teachers often benefit from assistance in discerning the best ways to meet the educational goals of children with a wide variety of needs. Teachers may also find it useful to acquire specialized skills to assist children with behavioural problems, communication disorders or with physical or mental disabilities to participate actively in the classroom. Parents and teachers may need assistance in determining the best educational settings for specific students so that their individual needs can be most effectively accommodated.

For this reason, in the province of British Columbia, physiotherapists and occupational therapists are critical in facilitating integration. Physiotherapists and occupational therapists play a collaborative and supportive role. Teachers and parents seek their expertise in meeting the educational needs of children with complex challenges and in integrating rehabilitation strategies with educational goals. Occupational therapists and physiotherapists must be prepared to consult, to assess and to monitor, to teach skills, to suggest adaptations to equipment and to the environment and to support parents, teachers and administrators. They also provide support and instruction to teacher assistants and to anyone else who aids in the instructional program. In addition, they offer assistance to the nursing care coordinators who supervise the nursing care given to some students with special needs. Because occupational therapists and physiotherapists provide support services to teachers and to their assistants, their intervention should be viewed as potentially having a positive effect upon all of the students in the classroom.

The *Inter-Ministerial Protocols for the Provision of Support Services to Schools*, established the framework for a collaborative approach between the Ministry of Education and the Ministry of Health and Ministry Responsible for Seniors regarding therapy services for school-aged children with special needs. The Ministry of Health developed the guidelines and standards to reflect the following intentions regarding the School-Aged Therapy Program:

- that there be collaboration among parents, teachers and health care workers;
- that the transition of young people with special needs into and out of school be facilitated;
- that the School-Aged Therapy Program operate both in the schools and in other settings;
- that health care agencies be responsible for developing, delivering and monitoring service;
- that funding for the School-Aged Therapy Program be shared equally between the Ministry of Education and the Ministry of Health and Ministry Responsible for Seniors.

Occupational therapists and physiotherapists who work within the School-Aged Therapy Program are committed to the individual child and family as well as to the larger issue of inclusion. They can assist children and families requiring continuing intervention to prepare for and to make the transitions from other programs. They support school staff who are striving to meet the needs of all of the children in the province. It will be partly as a result of their dedication and expertise that students who need extra support in British Columbia will be successfully included in educational and community settings.

II. PHILOSOPHY

The attitudes of those who are working with children who need extra support are a significant factor in the success of integration. All of those who work in educational settings must examine their own impressions about children with special needs and about people with disabilities, generally. They must acknowledge these feelings before they can satisfactorily respond to questions and concerns raised by other parents and students. It is critical for them to be capable of looking past the disability in order to perceive each child as a unique and remarkable being with strengths, talents, abilities and preferences as well as needs. Only then can they become positive role models, conveying understanding and acceptance of all children.

It is necessary for those who are accustomed to associating with children who have special needs, to support and assist those for whom this experience is a new one. Occupational therapists and physiotherapists have often had more opportunity to work with children who need extra support than have school staff. It may be helpful for them to offer specific information about students' conditions or disabilities, but, at the same time, they can emphasize that focusing on labels may cause people to have limited or inaccurate expectations of what students are capable of doing and may lead them to lose sight of children's uniqueness and to alter their behaviour towards them. In this way, occupational therapists and physiotherapists can assist others to view every child as a whole child who has an individual personality as well as strengths, interests, likes and dislikes, all of which are important components in individualized planning for education.

Collaborative consultation is the means by which occupational therapists and physiotherapists can best offer support to teachers who are including students with complex challenges in their classrooms. By collaborating to develop strategies which support the student's educational goals, teachers and therapists assist the student as learner. All of the members of the collaborative team should agree on the educational priorities of the student who needs extra support and apply the skills and expertise of their disciplines to realize these shared goals. Team plans should indicate the most appropriate member of the team to carry out specific activities. In support of educational goals, physiotherapists and occupational therapists develop techniques which can be

demonstrated to parents, educators, teacher assistants and community workers who integrate them at home, in the classroom and in community settings. As part of the collaborative team, parents communicate to teachers and therapists, the goals and aspirations that they have for their children. Physiotherapists and occupational therapists can support the families of students with special needs by assisting them to implement rehabilitation goals which support educational objectives and which work in the home, school and community. They can help parents to integrate their child into other community settings and act, with parents, as advocates for young people who need extra support.

III. PROGRAM CRITERIA

The program criteria indicate the precepts by which the School-Aged Therapy Program operates.

A. Student-Centered

The School-Aged Therapy Program exists primarily to assist students who have special needs to improve their ability to function in educational settings as well as at home and in community settings. Occupational therapists and physiotherapists support others who are assessing or working with students to act with sensitivity, understanding and consideration. All those who work with young people with special needs should have a thorough understanding of normal growth and development. At the same time they must be flexible in their expectations of all students because they realize that every person has an individual pace and a characteristic learning style. They should be aware that unconventional approaches may be the best ways for some students to attain educational goals. Based on a philosophy of respect and courtesy, on a strong background in child development and on a flexible view of education, those who work in the School-Aged Therapy Program enhance the lives and increase the benefits of education for many students in the province. Occupational therapists and physiotherapists must be familiar with the students' roles in community, family and educational settings and plan services appropriate to each student's goals.

B. Family-Focused

The School-Aged Therapy Program as well as educational reform initiatives regard the student's family members as the pivotal individuals in the life of the child and as partners in service planning and provision. Members of the collaborative team should be aware of the aspirations and hopes of the parents and the life goals that they have for their child. Although service providers can assist parents to have realistic expectations concerning their child, they need to respect the goals that parents have developed. Family members are part of the collaborative school-based team and are involved in the development of the Individual Educational Plan (IEP). When contacting a family, it is important to recognize and to appreciate that parents of students who need extra support have varying personal and family responsibilities. Families may choose to involve themselves in their children's educational planning in diverse ways. However, all

parents need to be encouraged to participate and to be given every opportunity to be included on the team. They should receive information regarding their child's progress, regularly. Their advice and wishes should be solicited and respected throughout the planning process.

C. Collaborative Model

The School-Aged Therapy Program utilizes a collaborative team approach as the most effective way of assuring high standards. The collaborative team includes parents and service providers working in an environment of equality and mutual respect. Physiotherapists and occupational therapists take an active role on the collaborative school-based team. They work with parents and teachers to develop Individual Educational Plans (IEP's) for students. They support parents and school staff by assisting them to establish realistic expectations for individual students and by helping them to focus on the whole child in the educational environment. The child's teacher or another educator may act as team manager, coordinating a variety of services and facilitating the collaborative school-based team. This arrangement utilizes the teacher's familiarity with the student and the environment in which he or she functions. This, in turn, increases the possibility that individual learning objectives will be well integrated into the student's day. The parents and the teacher usually guide the team in making recommendations concerning the educational goals for the student and, with service providers, plan how these goals can be supported. It is critical for the physiotherapist and occupational therapist to communicate with the child's teacher frequently, so that therapeutic goals always support educational goals and so that therapy can become part of the daily routine of the student who needs extra support. For a more detailed discussion of the collaborative approach and the process of collaborative consultation, please refer to Appendices A and B.

The primary role of all members of the support team is the provision of services that will help children to benefit from their educational or community programs. All of the therapists' activities contribute to this purpose, whether they are providing therapy, consulting with other staff, supporting and monitoring others who conduct motor activities or participating in the process of establishing personalized learning goals. Underlying all of these activities is the collaborative process.

The collaborative consultation process was introduced into education as a means of systematically addressing the diverse educational needs of children with disabilities. A typical school-based team includes parents, teachers, teacher assistants, administrators, psychologists and the related service providers (OT, PT, and speech-language pathologist). A child who has an orthopaedic impairment, an intellectual disability and a speech disorder clearly presents a multiplicity of needs that require the expertise of people from many disciplines. However, unless these specialists work collaboratively and regularly exchange information, they may each see the problems in their areas as paramount and may be inclined to de-emphasize difficulties in other areas, perhaps to the detriment of the child's progress. When the collaborative process in the school is used, the teacher may consult the speech-language pathologist to help the child to develop the functional communication needed for other learning. The speech-language pathologist, in turn, may rely on the physiotherapist and occupational therapist to determine effective positioning, to assist the child to increase breath control and to facilitate the student's handling of learning materials. No single discipline has all of the answers. In fact, rarely, can a single discipline even ask all of the necessary questions. People from different disciplines who trust one another's judgement, who learn from one another and who work together are able to carry out comprehensive and coherent educational programs.

The collaborative team is a group of people who work together to achieve a common goal. In order to do this, all team members must be committed to the following:

- focusing their efforts on addressing the needs of school-aged children by integrating assessment information and by developing goals based on input from the family and all pertinent disciplines;
- meeting periodically, whether formally or informally, to exchange information and to keep one another abreast of changes in the child;
- demonstrating a high level of competence in their own disciplines and respecting the contributions of other professionals;
- demonstrating respect for the contributions of the family by actively seeking ways to incorporate recommendations into the child's goals;

- consciously and continually working to educate other team members in their own disciplines by welcoming questions and explaining terms and concepts in ordinary language;
- planning rehabilitation goals that will enhance the child's participation in the home and in educational or community programs.

