



TELECONFERENCE/VIRTUAL MEETING
OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD
Room 121C, 1400 East Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
March 8, 2016

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.

AGENDA

9:30 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

- A) Adoption of Agenda (1-3)**
- B) Approval of Minutes of December 2, 2016 (4-6)**
- C) Administrative Updates (7-11)**
 - 1) Election of Officers
 - 2) Liaison Appointments and Delegated Authorities
 - 3) Department and Staff Updates
 - 4) Board Members – Term Expiration Dates
 - a) Brian Holmquist – 07/01/2013
 - b) Gaye Meyer – 07/01/2018
 - c) Laura O’Brien – 07/01/2015
 - d) Dorothy Olson – 07/01/2011
 - e) Corliss Rice – 07/01/2013
 - f) Amy Summers – 07/01/2018
 - 5) Wis. Stat. s 15.085 (3)(b) – Biannual Meeting with the Medical Examining Board
- D) Legislative/Administrative Rule Matters (12)**
 - 1) Update on Assembly Bill 726/Senate Bill 568 Relating to Renaming, Changing Membership and Eliminating Certain Professional Licensure Boards
 - 2) Update on Senate Bill 698 Relating to Duties and Powers of DPS
 - 3) Update on Other Legislation and Pending or Possible Rulemaking Projects
- E) The American Occupational Therapy Association (AOTA) Revised and Adopted Official Documents – Board Review (13-128)**
- F) Speaking Engagement(s), Travel, or Public Relation Requests**
 - 1) Wisconsin Occupational Therapy Association (WOTA) Spring Conference – Consider Attendance

G) Informational Item(s)

- 1) White House Report on Occupational Licensing (**129**)
- 2) National Conference of State Legislatures (NCSL) Partnership Project on Telehealth: Telehealth Policy Trends and Considerations (**130**)

H) Items Added After Preparation of Agenda:

- 1) Introductions, Announcements and Recognition
- 2) Administrative Updates
- 3) Education and Examination Matters
- 4) Credentialing Matters
- 5) Practice Matters
- 6) Legislation/Administrative Rule Matters
- 7) Liaison Report(s)
- 8) Informational Item(s)
- 9) Disciplinary Matters
- 10) Presentations of Petition(s) for Summary Suspension
- 11) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
- 12) Presentation of Proposed Decisions
- 13) Presentation of Interim Order(s)
- 14) Petitions for Re-Hearing
- 15) Petitions for Assessments
- 16) Petitions to Vacate Order(s)
- 17) Petitions for Designation of Hearing Examiner
- 18) Requests for Disciplinary Proceeding Presentations
- 19) Motions
- 20) Petitions
- 21) Appearances from Requests Received or Renewed
- 22) Speaking Engagement(s), Travel, or Public Relation Request(s)

I) Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 440.205, Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).

J) Deliberation on Division of Legal Services and Compliance (DLSC) Matters

- 1) **Monitoring**
- 2) **Administrative Warnings**
 - a) 14 OTB 007 – G.M.B. (**131-133**)
- 3) **Proposed Stipulations, Final Decisions and Orders**
- 4) **Case Closing**
 - a) 15 OTB 002 (**134-136**)

K) Open Cases

L) Deliberation of Items Added After Preparation of the Agenda

- 1) Education and Examination Matters
- 2) Credentialing Matters

- 3) Application Matters
- 4) Disciplinary Matters
- 5) Monitoring Matters
- 6) Professional Assistance Procedure (PAP) Matters
- 7) Petition(s) for Summary Suspensions
- 8) Proposed Stipulations, Final Decisions and Orders
- 9) Administrative Warnings
- 10) Proposed Decisions
- 11) Matters Relating to Costs
- 12) Complaints
- 13) Case Closings
- 14) Case Status Report
- 15) Petition(s) for Extension of Time
- 16) Proposed Interim Orders
- 17) Petitions for Assessments and Evaluations
- 18) Petitions to Vacate Orders
- 19) Remedial Education Cases
- 20) Motions
- 21) Petitions for Re-Hearing
- 22) Appearances from Requests Received or Renewed

M) Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

- N) Open Session Items Noticed Above not Completed in the Initial Open Session
- O) Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate
- P) Ratification of Licenses and Certificates