D. Competent and Qualified Staff

Physiotherapists and occupational therapists who work in the schools must have special skills in addition to those which make them competent clinicians. They must have a strong belief in meeting individual needs in any environment. They must have excellent team skills as well as problem-solving skills, because it is by means of the collaborative team that decisions about educational programs and the integration of rehabilitation goals with educational goals occur. They must have considerable teaching skills because, instead of delivering therapy directly, they frequently support others in implementing activities to support the goals of the child. They monitor the child's program, evaluate progress and assess. Physiotherapists and occupational therapists working in the schools must be versatile individuals who are good communicators. They must appreciate working in an environment which demands flexibility, for the school may have little in the way of adaptive equipment and may have limited space and many barriers. They must have developed rapport with young people because, in an educational setting, other students often participate in therapeutic activities.

E. Use of Documentation

Physiotherapists and occupational therapists in educational settings document according to professional and organizational standards. Documentation should be appropriate to the educational setting. The purpose of documentation is to provide a clear, accurate record for teachers, families, and service providers concerning the child's progress. Documentation is geared towards specific goals for each student. Physiotherapists and occupational therapists use a method of documentation that provides information about expected outcomes, how service is being delivered and the degree to which the service meets the needs of the student, the family and the school. The language used in any documentation is clear, concise and free of jargon. Parents as well as schools receive copies of all reports written. Examples of documentation reports can be found in the *School-Aged Therapy Program: Resource Manual.*

F. Confidentiality

Confidentiality is maintained in all settings at all times. Information-sharing must conform to the requirements of *The Freedom of Information and Privacy Act.* For the purpose of research and program development, findings and statistical conclusions may be released providing individuals are not identified. For occupational therapists and physiotherapists to function effectively parents must agree to share relevant information with schools and therapists. Appropriate release and consent forms should be signed.

G. Medical Consultation

Effective January, 1995, all physiotherapists in British Columbia must be registered with the College of Physical Therapists of British Columbia. Physicians' orders will not be required for physiotherapy service. School physiotherapists may be either chartered or registered. Occupational therapists are not required by law to have a physician's referral in order to provide service. However, therapists should maintain contact with the students' physicians and draw on medical support whenever necessary.

IV. PROGRAM GOAL

Physiotherapy and occupational therapy services in school, home and community settings are provided to school-aged children with special needs so that they may benefit from educational and community programs. The primary goal of the School-Aged Therapy Program is to offer these services to meet the needs of the students as well as to offer a spectrum of services to persons working with them.

The major objectives of the program are:

1. to maintain, monitor or improve students' physical or motor functioning;
2. to assist school-aged children to meet their educational goals;
3. to work with family members, teachers and teacher assistants to help them to integrate activities into the daily routines of students at home, in the community and in educational settings which assist students to meet their goals;
4. to support parents, caregivers, teachers and other service providers who work with school-aged children;
5. to facilitate each child's transition from one program to another, eg. transitions from preschool to school, primary through graduation, school to adult programs;
6. to foster inter-agency cooperation with all ministries and agencies involved in providing support to school-aged children with special needs and their families.

V. POPULATION SERVED

School-aged children with special needs include those with visual, hearing or physical disabilities; chronic health problems; speech and language disorders; severe learning disabilities; severe behavioural disorders and intellectual disabilities. All school-aged children who have special needs who require individualized plans and services should have access to appropriate interventions. In British Columbia, children who attend public, independent or alternative schools as well as children who are in education programs at home all have the right to appropriate intervention for the purpose of enhancing their ability to function.

The School-Aged Therapy Program is a multi-phase program. Initially, it will focus on the children who have the greatest need for physiotherapy and occupational therapy services. As additional resources are made available the program will be expanded.

VI. PHYSIOTHERAPY AND OCCUPATIONAL THERAPY SERVICES

Occupational therapists and physiotherapists provide services that help children to achieve their highest possible level of independent functioning within the home, the school and the community. These services may include screening, assessment, program planning, intervention, consultation, administration, education and research.

Occupational therapists provide services that promote the quality of movement and posture including fine motor function, splinting and motor planning. They are also concerned with visual motor function, sensory processing and independence in self-care, productivity and leisure, including feeding and dressing, functional mobility, transfers and mobility. They assist in the enhancement of community living skills, including prevocational and vocational skills. They help the child to develop social skills and appropriate behaviour.

Physiotherapists provide services to promote the quality of gross motor function and posture and to develop motor skills. They are also concerned with preventing and/or controlling joint deformities and postural deviations. They promote safe, independent mobility and provide and assist in the use of splints, braces and prosthetic devices. They teach safe lifting, carrying and transfer techniques. They consult on environmental adaptation to enhance the independence of students.

When working with school-aged children, physiotherapists and occupational therapists employ a functional approach to therapy. This approach aims to help school-aged children participate fully in educational and community programs by providing intervention that focuses on generalization, independence and transition within the context of any environment in which the child functions. Therapy becomes more functional when an individual is able to generalize new skills beyond the therapy situation and apply them elsewhere. A functional approach to therapy strives to provide school-aged children with skills and adaptations that allow them to become as independent as possible in a variety of environments. It also attempts to assist students and their parents to make transitions from one setting to another. Practitioners of functional therapy view young people from a broad perspective that includes the many environments in which they live

and are expected to live in the future.

When working with school-aged children, the services of occupational therapists and physiotherapists may also include:

- providing a liaison between home, school and community;
- working closely with teachers, parents and other personnel to provide programs;
- assisting teachers, teacher assistants, parents and other personnel to present tasks and materials most appropriate to individuals;
- assisting with transitions to a new school or environment;
- interpreting medical information and its implications for the student;
- referring to appropriate community and/or medical services;
- promoting effective use of leisure time;
- assessing the educational and community environments to prevent, modify or alleviate barriers in order to facilitate the functioning of children with disabilities;
- recommending specialized equipment or modifications to promote independence;
- providing information and training in a variety of areas including: overviews of disabilities and their effects on school performance; back care; proper techniques for lifting, handling and transferring students with physical disabilities; disability awareness and implications for other students and teachers in the school;
- suggesting seating and positioning techniques;
- recommending adaptations to physical education activities and recreation programs to facilitate the functioning of children with disabilities;
- assisting the school to develop individualized evacuation procedures for emergencies;
- referring to community resources for further information.

VII. PROFESSIONAL ACTIVITIES

The School-Aged Therapy Program supports a student's educational goals through various types of intervention. Occupational therapists and physiotherapists collaborate with parents and classroom teachers in order to help to establish and maintain educational programs that best fit the needs of each student. They also collaborate with the student's parents in order to incorporate their goals and desires into their child's educational program. The following section discusses the services offered by occupational therapists and physiotherapists in the School-Aged Therapy Program.

A. Referral and Screening

Before a student may receive any services such as physiotherapy or occupational therapy, certain procedures must be completed. These procedures comprise the process of referral and screening. This process is a way to identify children who qualify for such services and constitutes a method for determining their needs. If the needs of a child cannot be met through the School-Aged Therapy program, that child is referred to the appropriate resource.

Students who are having difficulty functioning in the community may be referred by parents, teachers, therapists, the school-based team or other service providers. After referral the child is screened by the appropriate professionals. If screening indicates that the child requires further assistance, a more in-depth assessment is carried out. Parents must consent to the referral of their child to occupational therapy and physiotherapy services.

B. Assessment

Assessments begin with the collection of data from several sources: the teacher, the family, other service providers and medical personnel. Physiotherapists and occupational therapists observe students in the home, school or in community programs, identify the skills needed in these environments and assess whether or not the child is able to meet them. They review the child's medical and educational records to determine what goals have been set and which strategies have been tried and have been used successfully in the past. In collaboration with parents, teachers and other service providers, they attempt to ascertain whether the child needs environmental

adaptations, better positioning, adaptive equipment, skill acquisition or altered expectations. When they consider it necessary, they conduct a formal assessment. Occupational therapists and physiotherapists analyze and interpret the data, identify problems, make recommendations and communicate these to the school-based team and to the families. With the parents, occupational therapists and physiotherapists identify skills that could be used at home and that will also be useful at school and in the community. They always consider whether an individual is facing a major transition which requires specific goal-setting. Periodic reassessments are conducted to determine if the current goals are meeting the student's needs.

C. Planning

As members of collaborative school-based teams, physiotherapists and occupational therapists assist in developing Individual Educational Plans (IEP's) for students with special needs. The IEP is a device for planning and adjusting the instructional program to best suit the needs of each child. It identifies areas in which students need assistance in order to benefit from their educational programs. It is reviewed and updated as required. In collaboration with parents and other members of the team, the occupational therapist and physiotherapist use the IEP to help to determine the amount and type of therapeutic intervention most helpful to each student in attaining academic, social and behavioural goals. Throughout the year, therapists carry out parts of the IEP that relate to their areas of responsibility. The IEP process is a good opportunity for occupational therapists, physiotherapists and parents to discuss goals which they have for the child in other settings.

D. Intervention

Intervention is the implementation of the program plan. When determining the amount and type of involvement a physiotherapist or an occupational therapist may have in a student's educational program, it is important to consider the student's level of performance, the specific educational environment in which the student is enrolled and the availability of other persons in the environment to assist in the educational process. The occupational therapist and physiotherapist look at all of these components in order to determine the pattern of intervention and the quantity of time required to deliver the needed services. It is necessary for therapists to use their assessment information combined with observations of the student in the classroom as well as

information from teachers, parents and other staff to determine the amount and type of intervention to employ.

Because the school-aged child frequently presents a broad array of needs that may change over time, schools and communities offer a range of services and support to individual children. Students should receive their educational programs in an integrated setting as often as possible. The environment that is most beneficial differs for each child and may change with time. Because therapy is integrated into daily activities, students needing this service can often receive it in the classroom. Rather than segregating students from their peers, the physiotherapist or the occupational therapist incorporates rehabilitation goals into familiar classroom activities. Some students who need a short term of intensive rehabilitation following surgical procedures or injury may need to be treated outside of the classroom, initially. In these cases the physiotherapist or occupational therapist endeavours to incorporate the rehabilitation goals into classroom activities as soon as possible. Other students may require direct therapy in the clinic or at home for specified periods. These sessions ideally occur after school or during holiday periods so as not to disrupt educational programs. Physiotherapists and occupational therapists provide service in an appropriate place when students require procedures which could compromise their dignity.

In the professional language of occupational therapy and physiotherapy, the term *direct therapy* refers to services offered by the therapist during which the child is present. The term *indirect therapy* refers to services for the child during which the child is not present, eg., attending planning meetings, finishing splints or ordering equipment for the child. Types of intervention include direct therapy, either individual or group, as well as consultation and monitoring which may constitute either direct or indirect therapy. Students with special needs require an individualized approach to intervention. The type, frequency and length of therapy services should be periodically assessed and, if necessary, altered, in order to address a developing child's changing needs.

Regardless of which type of intervention is considered best for an individual student, the school-based team assesses the student's needs, develops objectives and strategies to meet these needs

and, after the program has been implemented, assesses its effectiveness. One or a combination of the following modes of intervention may be considered.

1. Consultation

During consultation the therapist assesses students in the home, school or community and suggests ways that parents, teachers and other service providers can integrate intervention strategies. As part of consultation, physiotherapists and occupational therapists may provide training to staff and parents; they may recommend sources of equipment; they may inform parents and service providers of appropriate readings and other resources. They may also plan in-service training programs; they may make recommendations about district special education policies; they may suggest ways to overcome or remove architectural barriers.

Occupational therapists and physiotherapists bring specific expertise to the school and, for this reason, other staff members often seek information from them and request their assistance with problem solving. When physiotherapists and occupational therapists confront situations for which they have no ready answer they collaborate with family members and other service providers. When service providers share their respective views and the approaches derived from each of their areas of expertise, they are more likely to arrive at strategies that will support students' goals.

2. Monitoring

During monitoring, the therapist observes the student to ensure that suggested integrated activities are appropriate. Monitoring may involve talking to the student's parents or to school and community staff and conducting any needed assessments.

Students may require only periodic monitoring if their physical conditions remain stable and their learning programs meet their educational needs. If changes in a student's physical status or learning program indicate a need for further intervention from the physiotherapist or occupational therapist, a brief period of direct therapy and/or consultation may become the method for service delivery.

Monitoring may include occasional hands-on interaction between the physiotherapist or the occupational therapist and the student to assess the student's status so that the therapist can update or refine her recommendations. Monitoring is usually done in conjunction with consultation.

3. Individual Therapy

Individual therapy is provided when goals can only be met through direct intervention from a therapist. Individual therapy may be delivered in the clinic, the home, the school or in the community, depending upon the needs of the student. Therapy should be delivered in the clinic when the student requires specialized equipment which is only available there. In the school, the physiotherapist or occupational therapist works directly with the student integrating rehabilitation goals into everyday activities with the sole purpose of enhancing the student's participation in the educational program. The physiotherapist or occupational therapist communicates extensively with parents and teachers in order to assess how and where intervention can be included. Individual therapy is short-term and is integrated into the school day as soon as possible.

4. Group Therapy

The therapist works with a student in a group with his or her peers. This group may be an integrated one or it may be a group of children with special needs. The therapist involves all of the children in activities which are designed to meet the goals of the student or students with special needs.

The lines between different methods of intervention are often blurred. All may occur during a single activity. For example, while monitoring teacher assistants who are conducting activities such as positioning with students, therapists may work directly with students to determine which approaches are most appropriate for them. They may then consult with teacher assistants and teachers to explain and demonstrate these approaches and to determine how these positioning techniques can best be used throughout the students' days. Thus, consultation is always a part of direct service (at the least to apprise others of how the student is progressing) and some direct service is always a part of consultation and of monitoring (using hands-on techniques to

determine and demonstrate techniques that are appropriate for the student).

During any of these activities: individual or group therapy, monitoring, consultation and instructing others, it is important that all of the staff members recognize that they are participating in the collaborative team process and that their common goal is to meet the needs of the children with whom they are working.

A student's need for therapy services may change at different stages in development or when there are changes in the student's social or physical environment. Through regular team meetings, the students' needs are reassessed and the type of intervention may be changed.

E. Transition Planning

Transitions which students make from early intervention programs to preschool, from classroom to classroom when included in schools and from high schools to post-secondary or community programs are periods which require thoughtful planning. The role of the school is, in part, to provide students with the skills that they will need in subsequent settings. When planning for a transition, the collaborative team, including parents, physiotherapists, occupational therapists, teachers and other service providers as well as students, when appropriate, meet to discuss the various options for a student and the support services that will be needed in the new setting. Communication is very important to a student's successful transition. The team prepares a report summarizing the student's progress and goals. This report can be conveyed to the new school or community program that that individual will attend. Planning for a student does not end with a placement decision. The team is an ongoing resource available throughout the school year to assist educational staff to modify the student's program or to help to solve problems.

F. Record-Keeping

The purpose of record-keeping is to measure the outcome of intervention and to monitor progress. Record-keeping is important in order to assure accountability and maintain high standards. See previous discussion of documentation in Chapter III.

G. Evaluation

Physiotherapists and occupational therapists should continually assess the relevance of the intervention through conversations with teachers and teacher assistants, through personal observations and through discussions with the student and with the family. Program assessments are performed on a regular basis.

VIII. SUMMARY OF ROLES IN THE SCHOOL

In schools, physiotherapists and occupational therapists may work with teachers, teacher assistants and nursing care coordinators. Together with the parents, teachers make recommendations concerning the educational goals for the student. Teachers plan with parents, therapists and other service providers how these goals can be supported. Frequently, teachers seek the expertise of physiotherapists or occupational therapists in assisting them to meet the educational needs of children with complex challenges and to integrate rehabilitation goals with educational goals. The child's teacher or resource teacher may act as team manager, coordinating a variety of services and facilitating the collaborative school-based team.

Teacher assistants usually work under the direction of a classroom teacher and may be assisted by the physiotherapist or occupational therapist in such activities as positioning and handling and helping students with eating and motor activities. As part of the classroom team, they perform various functions including personal care, classroom observation and instructional assistance.

Nursing care coordinators support and monitor teacher assistants in areas involving nursing care. They also identify students' health needs including the level of care and the need for equipment and supplies. Nursing care coordinators ensure that caregivers are able to carry out specific tasks and they provide or arrange for instruction to be given to caregivers, if it is required.

IX. RELATIONSHIP TO OTHER SERVICES

The following section discusses some of the programs and services which have been designed to assist families who are caring for children who need extra support. Because all of these services seek to support young people with disabilities and those who teach and care for children with special needs, extensive communication among those working in various programs should exist. It is particularly important for people working in any of the support services to be aware of the strengths and needs of the families of these students so that appropriate help can be offered.

A. Special Education Technology Service (SET-BC)

Special Education Technology Service (SET-B.C.) is a program sponsored by the Ministry of Education to support school-aged children requiring special technology to assist them to meet their educational goals. SET-B.C. is part of the overall technology service providing the educational component for school-aged children requiring this service. There are eight regional representatives of SET-B.C. employed by local school districts. SET-B.C. and the school therapists should always work in collaboration. When requested, the Neuromotor Program provides health assessment consultation to the school therapists. (See a discussion of the Neuromotor Program in Section N, Sunny Hill Health Centre for Children). When school-aged children require both of these services, representatives from relevant programs and SET-B.C. meet on a regular basis with school therapists in order to make recommendations for technology. Meetings between representatives from SET-B.C., school district personnel and the School-Aged Therapy Program promote coordinated service.

B. Provincial Integration Support Program

The Provincial Integration Support Program is an outreach service funded by the Ministry of Education whose mandate it is to assist schools throughout British Columbia in meeting educational needs of students with multiple/severe disabilities. A team consisting of a teacher, an occupational therapist, a physiotherapist, a speech-language pathologist and a vision teacher provide support through a variety of services. The program provides information and strategies specific to the student with multiple/severe disabilities to maximize that student's learning. The

program also provides information, in-service training and teaching strategies to support the classroom teacher and support team to meet the educational needs of the student with multiple/severe disabilities. For further information telephone the PISP program coordinator at 595-2088 or fax at 592-5976.

C. Early Intervention Program

The Early Intervention Program is a system of services that provides intervention and support to children with special needs and to their families. These services occur in child development centres or community agencies as well as in the child's home and in programs within the community. The Early Intervention Program attempts to identify needs and to provide treatment as early as possible in the lives of children. This program provides therapy services in the form of physiotherapy, occupational therapy and speech/language therapy as well as family support services to children who have or are suspected of having, a neurological disorder or a significant developmental delay. The Early Intervention Program offers these services from the time of the child's birth or after the identification of a special need, until school entrance.