ADJOURNMENT

NEXT MEETING DATE JUNE 22, 2016

ORAL EXAMINATION OF ONE CANDIDATE FOR LICENSURE

ROOM 124E

10:00 A.M. OR IMMEDIATELY FOLLOWING FULL BOARD MEETING

CLOSED SESSION – Reviewing Applications and Conducting Oral Examinations of One Candidate for Licensure – Brian Holmquist and Laura O’Brien

OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD

December 2, 2015

PRESENT: Brian Holmquist, Gaye Meyer, Laura O'Brien, Dorothy Olson (*via Phone,*) Corliss Rice (*via GoToMeeting,*) Amy Summers

STAFF: Tom Ryan, Executive Director; Nifty Lynn Dio, Bureau Assistant; and other Department staff

CALL TO ORDER

Brian Holmquist, Chair, called the meeting to order at 9:33 a.m. A quorum of six (6) members was confirmed.

ADOPTION OF AGENDA

Amendments to the Agenda

- Additional item received for D.2

MOTION: Gaye Meyer moved, seconded by Amy Summers, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES

MOTION: Gaye Meyer moved, seconded by Laura O'Brien, to approve the minutes of June 10, 2015 as published. Motion carried unanimously.

LEGISLATIVE/ADMINISTRATIVE MATTERS

9:30 A.M. PUBLIC HEARING – CR15-053

MOTION: Laura O'Brien moved, seconded by Gaye Meyer, to accept all Clearinghouse comments for CR15-053 relating to self-referral of occupational therapy services. Motion carried unanimously.

MOTION: Laura O'Brien moved, seconded by Amy Summers, to authorize the Chair to approve the Legislative Report and Draft for Clearinghouse Rule CR15-053 relating to self-referral of occupational therapy services for submission to the Governor's Office and Legislature. Motion carried unanimously.

Discussion of Possible Scope Statement Regarding Changes to Supervision Rules Related to Home Health and Birth to 3 OT Services

MOTION: Laura O'Brien moved, seconded by Corliss Rice, to request DSPS staff draft a Scope Statement amending OT 4.04 supervision and practice of Occupational Therapy Assistants. Motion carried unanimously.

MOTION: Gaye Meyer moved, seconded by Dorothy Olson, to designate the Chair or Vice Chair to approve the Scope Statement amending OT 4.04 relating to supervision and practice of Occupational Therapy Assistants for submission to the Governor's

Office and publication, and to authorize the Chair or Vice Chair to approve the scope for implementation no less than 10 days after publication. Motion carried unanimously.

NBCOT 2016 STATE REGULATORY LEADERSHIP FORUM – CONSIDER ATTENDANCE

MOTION: Laura O'Brien moved, seconded by Amy Summers, to authorize the Chair or other member to be determined by the Alternate Travel Liaison and Board Executive Tom Ryan to attend the National Board for Certification in Occupational Therapy 2016 State Regulatory Leadership Forum on May 11-13, 2016 in New Orleans, Louisiana and to authorize travel. Motion carried unanimously.

MOTION: Laura O'Brien moved, seconded by Gaye Meyer, to authorize Amy Summers to attend the American Occupational Therapy Association (AOTA) 2016 Annual Conference & Expo on April 7-10, 2016 in Chicago, Illinois and to authorize travel. Motion carried unanimously.

WISCONSIN OCCUPATIONAL THERAPY ASSOCIATION (WOTA) SPRING CONFERENCE – CONSIDER ATTENDANCE

MOTION: Laura O'Brien moved, seconded by Amy Summers, to authorize Travel Liaison or Alternate Travel Liaison to appoint a speaker should a request be received for a Board Member to speak at the 2016 Wisconsin Occupational Therapy Association (WOTA) Spring Conference. Motion carried unanimously.

CLOSED SESSION

MOTION: Laura O'Brien moved, seconded by Gaye Meyer, to convene to Closed Session to deliberate on cases following hearing (§ 19.85(1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 440.205, Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Brian Holmquist – yes; Gaye Meyer – yes; Laura O'Brien – yes; Dorothy Olson – yes; Corliss Rice – yes; Amy Summers – yes. Motion carried unanimously.