D. Associate Family Program

The Associate Family Program is a program developed by the Services for Community Living Branch of the Ministry of Health and Ministry Responsible for Seniors which secures community-based family living of high quality for children with multiple handicaps. The Associate Family Program matches associate caregiving families with children with multiple disabilities whose natural families are unable to assume the ongoing care of these children. Because the care given by the associate family is viewed as a long-term arrangement, children experience a sense of stability and belonging. At the same time, the natural parents are encouraged to remain actively involved with the planning and care for their children. This program is based on the conviction that children benefit most when living as part of a nurturing family, rather than in an institutional setting. For more information, call 660-0660 in Vancouver and the Lower Mainland and 952-1494 in Victoria.

E. Nursing Respite Program

The Nursing Respite Program, funded by the Ministry of Health and Ministry Responsible for Seniors, provides periods of relief or rest to families who are caring for children under the age of nineteen, who have highly specialized medical needs or who are technology-dependent. Respite is usually provided in the child's home by registered and licensed practical nurses. This program which assists families to continue to care for their children who need extra support at home works in concert with other community supports and is not intended to replace "round the clock" hospital care. Children who are in the Nursing Respite Program are usually eligible for the benefits of the At Home Program. For more information, call 660-7797 in Burnaby or contact the Resource Line of the Ministry of Health at 1-800-465-4911.

F. In-School Support for Students with Special Needs

In-School Support for Students with Special Needs is a service provided in educational settings to students who have highly specialized medical needs and who require nursing care. Some students in this program require care which can only be delivered by a nurse. The nursing needs of other students can be met by non-professional caregivers who have received child-specific training by a nurse, in conjunction with the student and the family. An Individual Health Care Plan is developed by a nurse, with the student and family, in consultation with involved health professionals, teachers and the school health team. The Individual Health Care Plan outlining nursing care requirements for certain students with special needs becomes part of that student's Individual Educational Plan. Nursing staff and teacher assistants who operate within the In-School Support Program receive support and work collaboratively with service providers from the School-Aged Therapy Program.

G. At-Home Program

The At Home Program is a joint program of the Ministry of Health and Ministry Responsible for Seniors and the Ministry of Social Services. The At Home Program assists the families of eligible children with respite care and provides financial assistance for selected medically necessary supports and services (including some dental care) associated with caring for a severely handicapped child at home. To obtain applications to the At Home Program, call your local health unit. For questions regarding eligibility or concerning the status of applications, call

952-1507. For questions regarding medical benefits or services, call 1-800-663-7202. For questions regarding respite care, call your local Services for People with Mental Handicaps office, Ministry of Social Services.

H. Family Support

The Services for People With Mental Handicaps, Ministry of Social Services, may provide other family support services for families with children with autism, mental handicaps or those who are eligible for At-Home respite. These services may include homemakers, behavioural support, respite, and special services for children. For information concerning this type of support contact your local office for Services for People with Mental Handicaps, Ministry of Social Services.

I. Queen Alexandra Centre for Children's Health

The Queen Alexandra Centre for Children's Health is a regional paediatric resource providing specialized multidisciplinary programs and services to children, families and communities. Programs and services are available to infants, children and adolescents (up to 19 years of age) with complex physical, intellectual, social or emotional challenges who require assessment, treatment, consultation, long-term follow-up or coordination. Support services and programs are also available to families of these children as well as to families who are at risk for developing related problems or needs. All programs and services offered by Queen Alexandra Centre for Children's Health are available to the people in the Capital Regional District; many are available to people on Vancouver Island. For some programs, Queen Alexandra Centre will accept referrals from across the province. For more information, call (604) 477-1826 in Victoria.

J. B.C.'s Children's Hospital

B.C.'s Children's Hospital is the main acute children's hospital in the province and therefore serves children throughout British Columbia. It has over forty clinics which treat every complex disorder of children from birth to sixteen years. Many of these clinics are disease-related and handle such diverse problems as diabetes, gastro-intestinal conditions, allergies, skin problems, bio-chemical diseases and post-operative surgical and orthopaedic conditions. The hospital is a

secondary resource; children are referred by a paediatrician or by a family doctor. B.C.'s Children's Hospital functions as a resource, often by telephone, to parents and caregivers throughout the province who have questions concerning medication or care of their children. B.C.'s Children's Hospital also acts as a resource for teachers who are dealing with children with complex physical problems, psychiatric disorders or diabetes. Support is often provided by community health nurses who are in contact with the hospital and go into communities and visit schools. For more information call (604) 875-2345 in Vancouver.

K. Greater Victoria Hospital Society

The Greater Victoria Hospital Society provides comprehensive paediatric services at the Victoria General Hospital site at Helmcken Road in Victoria. Selected tertiary, secondary and primary care programs are available in a variety of sub-specialties. The hospital's acute care services are provided through paediatric in-patient units (including intensive care capability) for children aged birth to seventeen years as well as a twenty-two bed special care nursery (SCN). There is also a Paediatric Medical/Surgical Day Care Unit and ambulatory and in-patient programs for mothers with high-risk pregnancies. The hospital promotes care closer to home with a number of interdisciplinary ambulatory programs and services for children and families. Some of these services include:

- a Child and Family Asthma Program;
- a Paediatric Diabetes Program;
- a Home Monitoring Program for Infants at Risk for Prolonged Apnoea;
- a Special Care Nursery Follow-Up Clinic;
- a Seizure Management Clinic;
- a Cystic Fibrosis Clinic;
- an Oncology Clinic (for children and adolescents with cancer or cancer-related diseases).

All services support a high level of care for families and children on Vancouver Island.

Discharge planning through a paediatric interdisciplinary team supports coordinated liaison with community agencies such as public health, child development facilities, rehabilitation programs and school programs. In addition, the REACH Program (Reentry Education About Classmate Hospitalization) is a community outreach service designed to make the transition from hospital

to school easier for a student who has suffered a major medical trauma.

The Dr. Glenn Simpson Family Resource Centre is a community resource centre and library located in the Victoria General Hospital which provides material and information for children and families to help them better understand and cope with health and family concerns. For more information about the resource centre, call 727-4212 Local 5281.

The HOPE Program (Hospital Orientation Preparation Experience) is available to schools to help healthy kindergarten children learn about the hospital in the relaxed familiar environment of their classrooms. The intention of this program is to promote positive feelings about the hospital and to reduce anxiety in children, should they need to face hospitalization in the future.

Information and resources are available by calling 727-4187, the Child and Family Ambulatory Unit at the Victoria General Hospital in Victoria.

L. G.S. Strong Adolescent and Young People's Program

G.S. Strong Adolescent and Young People's Program is part of B.C. Rehabilitation Society and is designed to assist people from the age of 12 to the early 20's in the following ways:

- rehabilitation after an injury or illness that may cause a disability;
- provision of assistance to people with disabilities to develop and/or to improve their independent living skills;
- education and treatment to assist teenagers with disabilities in the transition from adolescence to adulthood.

This assistance may be provided to young people as in-patients, as out-patients, in an educational workshop or in their own homes. For further information, call 734-1313 in Vancouver.

M. Community Hospitals

The out-patient departments of many community hospitals may provide recuperative post-operative care for children who temporarily require more intense therapy for the recovery period before they are able to return to their regular school programs.

N. Sunny Hill Health Centre for Children

Sunny Hill Health Centre for Children is a provincial resource for the provision of specialized services to children with developmental disabilities. In partnership with families and community service providers, Sunny Hill provides clinical services, research and education.

Sunny Hill is a referral centre for children and youth up to 19 years of age who require inter-disciplinary assessment, treatment and follow-up. Sunny Hill's focus is on the provision of tertiary services to children with developmental disabilities. Services complement and do not duplicate the services offered in the community. Sunny Hill is funded by the Ministry of Health and Ministry Responsible for Seniors.

Sunny Hill provides services through a number of inter-disciplinary programs: Brain Injury Program, Child Development Diagnostic Program, Feeding Assessment Unit, General Rehabilitation (In-Patient), Infants and Children At-Risk Program, Long Term Care and Respite Programs (In-Patient), Neuromotor Program, Positioning Assessment Unit and Regional Rehabilitation.

Recently, four vision consultants joined the staff of Sunny Hill in the Visually Impaired Program (VIP) which is located at B.C.'s Children's Hospital. The VIP Program will relocate to Sunny Hill Health Centre for Children by early 1995.

Most programs have in-patient and out-patient components. The Early Intervention Program funds outreach services for many of Sunny Hill's programs. All programs are designed to support families and community-based teams. The Positioning Assessment Unit provides supportive assessment services to a number of regions on an outreach basis in order to augment local resources in the prescription of positioning and mobility systems for referred children.

Physiotherapists and occupational therapists serving children in the School-Aged Therapy Program may frequently need to gain access to the services of the Neuromotor Program. The Neuromotor Program is an interdisciplinary team available to support families and community teams working with children who have significant neuromotor disabilities. Services include

assessment, consultation and training in all areas of neuromotor disability. The Neuromotor Program offers a continuum of services although the majority of the children are seen on an outreach basis. The Neuromotor team is available for consultation with school therapists when the therapists request assistance in providing the appropriate support for students in educational settings. This may include assistance in the areas of positioning, feeding and adapted computer access. The services of the Neuromotor Program are coordinated with Special Education Technology (SET-BC) and other Provincial Resource Programs funded by the Ministry of Education.

A Sexual Health Resource and Referral Centre (SHRRC) promotes sexual health among children and youth with disabilities since these children are believed to be at greater risk for sexual abuse. The SHRRC Program will include a resource library, a directory of professionals experienced in this field and will offer training and education programs.

A computer network links Sunny Hill to child development centres in order to facilitate information exchange and access to literature and product databases. This network facilitates intercommunication among child development centres, health units, community agencies and the Ministry of Health and Ministry Responsible for Seniors. It can be used by health care professionals to solicit information, to address bulletin boards and to provide and receive assistance in solving problems related to clinical issues. Sunny Hill provides support as well as an instruction manual for those wishing to utilize the computer network. In addition, Sunny Hill offers a range of educational opportunities to families and service providers who benefit from orientation to provincial services and specialized training in specific treatment and assessment skills. For more information, call the Therapy Department at Sunny Hill Health Centre for Children at (604) 434-1331 in Vancouver.

O. The School Therapy Special Interest Group

The School Therapy Special Interest Group is an informal group of occupational therapists and physiotherapists. The group was begun in the Lower Mainland in order to discuss common interests with regards to school therapy. For more information contact the School Therapy Special Interest Group at The Neurological Centre in Vancouver at 451-5511.

X. PROFESSIONAL DEVELOPMENT

Many physiotherapists and occupational therapists have had little or no experience working in an educational setting. Because the school is a novel work setting for many therapists, professional development is a particularly important aspect of the School-Aged Therapy Program. The following section outlines the professional development available to those involved in this program.

A. Computer network

A computer network through Sunny Hill Health Centre allows therapists throughout the province to communicate with one another. Sunny Hill provides a manual as well as other support for those wishing to use the computer network.

B. Resource Manual to Aid Service Providers

In cooperation with Sunny Hill Health Centre for Children, the Child Development and Rehabilitation Section has developed a resource manual for caregivers and service providers in the School-Aged Therapy Program. The *School-Aged Therapy Resource Manual* provides technical information to physiotherapists and occupational therapists as well as information for parents, educators and community workers. The manual includes an outline for a conceptual model for practice with sample forms suitable for adopting or adapting for individual community use. It contains technical information regarding splinting and casting, eating and drinking, assistive technology, and assisted mobility equipment as well as practical information concerning adapting activities for recreation, leisure and physical education, positioning, handling and back care.

C. Ministry of Health Consultants

Professionals on the staff of the Child Development and Rehabilitation Section provide consultation on various aspects of the Early Intervention Program and the School-Aged Therapy Program. For more information call 952-1866.

D. Training Programs

The Child Development and Rehabilitation Section provides funding and collaborates with health agencies to develop and facilitate educational opportunities for service providers working in the School-Aged Therapy Program.

E. Ministry of Health Library

The Ministry of Health Library consists of a large library collection, housed in the main library in Victoria and a much larger virtual library collection (networking links with other libraries, databases, personnel, etc). The Ministry of Health Library holds both print materials and audiovisual materials. Library staff provide information services to employees of the Ministry of Health and Ministry Responsible for Seniors. They also assist staff from other ministries, students and the general public in their information requests. In addition, they borrow from and lend materials to libraries across Canada and the United States.

F. Table of Contents Service

The Ministry of Health and Ministry Responsible for Seniors, through its *Table of Contents Service*, enables provincial agencies to gain access to a large number of relevant journals which are housed in the Ministry of Health Library. In this way, community-based teams and the families of children who need extra support, anywhere in British Columbia, are able to obtain information and support from a central information source. Each health region has a coordinator to assist therapists to obtain articles from the Ministry of Health Library. You may contact the Paediatric Rehabilitation Consultant to find out the coordinator in a particular health region.

G. Manuals in Draft

The Child Development and Rehabilitation Section is developing a manual entitled *Supervision and Evaluation in the School-Aged Therapy Program*. This manual presents occupational therapists and physiotherapists who are working with school-aged children and their supervisors with a model for service delivery as well as with practical information about ways to recruit and retain therapists, and methods for writing contracts. In addition, it outlines the hallmarks of effective therapy and includes a performance self-evaluation tool.

XI. ACCOUNTABILITY AND QUALITY ASSURANCE

It is essential that accountability as well as the assurance of excellence be a part of the School-Aged Therapy Program. Every health agency contracted to provide a school-aged therapy program should have a comprehensive quality management program in place. Guidelines for a quality management program have been developed by the Child Development and Rehabilitation Section. These guidelines include a method for continuously evaluating program, service delivery and individual performance. In a quality management program the following areas are addressed:

Focus population

- that the persons served are those designated as the focus population.

Program Components

- that programs meet the needs of the individuals requiring service;
- that programs are in accordance with the principles outlined in the *Inter-Ministerial Protocols for the Provision of Support Services to Schools.*

Service delivery

- that services delivered are in accordance with the principles outlined in the *Inter-Ministerial Protocols for the Provision of Support Services to Schools*;
- that services delivered meet the program criteria;
- that the amount of service delivered is appropriate.

Individual Performance Evaluation

- that individual performance meet professional standards as well as the principles outlined in *Program Guidelines: School-Aged Therapy Program - Occupational Therapy and Physiotherapy.*

Fiscal area

- that funds are being used appropriately;
- that expenditures have been documented according to accepted accounting principles;
- that funds are being used within the limits set by the budget.

Educational opportunities

- that in-service training be available for and utilized by, individuals involved in these programs.

Professional Development

- that occupational therapists and physiotherapists are expected to keep abreast of current literature in their respective professions and to remain up-to-date in modes of service delivery.

New Directions for a Healthy British Columbia (1993), emphasizes the need for accountability in the health care system through an evaluation of outcomes. It is critical that families and agencies monitor and evaluate client goals and outcomes in light of the adoption of a family-centred, community-based model of service delivery. Evaluating outcomes also permits the Child Development and Rehabilitation Section to support communities and regions in planning future programs and to assist agencies to be accountable for the quality of their programs. The ***Developmental and Rehabilitation Information System (DRIS)*** has two main functions: to provide agency file, case management and service delivery information and to capture in an evaluation framework, evidence-based best practices in the field of early intervention - practices consistent with contemporary knowledge of child development, family functioning and community supports and services. This framework encourages common directions for early intervention within the province while respecting diversity across service agencies. In order to ensure that these new directions are effective and efficient, a computer system has been developed which collects relevant data allowing families and agencies to oversee client goals and outcomes and to monitor program objectives and indicators. By translating guiding principles into measurable objectives and indicators, *DRIS* can also give concrete information about whether practice adheres to these principles. In providing information to all levels, this system influences all aspects of service delivery and planning. In conforming with *New Directions for a Healthy British Columbia* (1993), *DRIS* enables the Child Development and Rehabilitation Section to emphasize accountability and to focus on an evaluation of outcomes. *DRIS* aids agencies to make management decisions and service providers to make clinical decisions. It promotes community participation in decision-making about local program and service needs and enhances the quality of decisions made by communities. *DRIS* helps to guide the Ministry in allocating supports and resources and, ultimately, it maximizes the benefits of early intervention for children and for families.

XII. COMPETENCIES

Occupational therapists and physiotherapists who work with students with special needs in an educational setting require many skills besides those that have made them competent in their respective professions. Because the preference, in the schools, is for consultation and monitoring, the therapist must become a skilled member of a collaborative team, must be able to integrate rehabilitation goals with educational goals and must help others, who do not share their therapeutic backgrounds, to implement rehabilitation goals in ordinary settings while the student is engaging in routine activities. The following section lists the principles supporting the integration of students with special needs in schools, indicates competencies suggested by these principles, lists objectives attained by a competent individual and recommends ways in which these objectives may be realized.

Principle No. 1

Every child is entitled to an individualized educational program in a classroom where that student is integrated with other students who do not have handicaps.

Competency

Occupational therapists and physiotherapists facilitate the student who needs extra support to become an active participant in the classroom.

Objectives

1. Therapists along with parents and teachers establish a common set of goals appropriate to the student in the educational setting.
2. Therapists have a good understanding of the school environment to ensure that goals are appropriate.
3. Physiotherapists and occupational therapists are able to perceive the needs of the child within the context of the school.
4. Physiotherapists and occupational therapists are able to provide the educational staff with ongoing in-service training.
5. Rehabilitation goals consistently support educational goals.

6. Therapeutic techniques can be implemented in routine activities in natural settings.

How To Achieve Objectives

1. Physiotherapists and occupational therapists, in consultation with other team members, use Individual Educational Plans (IEP's) as well as Individual Health Care Plans to meet the needs of individual students. (1)
2. Physiotherapists and occupational therapists plan functional approaches to facilitate the program goals. (2 and 3)
3. Physiotherapists and occupational therapists meet regularly to discuss and evaluate personalized learning goals. Team members share their expertise at these meetings. (3 and 5)
4. Physiotherapists and occupational therapists give training and direction to others in order that rehabilitation goals can be implemented. (4)
5. Physiotherapists and occupational therapists are able to gather information from observations and interactions in educational settings. (5)
6. Physiotherapists and occupational therapists demonstrate skill in incorporating other students into the therapy sessions. (6)
7. Physiotherapists and occupational therapists demonstrate ways in which rehabilitation goals can become a part of the daily routines in the home, school or community setting. (6)

Principle No. 2

A collaborative team approach, applied to educational programming is the most effective way of meeting the needs of students with special needs in the educational setting. The team includes parents and service providers working in an environment of equality and mutual respect.

Competency

Physiotherapists and occupational therapists are capable of using a collaborative team approach.

Objectives

1. Physiotherapists and occupational therapists are effective members of a team.
2. Physiotherapists and occupational therapists are effective communicators.
3. Physiotherapists and occupational therapists are effective consultants.