The Board convened into Closed Session at 10:56 a.m.

(Dorothy Olson and Corliss Rice excused themselves and disconnected from the meeting at 10:59 a.m.)

RECONVENE TO OPEN SESSION

MOTION: Lauren O'Brien moved, seconded by Gaye Meyer, to reconvene in Open Session at 11:34 a.m. Motion carried unanimously.

RATIFICATION OF LICENSES AND CERTIFICATES

MOTION: Laura O'Brien moved, seconded by Amy Summers, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Lauren O'Brien moved, seconded by Gaye Meyer, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 11:36 a.m.

DRAFT

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Nifty Lynn Dio, Bureau Assistant		2) Date When Request Submitted: 12/23/15 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting									
3) Name of Board, Committee, Council, Sections: Occupational Therapists Affiliated Credentialing Board											
4) Meeting Date: 03/08/2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Administrative Updates 1. Election of Officers 2. Liaison Appointments and Delegated Authorities									
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A									
10) Describe the issue and action that should be addressed: 1. Elect Officers for 2016 2. The Chair Appoints Liaisons 3. The Board should consider continuation or modification of previously delegated authorities											
11) Authorization <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; border-bottom: 1px solid black;">Nifty Lynn Dio</td> <td style="width: 30%; border-bottom: 1px solid black; text-align: right;">12/23/15</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Signature of person making this request</td> <td style="border-bottom: 1px solid black; text-align: right;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Supervisor (if required)</td> <td style="border-bottom: 1px solid black; text-align: right;">Date</td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black;">Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date</td> </tr> </table>				Nifty Lynn Dio	12/23/15	Signature of person making this request	Date	Supervisor (if required)	Date	Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date	
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Signature of person making this request	Date										
Supervisor (if required)	Date										
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date											
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.											

Occupational Therapists Affiliated Credentialing Board

2015 OFFICERS	
Board Chair	Brian Holmquist
Vice Chair	Laura O'Brien
Secretary	Gaye Meyer

APPOINTMENT OF LIAISONS

2015 LIAISON APPOINTMENTS	
Credentialing Liaison	Laura O'Brien, Gaye Meyer <i>Alternate: Brian Holmquist, Dorothy Olson</i>
Monitoring Liaison	Laura O'Brien <i>Alternate: Dorothy Olson, Gaye Meyer</i>
Education and Exams Liaison	Laura O'Brien, Brian Holmquist <i>Alternate: Gaye Meyer, Dorothy Olson</i>
Legislative Liaison	Laura O'Brien <i>Alternate: Brian Holmquist</i>
Travel Liaison	Brian Holmquist <i>Alternate: Laura O'Brien</i>
Rules Liaison	Laura O'Brien <i>Alternate: Gaye Meyer, Brian Holmquist</i>
Professional Assistance Procedure Liaison	Gaye Meyer <i>Alternate: Laura O'Brien, Brian Holmquist</i>
Screening Panel	Laura O'Brien, Gaye Meyer, Brian Holmquist <i>Alternates: Dorothy Olson</i>

MOTION: Laura O'Brien moved, seconded by Dorothy Olson, to affirm the Chair's appointment of liaisons for 2015. Motion carried unanimously.

DELEGATED AUTHORITY MOTIONS

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, that, in order to facilitate the completion of assignments between meetings, the Board delegates its authority by order of succession to the Chair, highest ranking officer, or longest serving member of the Board, to appoint liaisons to the Department to act in urgent matters, to fill vacant appointment positions,

and to act where knowledge or experience in the profession is required to carry out the duties of the Board in accordance with the law. Motion carried unanimously.

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, that the Board delegates authority to the Chair, highest ranking officer, or longest serving member of the Board, to sign documents on behalf of the Board. In order to carry out duties of the Board, the Chair, highest ranking officer, or longest serving member of the Board have the ability to delegate this signature authority to the Board's Executive Director for purposes of facilitating the completion of assignments during or between meetings. Motion carried unanimously.

MOTION: Laura O'Brien moved, seconded by Dorothy Olson, that Board Counsel or another Department attorney is formally authorized to serve as the Board's designee for purposes of Wis. Admin. Code § SPS 1.08(1). Motion carried unanimously.