How to Achieve Objectives

1. Physiotherapists and occupational therapists understand their roles on the team. (1)
2. Physiotherapists and occupational therapists know how to delegate responsibilities, and facilitate team goals. (1)
3. Physiotherapists and occupational therapists have developed the interpersonal skills and problem-solving skills which allow them to function as effective participants on a team. (1 and 2)
4. Physiotherapists and occupational therapists know how to communicate without using excessive clinical jargon so that others can understand their goals. (2)
5. Physiotherapists and occupational therapists support and teach parents and others who work with the child to integrate therapy into the child's daily life. (3)

Principle No. 3

All children have a right to participate in all appropriate aspects of community life.

Competency

Physiotherapists and occupational therapists assist children with special needs to be included in the community.

Objectives

1. Physiotherapists and occupational therapists thoroughly understand and can articulate the philosophy of inclusion of individuals with special needs in the community.
2. Physiotherapists and occupational therapists assist in the integration of children with special needs into community programs.

How To Achieve Objectives

1. Physiotherapists and occupational therapists assist parents to gain access to appropriate programs for their children. (1 and 2)
2. Physiotherapists and occupational therapists assist families to establish realistic goals and expectations for their children and help them to perceive how these can be achieved in an inclusive setting. (2)

Principle No. 4

Every child should be viewed as a whole child and as a learner.

Competency

Physiotherapists and occupational therapists view every child as a whole child and they assist others to do the same.

Objectives

1. Physiotherapists and occupational therapists examine and acknowledge their own feelings about students with disabilities.
2. Physiotherapists and occupational therapists assist others to view the student with special needs as a whole child with a unique learning potential.

How to Achieve Objectives

1. Physiotherapists and occupational therapists do not label the student or have preconceived ideas about the student's potential or capability. (1 and 2)
2. Physiotherapists and occupational therapists regard the educational setting as the appropriate place for learning and develop rehabilitation goals which facilitate the student's functioning in the school. (2)
3. As members of a collaborative team, physiotherapists and occupational therapists share viewpoints with other members, from other disciplines, so that each child is viewed in a holistic way. (2)

BIBLIOGRAPHY

"Adapted Physical Education, Occupational Therapy and Physical Therapy in Special Education Programs in Colorado: Guidelines for Implementation", Task Force for The Special Education Services Unit, Colorado Department of Education, 1979.

Banks, Sheila, "The Canadian Model of Occupational Performance: Its Relevance to Community Practice", *Canadian Journal of Occupational Therapy*, Vol. 58, No. 3, August, 1991.

Biesinger, Matilda, Lazar, Susan & Bundy, Anita, "Making a Difference: OT's and PT's in Public Schools", *Student Referral to Occupational Therapy*, June, 1991.

British Columbia Premier's Advisory Council for Persons With Disabilities, *Review of Occupational and Physiotherapist Services to School Aged Children in British Columbia*, Review conducted and report written by Erika R. Trimble, November, 1990.

Bundy, A., "Writing Functional Goals for Evaluation", in C.B. Royeen (Ed.), *AOTA Self-Study Series: School-Based Practice for Related Services*, Rockville, MD, AOTA, 1991.

Canadian Association of Occupational Therapy, *Position Paper on Occupational Therapy in Schools*, CAOT, October, 1990.

Canadian Association of Occupational Therapy, *Client Participation in Occupational Therapy*, Position Paper, CAOT, March, 1991.

Carrol, M.J., Mansbridge, J., Daniels, L.E., Mattice, R. & Coat, R.J., "Implementing Transdisciplinary Services for Students With Multiple Handicaps: One District's Approach", *B.C. Journal of Special Education* , Vol. 14, No. 3, 1990.

Donaldson, R. & Christiansen, Jeanne, "Consultation and Collaboration: A Decision-Making Model", *Teaching Exceptional Children*, Winter, 1990.

Dunn, W., "A Comparison of Service Models in School Based Occupational Therapy Services: A Pilot Study", *The Occupational Therapy Journal of Research*, Vol. 10, No. 5, Sept/Oct., 1990.

Dunn, W., "Integrated Related Services" in Peck, A., Meyer, L. & Brown, A. (Eds.), *Issues in the Lives of Critical People with Severe Disabilities*, Paul H. Brookes Publishing, Baltimore, 1991.

Dunn, W., *Paediatric Occupational Therapy. Facilitating Effective Service Provision.* Slack Incorporated, Thorofare, NJ, 1991.

BIBLIOGRAPHY

Dunst, C.J., Trivette, C.M., Davis, M., & Weeldreyer, J.C., *Enabling and Empowering Families of Children with Health Impairments*, Pre-publication Draft: *Children's Health Care*, In Press. Family, Infant and Preschool Program, Western Carolina Center, Morganton, North Carolina, 1990.

Fetters, L., "Measurement and Treatment in Cerebral Palsy: An Argument for a New Approach", *Physical Therapy*, Vol. 71, Number 3, March 1991.

Giangreco, M.F., "Delivery of Therapeutic Services in Special Education Programs for Learners with Severe Handicaps", *Physical and Occupational Therapy in Pediatrics*, Vol. 6, No. 2, Summer, 1986.

Goldkamp, O., "Treatment Effectiveness in Cerebral Palsy", *Archives of Physical Medicine and Rehabilitation*, Vol. 65, No. 5, May, 1984.

Guralnick, M.J., *Accomplishments and Future Directions in Early Childhood Mainstreaming*, Child Development and Mental Retardation Center, University of Washington, Seattle, Wa 98195, 1990

Harris, S.R., *Functional Abilities In Context*, Proceedings II: Step Conference, Fall, 1990.

Harris, S.R., "Efficacy of Physical Therapy in Promoting Family Functioning and Functional Independence for Children with Cerebral Palsy", *Pediatric Physical Therapy*, 1990.

Hylton, J., Reed, P., Hall, S., & Geirello, N., *Consultation and Team Skills for Therapists in Educational Settings*, Oregon Health Sciences University and the Oregon Department of Education, Office of Special Education and Rehabilitative Service, Grant Number G008630055, 1990.

Hylton, J., Reed, P., Hall, S., & Geirello, N., *The Role of The Physical Therapist and Occupational Therapist in the School Setting*, Oregon Health Sciences University and the Oregon Department of Education, Office of Special Education and Rehabilitative Service, Grant Number G008630055, 1987.

Kibele, A., "Occupational Therapy's Role in Improving the Quality of Life for Persons with Cerebral Palsy", *American Journal of Occupational Therapy*, 43, 1989.

McEwen, Irene R., "School Physical Therapy: How Does It Relate to Education?", Conference Paper, April, 1987.

Magill-Evans, J., & Madill, H., "Occupational Therapy in Schools: Identifying Items For A Referral Instrument", *Canadian Journal of Occupational Therapy*, June, 1990.

Martin, K.,. "Physical Therapy in Educational Environments: Update in National Guidelines", *Physical Therapy in Educational Environments*, Tacoma, Wa., 1989.

BIBLIOGRAPHY

Ministry of Education, *Year 2000.* Province of British Columbia, Ministry of Education, Educational Programs, 1990.

Ministry of Health and Ministry Responsible for Seniors, *Early Intervention Program Handbook.* Province of British Columbia, Speech and Language Services and Early Intervention Programs Branch, 1993.

Noie, D.R., "Occupational and Physical Therapy As Related Services", *Teaching Exceptional Children,* Winter, 1983.

Occupational Therapy Guidelines For Client-Centered Practice, Canadian Association of Occupational Therapists, Toronto, Ontario, 1991.

Piper, M.C., *Reduction of Severity of Disability - Treatment, Therapy Research,* Faculty of Rehabilitation Medicine, University of Alberta, Edmonton, Alberta, Conference Proceedings, 1988.

Piper, M.C., *Issues and Priorities in Pediatric Therapy Research.* Proceedings of the Symposium on Priorities for Physical Therapy in Maternal Child Health, Quail Roos, Rougemont, N.C. 1987.

Reed, Penny, "It's Time for the Metamorphosis: Integrating Occupational and Physical Therapy into Programs for Students", Paper presented at the Annual Conference of the Association for the Severely Handicapped, October, 1987.

Scrutton, D. "Aim-Oriented Management". In: Scrutton, David (Ed.), *Clinics in Developmental Medicine,* No. 90, Management of the Motor Disorders of Children with Cerebral Palsy. Spastics International Medical Publications, Oxford Blackwell Scientific Publications Ltd., Philadelphia, J.B. Lippincott Co., 1984.

Shelton, T.L., Jeppson, E.S., & Johnson, B.H., *Family Centered Care for Children With Special Health Care Needs,* Association for the Care of Children's Health with Support from the Division of Maternal and Child Health, U.S. Public Health Service, 1989.

Stainback, W. & Stainback, S., *Support Networks For Inclusive Schooling: Interdependent Integrated Education.* Paul H. Brookes Publishing Co., 1990.

Wilson, J.M., "Cerebral Palsy", In: S.K. Campbell (Ed.), *Pediatric Neurologic Physical Therapy,* New York, Churchill Livingstone, 1984.

Wright, T., & Nicholson, J., "Physiotherapy for the Spastic Child: An Evaluation", *Development Medicine Child Neurology,* 15, 1973.

APPENDIX A: COLLABORATIVE CONSULTATION AS A PROCESS[1]

Collaborative consultation is an interactive process that provides a forum for discussion and decision-making among people who bring a variety of backgrounds and experiences to a shared concern. By working collaboratively, parents, teachers and therapists assist students to achieve maximum benefit from educational or community programs.

Collaborative consultation is the way in which physiotherapists and occupational therapists can best offer support to families, teachers and other adults who are including school-aged children with complex challenges in their classrooms or in their community programs. In the process of collaborative consultation members of the team establish a partnership based on trust and mutual respect in order to work together to develop strategies and plans.

Collaborative consultation consists of a series of fairly simple phases that make up a complex process. As with any human interaction, the phases do not flow in an uninterrupted, smooth progression but move back and forth in a sometimes unpredictable, but nonetheless, comprehensible manner. Team members recognize the dynamic flow of the phases and utilize this understanding to manage the process. However, in circumstances in which the process encounters difficulties, each team member needs to reflect upon the phases to determine at what point problems occurred and how they can be rectified.

---

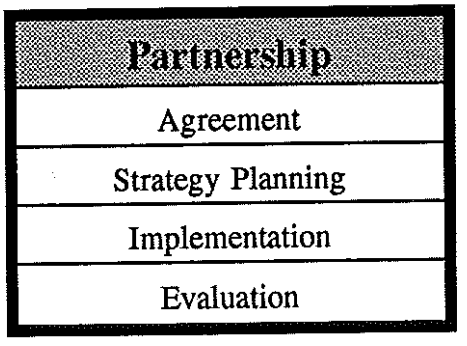
[1]Adapted with permission from: Hylton, J., Reed, P., Hall, S., & Geirello, N., *Consultation and Team Skills for Therapists in Educational Settings* Oregon Health Sciences University, Child Development and Rehabilitation Center, Portland Oregon, U.S.A. (1990).

The five phases of the collaborative consultation process are listed below and then described in detail. All team members participate as equal partners in all phases of the process of collaborative consultation.

PHASE I. PARTNERSHIP
PHASE II. AGREEMENT
PHASE III. STRATEGY PLANNING
PHASE IV. IMPLEMENTATION
PHASE V. EVALUATION

PHASE I. PARTNERSHIP

The collaborative consultative process progresses within the context of a personal relationship. Two variables always operate throughout the process: the relationship of the team members and the work on the problem itself.



The first step in establishing partnerships with others involves looking at oneself. Team members examine their own styles of communication and become aware of the ways in which they are perceived by others. People who work in a team assess which aspects of their personalities can promote a climate of openness, trust and credibility, and which may impede relationships.

It is essential to take the time to establish a partnership in which all members feel that their experiences and contributions are valuable. A truly collaborative process can only work effectively when team members facilitate others to contribute their skills and knowledge.

Team members provide support and information to each other to contribute to the team process and to facilitate progression through the phases of collaboration. They are there to contribute to the solution of a problem as equal partners.

Defining the problem is another important part of Phase I. Team members listen carefully and encourage teachers, parents or others to discuss the problem in as much detail as possible. Team members then attempt to clarify the problem. This is best done by acknowledging feelings, by reflecting what they hear and by asking pertinent questions. Sometimes the initial statement of the problem reflects only part of the problem or does not describe the situation accurately. Even so, during the partnership phase, team members try to define the problem in such a way that it reveals the perception of the person presenting the problem.

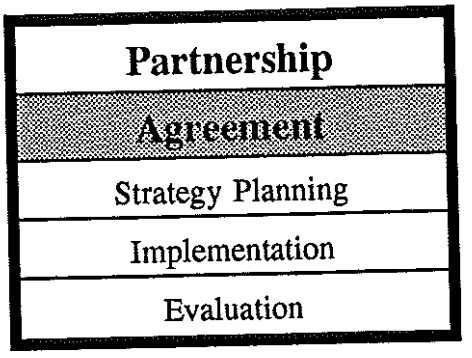
PHASE II. AGREEMENT

In the process of collaborative consultation a working agreement is vital to ensure a successful relationship among team members. In order to avoid unpleasant misunderstandings, there should be a clear agreement about what problem will be addressed; there should be a shared perception about what results are to be anticipated; there should be an arrangement about task allocation; and there should be a time frame for working on the problem. During this phase, team

members ask themselves:

"What kind of support should I offer based on what I know about the teacher's needs?"

"How should I offer this support?"



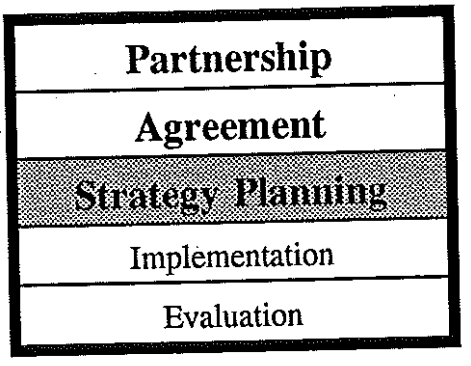
These questions are similar to those asked when planning a program for a student. Just as there are various ways to work with students, the means by which a team solves problems and supports its members can take many forms. These may include asking questions, educating, diagnosing or making suggestions. During this time the members of the team come to an agreement concerning the way in which each person's expertise can best be utilized.

Because collaborative consultation is based upon interpersonal relationships, an agreement to work together as a team extends beyond verbal or written words to a psychological contract between the participants. It is the commitment to work together towards change, based on a foundation of mutual trust and respect, that makes an agreement truly binding.

PHASE III. STRATEGY PLANNING

In this phase team members consider the practical aspects of the situation on which they have agreed to work. In the process of planning, it is necessary to collect and analyze information. It is important to ask questions such as:

- Who is involved?
- How does the situation affect each individual?
- What has already been tried to solve this problem and with what result?
- When is the problem most and least critical?
- What additional information is needed and where can it be found?



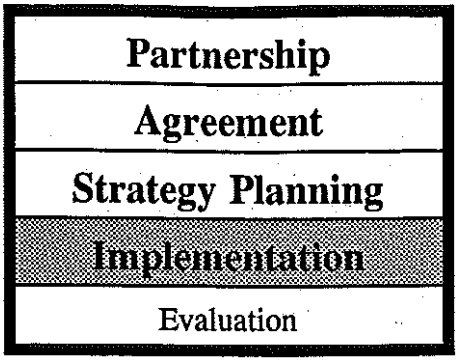
When all of the pertinent information has been collected, team members proceed to discuss ways to deal with the problem.

In the process of collaborative consultation, all team members must feel encouraged to share and contribute their ideas. There is seldom a single solution to a particular problem. Every situation, concern and environment is unique and may require a different approach. Even similar problems shared by two different students may require different solutions. The advantage of working in a team is that group discussion frequently produces more novel and varied ideas than would be likely if team members formulated solutions independently.

PHASE IV. IMPLEMENTATION

During the implementation phase the teacher or parent implements carefully developed plans and experiments with new strategies or materials. There are many ways other team members can offer support during the implementation phase. They can present workshops to help generate

approaches necessary to implement the plan of action. Team members can locate necessary materials and resources for the student and help teachers determine how best to use them.

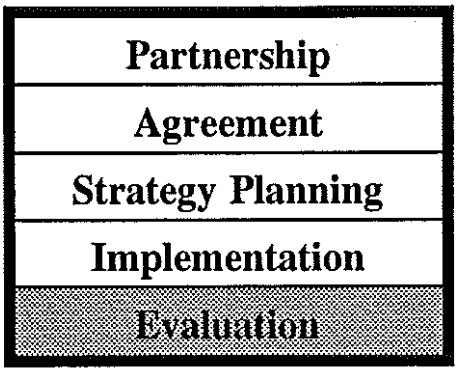


Although a collaborative consultation usually focuses on only one child, the strategies which a teacher acquires during the collaborative consultation often can be generalized to other children. For example, if the teacher learns how to plan and position materials for a child who has both a motor impairment and a visual impairment, she probably will become more aware of how to plan and position materials for other children, as well.

If problems arise during the implementation phase, team members remain readily available to the parent or teacher. Plans and strategies need frequent evaluation during this phase. If they are not working, team members should plan again. This process of evaluation, replanning and implementing new strategies is needed during this phase in order to ensure that collaborative consultation has produced positive outcomes.

PHASE V. EVALUATION

Evaluation is vital to the consulting process. Team members gather information regarding the effectiveness of strategies that they have developed. They use this data to improve, refine or redirect the process or to signal that the consultation has been successful and that it can end.



Although strategy planning and evaluation is a process involving the entire team, a single individual frequently implements the plans. Therefore, that person must find the strategies acceptable. Along with team members, this individual should look for ways to incorporate the strategies into the daily routine of the program. If certain strategies make particular team members uncomfortable, the procedures should be altered. Some individuals benefit from observing another person model the strategy. Others require time to practice the new approach. If a strategy does not appear to be working, team members devote some time to understanding the apparent reasons for its failure so that they can decide whether to make changes or whether to provide additional assistance.

Collaborative consultation comes to an end when strategies developed by team members are being implemented effectively and competently. Ending a consultative relationship is generally the best sign that the plan has been successful! However, it is important to know that collaborative consultation is available when it is needed.

APPENDIX B: A COLLABORATIVE DECISION-MAKING PROCESS[2]

During collaborative consultation it is necessary for the team members to participate in a decision-making process. It is important for all members of the team to feel that their ideas have been taken into consideration when a decision is made. The use of a planned, structured process can improve the quality of decisions.

The following five-step decision-making process complements the collaborative consultation process described above. It can be used in any situation where two or more people must make a decision.