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, to adopt the 'Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor' document as presented. Motion carried unanimously.

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Kelley Sankbeil Monitoring Supervisor Division of Legal Services and Compliance		2) Date When Request Submitted: January 9, 2016 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 														
3) Name of Board, Committee, Council, Sections: Occupational Therapists Affiliated Credentialing Board																
4) Meeting Date: March 8, 2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Delegation of Authority to Monitoring Liaison and Department Monitor														
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:														
10) Describe the issue and action that should be addressed: Delegated Authority Motion: <p style="text-align: center;"><i>“ _____ moved, seconded by _____ to adopt/reject the Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor document as presented in today’s agenda packet.”</i></p>																
<table style="width: 100%; border: none;"> <tr> <td style="width: 10%; border: none;">11)</td> <td style="width: 60%; border: none; text-align: center;"> </td> <td style="width: 30%; border: none; text-align: center;"> Authorization January 9, 2016 </td> </tr> <tr> <td style="border: none;">Signature of person making this request</td> <td colspan="2" style="border: none; text-align: right;">Date</td> </tr> <tr> <td style="border: none;">Supervisor (if required)</td> <td colspan="2" style="border: none; text-align: right;">Date</td> </tr> <tr> <td colspan="3" style="border: none;">Executive Director signature (indicates approval to add post agenda deadline item to agenda)</td> <td style="border: none; text-align: right;">Date</td> </tr> </table>				11)		Authorization January 9, 2016	Signature of person making this request	Date		Supervisor (if required)	Date		Executive Director signature (indicates approval to add post agenda deadline item to agenda)			Date
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Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor

The Monitoring Liaison (“Liaison”) is a Board/Section designee who works with department monitors to enforce Board/Section orders as explained below.

Current Authorities Delegated to the Monitoring Liaison

The Liaison may take the following actions on behalf of the Board/Section:

1. Grant a temporary reduction in random drug screen frequency upon Respondent’s request if he/she is unemployed and is otherwise compliant with Board/Section order. The temporary reduction will be in effect until Respondent secures employment in the profession. The Department Monitor (“Monitor”) will draft an order and sign on behalf of the Liaison.
2. Grant a stay of suspension if Respondent is eligible per the Board/Section order. The Monitor will draft an order and sign on behalf of the Liaison.
3. Remove the stay of suspension if there are repeated violations or a substantial violation of the Board/Section order. In conjunction with removal of any stay of suspension, the Liaison may prohibit Respondent from seeking reinstatement of the stay for a specified period of time. The Monitor will draft an order and sign on behalf of the Liaison.
4. Grant or deny approval when Respondent proposes continuing/remedial education courses, treatment providers, mentors, supervisors, change of employment, etc. unless the order specifically requires full-Board/Section approval.
5. Grant a maximum of one 90-day extension, if warranted and requested in writing by Respondent, to complete Board/Section-ordered continuing education.
6. Grant a maximum of one extension or payment plan for proceeding costs and/or forfeitures if warranted and requested in writing by Respondent.
7. Grant full reinstatement of licensure if Respondent has fully complied with all terms of the order without deviation. The Monitor will draft an order and obtain the signature or written authorization from the Liaison.
- 8. Grant or deny a request to appear before the Board/Section in closed session.**

Current Authorities Delegated to the Department Monitor

The Monitor may take the following actions on behalf of the Board/Section, draft an order and sign:

1. Grant full reinstatement of licensure if CE is the sole condition of the limitation and Respondent has submitted the required proof of completion for approved courses.
2. Suspend the license if Respondent has not completed Board/Section-ordered CE and/or paid costs and forfeitures within the time specified by the Board/Section order. The Monitor may remove the suspension and issue an order when proof completion and/or payment have been received.