STEP 1: DEFINING THE PROBLEM AND GATHERING INFORMATION

When making a decision in the context of a team, it is important for all team members to share their knowledge and any relevant information. When attempting to solve a problem, team members may need to gather additional data in order to identify needs and to establish goals. It is important to draw upon all of those involved for information and to ascertain the difference between fact and opinion.

Based on the information collected, the team defines the problem, phrasing it in terms of the discrepancy between the present situation and the desired goal. The problem statement represents only this discrepancy; it is not stated in the form of a solution. For example, if caring for the physical needs of a child with a disability means that the teacher must turn her attention from the group activity, the problem statement might be, "There is no time available to take Suzie to the bathroom; at least 10 minutes is needed twice a day to do this."

---

[2]Adapted with permission from: Hylton, J., Reed, P., Hall, S., & Geirello, N., *Consultation and Team Skills for Therapists in Educational Settings* Oregon Health Sciences University, Child Development and Rehabilitation Center, Portland Oregon, U.S.A. (1990).

STEP 2: GENERATING ALTERNATIVES

The team generates as many alternatives as possible while a member lists them so that everyone can see. During this phase, the team brainstorms. The following guidelines may be helpful.

- List all possible solutions.
- Build on previous suggestions. Consider long and short term alternatives.
- Encourage unusual suggestions which could lead to excellent, viable solutions.
- Insist on full group participation. Maintain an atmosphere of trust.
- Do not evaluate alternatives during this step.
- The leader announces that the team will begin brainstorming, particularly if new members (such as parents) are present, and states the purpose of brainstorming (to generate as rapidly as possible, as many alternatives as possible).
- A short time line (such as 2 minutes) may help stimulate brainstorming and eliminate discussion.

STEP 3: SELECTING ALTERNATIVES

At this point, the team systematically evaluates the benefits of each alternative in light of the needs identified earlier. In order to do this, the team performs the following activities.

- It evaluates the possibilities in each of the alternatives.
- It evaluates the alternatives relative to overall goals.
- It acknowledges and reexamines any unstated assumptions.
- It checks to ensure that alternatives make full use of all resources and disciplines at hand, or tests some combination of alternatives as a viable solution.
- It explores how each alternative will affect the family, school and community and the extent of their commitments to alternatives.

At the end of the discussion, there may be several outcomes. The ideal situation is one in which there is a single conspicuous alternative available, which the team implements. Another scenario may result in multiple, viable alternatives being proposed and any one of them selected for implementation. On the other hand, a combination of two or more alternatives may be selected from among the many alternatives proposed. If, at the end of the discussion, no alternative is acceptable, the team reviews the overall goals, and gathers more information.

When selecting alternative plans, the ideal decision-making method is **unanimous consent**. If all team members agree that a particular alternative is best, they each will be more willing to implement the decision. If unanimous consent is not possible, consensus is the most effective method because it allows members to voice their concerns and to negotiate a compromise.

STEP 4: IMPLEMENTING THE PLAN

Once an alternative is selected, a plan is designed for implementing and monitoring the intervention strategies. The team maintains accurate records while developing the plans so everyone has a common understanding and acceptance of the solutions and goals.

While the intervention is being implemented and monitored, the team should take the following action.

- Plan the sequence of steps to be taken.
- Formulate evaluation criteria.
- Determine and assign roles and responsibilities.
- Identify the necessary resources and determine how they will be provided.
- Establish a date for the next team meeting where the alternative can be evaluated.
- Designate a case manager.

During the implementation phase, it is important that the team follow the agreed-upon plan. This is critical in attempting to provide an effective intervention which can be evaluated.

STEP 5: MONITORING THE PLAN

The team assesses the outcomes to determine if the interventions are successful. If the results are unsatisfactory, the team determines the reason why by asking the following questions:

- Was there insufficient data?
- Has there been a new development?

In order to determine an alternative intervention, the team meets to reexamine its evaluation criteria, to look at the previously generated alternatives and to begin the decision-making process again.

APPENDIX C:
INTER-MINISTERIAL PROTOCOLS
FOR THE PROVISION OF
SUPPORT SERVICES TO SCHOOLS:
PROTOCOL AGREEMENT BETWEEN THE MINISTRIES OF EDUCATION AND HEALTH REGARDING PHYSIOTHERAPY AND OCCUPATIONAL THERAPY

PROTOCOL AGREEMENT

BETWEEN THE MINISTRIES OF:

Education and Health

REGARDING THE FOLLOWING SERVICES:

Physiotherapy and Occupational Therapy

I. Background

The determination of the need for physiotherapy and occupational therapy services is the responsibility of the Ministry of Health. Determination of the educational system's need for assistance is the responsibility of the Ministry of Education. Services include assessment, arranging and providing treatment if required, consultation, and monitoring.

When direct services of an occupational therapist/physiotherapist are required, either temporarily or long-term, the student's physician generally makes the referral to a community-based occupational therapist/ physiotherapist. These services would normally be carried out at times which would provide minimum disruption to the student's learning activities.

Schools require the assistance of occupational therapists and physiotherapists in school settings for those students for whom the absence of these services provides an impediment to learning. These services are primarily assessment, consultation for school staff, training of staff, monitoring and ongoing evaluation of students in classroom settings.

II. Target population

Students with physical or motor difficulties, or neurological problems which affect their physical or motor functioning.

III. Services to be provided

- Direct Services:
  - physiotherapy
  - occupational therapy

- Support Services:
  - consultation to school personnel
  - training of teachers and paraprofessionals
  - on-site demonstrations of routines in classrooms
  - on-site monitoring and evaluation of physical adjustment to classroom settings

IV. Obligations of each Ministry

Ministry of Health

- The Ministry of Health will determine the need for physiotherapy and occupational therapy in school settings in consultation with the Ministry of Education. Physiotherapists and occupational therapists will carry out direct therapy using the setting and means least disruptive to the educational program. Assessment and consultation will be provided to schools upon request.

- The Ministry of Health will provide direct occupational therapy and physiotherapy services in designated Provincial Resource Programs (estimated 8 FTEs in the province) and arrange for the provision of contracted rehabilitation services required. Contract monitoring will be the responsibility of Ministry of Health rehabilitation personnel with tracking mechanisms to be developed through agreement with the Ministry of Education.

Ministry of Education

- The Ministry of Education will include funds in the Fiscal Framework to enable school boards to contract for the services of physiotherapists and occupational therapists to provide the following educational support services:

  - provision of assessment information;
  - consultation to school staff;
  - training paraprofessionals and/or teachers to carry out routines such as positioning, seating, feeding, or motor activities for optimal maintenance of the student in a classroom setting during the school day;
  - monitoring and ongoing evaluation of students in classroom settings.

- School boards will contract to the Ministry of Health for the provision of these services to schools whenever possible. Where the Ministry of Health is unable to provide these services, the school board may contract a certified occupational therapist or physiotherapist in private practice for the provision of these services. The Ministry of Health will set standards for contracted services.

Approved and agreed to this tenth day of October, 1989.

A. L. (Sandy) Peel
Deputy Minister of Education

S. P. Dubas
Deputy Minister of Health

Re: Protocol Agreement - Physiotherapy - Occupational Therapy

The attached Information Circular is being issued jointly by the Ministry of Education and the Ministry of Health.

for Valerie Mitchell
Deputy Minister
Ministry of Education and
Ministry Responsible for
Multiculturalism and Human Rights

Douglas Allen
Deputy Minister
Ministry of Health and
Ministry Responsible
for Seniors

Attachment

GEE:eeb
A:\Protocol.Agr

Superintendents of Schools:
Directors of Instruction (Special Education):
Medical Health Officers/Directors:
Continuing Care Administrators:
Public Health Nursing Administrators:
Executive Directors, Child Development Centres:

Re: Protocol Agreement - Physiotherapy and Occupational Therapy between the Ministries of Education and Health

In support of the Protocol Agreement between the two Ministries, the Government of British Columbia has made funds available to the Ministry of Health to fund up to 26 Occupational Therapists and Physiotherapists to support the school system.

The Program is being resourced in school districts, through a collaborative approach via, in most instances, the nearest Child Development Centre (CDC). A list of CDCs and contact persons is attached. In areas of the Province where there are no CDCs within reasonable travelling distance, or in instances where no contact has been made to your school district by a CDC or Ministry of Health Speech and Language Services and Early Intervention Programs staff, contact should be made with the Ministry of Health in Victoria. You may telephone Jeanne Faith at 387-2349, or Bradford Gee at 387-2451. Given the dual responsibilities contained within this Protocol, there is a need for a negotiated agreement between health agencies and school districts before funds can be committed under this Program.

The major principles of the Occupational Therapy/Physiotherapy Program are as follows:

- Therapy goals will be integrated into the child's daily and family life.
- A collaborative program between parents, education staff and therapy staff.
- This is a related service to support educational and life goals.
- The goals of therapy in the school program must be educationally relevant.
- The scope of practice includes all school-aged children, whether they attend school or not (e.g. at home or all independent schools).
- The service would take place in the home, school, and/or community at large.
- The range of intervention will include: direct (individual and group), indirect - (consultative or monitoring).
- Necessary planning should take place to insure a smooth transition for the child from preschool to school, and from school to community.

. . . /2

The Ministry of Health and Ministry Responsible for Seniors welcomes your comments and suggestions concerning this handbook.

Comment

Please submit completed form to:

Child Development and Rehabilitation Section
Ministry of Health and Ministry Responsible for Seniors,
Province of British Columbia,
Courtyard Level,
1520 Blanshard Street,
Victoria, British Columbia
V8W 3C8

January 1995