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Dale Kleven Administrative Rules Coordinator		2) Date When Request Submitted: 2/25/16 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Occupational Therapists Affiliated Credentialing Board			
4) Meeting Date: 3/8/16	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Legislative and Administrative Rule Matters – Discussion and Consideration 1. Update on Assembly Bill 726/Senate Bill 568 Relating to Renaming, Changing Membership and Eliminating Certain Professional Licensure Boards 2. Update on Senate Bill 698 Relating to Duties and Powers of DSPS 3. Update on Other Legislation and Pending or Possible Rulemaking Projects	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both		8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:
10) Describe the issue and action that should be addressed: 1. Assembly Bill 726: http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab726 Senate Bill 568: http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb568 2. Senate Bill 698: http://docs.legis.wisconsin.gov/2015/proposals/reg/sen/bill/sb698			
11) Authorization			
<i>Dale Kleven</i>		<i>February 25, 2016</i>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date			
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January 4, 2016

Dear State Regulatory Body Members and Staff:

This year AOTA's Representative Assembly adopted new official documents of the Association and several official documents were revised. Each year, the documents are published as a supplement to the November/December issue of *American Journal of Occupational Therapy* (AJOT). These documents are available on the AOTA website (www.aota.org), and we are happy to provide the enclosed copy of these new and revised documents as published in the AJOT supplement to you as a reference. The enclosed materials contain a number of helpful documents including:

AOTA Official Documents

- *Official Documents Available From the American Occupational Therapy Association*
- *Glossary (2014)*
- *Academic Terminal Degree (2013)*
- *Complex Environmental Modifications*
- *Enforcement Procedures for the Occupational Therapy Code of Ethics*
- *Guidelines for Reentry Into the Field of Occupational Therapy*
- *Importance of Interprofessional Education in Occupational Therapy Curricula*
- *Occupational Therapy Code of Ethics (2015)*
- *Occupational Therapy for Children and Youth Using Sensory Integration Theory and Methods in School-Based Practice*
- *Occupational Therapy's Perspective on the Use of Environments and Contexts to Facilitate Health, Well-Being, and Participation in Occupations*
- *Philosophy of Occupational Therapy Education (2014)*
- *Scope of Occupational Therapy Services for Individuals with Autism Spectrum Disorder Across the Life Course*
- *Standards for Continuing Competence*
- *Standards of Practice for Occupational Therapy*
- *Value of Occupational Therapy Assistant Education to the Profession*

We would also like to take this opportunity to let you know that AOTA's 2014 Annual Conference and Exposition will be held in **Chicago, Illinois April 7-10, 2016**. As always, it will be an exciting and stimulating event with many professional development opportunities. This year we will be holding a State Regulatory Forum for state regulatory board members and administrators on Friday, April 8. Look for more details on this event soon. We hope that many Board members and staff will join us this year.

If you have any questions, or if I can be of assistance to you, please feel free to contact me at AOTA.

Sincerely,



Chrissy Vogeley
Manager, State Affairs

Enclosure



The American Journal of Occupational Therapy

November/December 2015
Volume 69(Supplement 3)

AOTA Official Documents

- 6913410003 **Official Documents Available From the American Occupational Therapy Association**
- 6913410005 **Glossary (2014)**
- 6913410010 **Complex Environmental Modifications**
- 6913410015 **Guidelines for Reentry Into the Field of Occupational Therapy**
- 6913410020 **Importance of Interprofessional Education in Occupational Therapy Curricula**
- 6913410030 **Occupational Therapy Code of Ethics (2015)**
- 6913410040 **Occupational Therapy for Children and Youth Using Sensory Integration Theory and Methods in School-Based Practice**
- 6913410050 **Occupational Therapy's Perspective on the Use of Environments and Contexts to Facilitate Health, Well-Being, and Participation in Occupations**
- 6913410055 **Standards for Continuing Competence**
- 6913410070 **Value of Occupational Therapy Assistant Education to the Profession**

The Association

- 6913420010 **2015 AOTA/AOTF Awards and Recognitions Recipients**
- 6913420020 **2015 Representative Assembly Summary of Minutes**
- 6913420030 **AOTA 95th Annual Business Meeting Minutes**
- 6913420040 **List of Educational Programs in Occupational Therapy**

Author Guidelines

- 6913430010 **Guidelines for Contributors to *AJOT***

Official Documents Available From the American Occupational Therapy Association

Official documents are documents “constructed by the Association and approved by the Association for the use of the Association and its membership” (AOTA, 2008). Items in **bold** are new for 2015 and are available in this supplement to the *American Journal of Occupational Therapy*. All official documents are printed in the *Reference Manual of the Official Documents of the American Occupational Therapy Association, Inc.* (20th ed.; American Occupational Therapy Association, 2015).

Incorporation Papers and Bylaws

Articles of Incorporation (1976)
Certificate of Incorporation (1917)
Bylaws (2013)
Glossary (2014)

Accreditation

2011 Accreditation Council for Occupational Therapy Education (ACOTE[®]) Standards

Concept Papers

A Descriptive Review of Occupational Therapy Education
The Role of Occupational Therapy in Disaster Preparedness, Response, and Recovery: A Concept Paper
Scholarship in Occupational Therapy

Ethics

Enforcement Procedures for the *Occupational Therapy Code of Ethics* (2015)
Occupational Therapy Code of Ethics (2015)

Guidelines

Guidelines for Documentation of Occupational Therapy
Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational
Therapy Services
Guidelines for Reentry Into the Field of Occupational Therapy (2015)
Occupational Therapy Practice Framework: Domain and Process, 3rd Edition

Specialized Knowledge and Skills Papers

Specialized Knowledge and Skills in Adult Vestibular Rehabilitation for Occupational Therapy Practice
Specialized Knowledge and Skills in Feeding, Eating, and Swallowing for Occupational Therapy Practice
Specialized Knowledge and Skills of Occupational Therapy Educators of the Future
Specialized Knowledge and Skills for Occupational Therapy Practice in the Neonatal Intensive Care Unit
Specialized Knowledge and Skills in Mental Health Promotion, Prevention, and Intervention in Occupational
Therapy Practice
Specialized Knowledge and Skills in Technology and Environmental Interventions for Occupational
Therapy Practice

Position Papers

Complementary and Alternative Medicine

Complex Environmental Modifications (2015)

Importance of Interprofessional Education in Occupational Therapy Curricula (2015)

Fieldwork Level II and Occupational Therapy Students: A Position Paper

Obesity and Occupational Therapy

Occupational Therapy's Commitment to Nondiscrimination and Inclusion

Occupational Therapy's Perspective on the Use of Environments and Contexts to Facilitate Health and Participation in Occupations (2015)

Occupational Therapy Services in the Promotion of Psychological and Social Aspects of Mental Health

Physical Agent Modalities

The Role of Occupational Therapy in Primary Care

The Role of Occupational Therapy in Wound Management

Scope of Practice

Telehealth

Value of Occupational Therapy Assistant Education to the Profession (2015)

Standards

Standards for Continuing Competence (2015)

Standards of Practice for Occupational Therapy (2015)

Statements

Academic Terminal Degree (2013)

Cognition, Cognitive Rehabilitation, and Occupational Performance

Driving and Community Mobility

Occupational Therapy Fieldwork Education: Value and Purpose

Occupational Therapy for Children and Youth Using Sensory Integration Theory and Methods in School-Based Practice (2015)

Occupational Therapy in the Promotion of Health and Well-Being

Occupational Therapy Services for Individuals Who Have Experienced Domestic Violence

Occupational Therapy Services in Early Childhood and School-Based Settings

Occupational Therapy Services in Facilitating Work Performance

The Philosophical Base of Occupational Therapy

Philosophy of Occupational Therapy Education (2014)

The Role of Occupational Therapy in End-of-Life Care

Scope of Occupational Therapy Services for Individuals With Autism Spectrum Disorder Across the Life Course (2015)

Societal Statements

AOTA's Societal Statement on Combat-Related Posttraumatic Stress

AOTA's Societal Statement on Health Disparities

AOTA's Societal Statement on Health Literacy

AOTA's Societal Statement on Livable Communities

AOTA's Societal Statement on Stress and Stress Disorders

AOTA's Societal Statement on Youth Violence

The American Occupational Therapy Foundation, Inc.

Bylaws (2006)

Certificate of Incorporation (1965)

Rescissions, Revisions, and Changes

References

- American Occupational Therapy Association. (2008, November). Policy 1.30–R. Definition of official documents. In *Policy Manual* (2013 ed.). Bethesda, MD: Author.
- American Occupational Therapy Association. (2015). *Reference manual of the Official Documents of the American Occupational Therapy Association, Inc.* Bethesda, MD: AOTA Press.

The
Glossary
of the
American Occupational Therapy
Association

Absence

Failure to attend or appear when expected; the state of being away or not present (e.g., the Treasurer is not present for the Association Annual Business Meeting)

Accreditation

The process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It applies only to institutions and their programs of study or their services.

ACOTE®

Accreditation Council for Occupational Therapy Education®

Ad Hoc

A special body (e.g., committee, task force, task group, body) not established by the Bylaws. An ad hoc body is appointed for a specific purpose and assigned a specific task that is not an ongoing function in the Association.

Advisory

Having the function of giving advice, usually with the implication that the advice given need not be followed

Agenda (plural of Agendum)

A list of things to be done, especially the program for a meeting (e.g., the order of business of the Assembly meeting)

Amendments

Changes to the Bylaws that are neither revisions nor technical corrections

Annual Business Meeting

The scheduled gathering of Association members that must occur at least one time per year

Annual Conference

A meeting of persons from across the country to discuss or consult on various topics or issues (e.g., the Annual Conference of the Association)

AOTF

American Occupational Therapy Foundation

AOTPAC

American Occupational Therapy Political Action Committee

Articles of Incorporation

The original statements that provided the framework for the development and organization of the Association

ASAP

Affiliated State Association Presidents

ASD

Assembly of Student Delegates

Associate Member

A category of AOTA membership for individuals who are interested in the profession of occupational therapy but are not an OT practitioner or student

Board

The AOTA Board of Directors

Body

An organized group of individuals that has an official function

BPPC

Bylaws, Policies, and Procedures Committee

CCCPD

Commission on Continuing Competence and Professional Development

Censure

A formal expression of strong disapproval that is public

Certification

The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association

Chairperson

The presiding officer

Code of Ethics

An official document that serves as a "public statement of principles used to promote and maintain high standards of conduct with the profession." (Preamble to the *AOTA Occupational Therapy Code of Ethics 2010*)

COE

Commission on Education

Commission

A group of people authorized or directed to carry out a duty or task. A commission is responsible for a broad area of information relevant to the Association.

COP

Commission on Practice

Council

An appointed or elected body of people with an administrative, advisory, or representative function

CRAC

Credentials Review and Accountability Committee

Credential

Evidence of authority, status, rights, entitlement, or privileges, usually in written form (e.g., written notice of election of a person as a representative from an election area)

EC

Ethics Commission

Election Area

A geographic area that is defined as eligible for representation in the Representative Assembly

Emergency, Association

An emergency that would alter the Association's ability to effectively conduct business and that may be declared by the Executive Director, President, or Vice President

Emergency, National

An emergency declared by the President of the United States or Congress that results in restriction of travel, expenditures or collections, or personal activity and that requires a temporary policy or procedure to meet the situation

Executive Director

The person selected by the Board of Directors to occupy the position of executive director

Executive Session

A meeting or portion of a meeting at which the proceedings are private and only members, special invitees, and designated staff may be present. In the Association, Executive Session is used primarily to discuss information and issues that involve proprietary information, privileged information affecting individual member and personnel matters of the Association, or matters that may be the subject of litigation and/or are subject to attorney-client privilege. The purpose is to protect confidentiality, not to deprive members of their right to know.

Fee

A sum paid or charged for a privilege (e.g., the fee for membership in the Association)

Fiduciary Duty

Responsibility of members in elected and appointed positions to act in good faith and in a manner reasonably believed to be in the best interest of the Association in accordance with the duty of care and duty of loyalty

Internationally Based Practitioners

OT, OTA, or student members of the Association who live outside the United States

NBCOT[®]

National Board for Certification in Occupational Therapy[®]

Occupational Therapist

Any individual initially certified to practice as an OT or licensed or regulated by a state, commonwealth, district, or territory of the United States to practice as an occupational therapist

Occupational Therapy Assistant

Any individual initially certified to practice as an OTA or licensed or regulated by a state, commonwealth, district, or territory of the United States to practice as an occupational therapy assistant

Official Documents

Those documents constructed and approved by the Association for the use of the Association and its members

OT

Occupational therapist

OTA

Occupational therapy assistant

OTAS

Occupational therapy assistant student

OTS

Occupational therapy student

Organizational Advisors

Critical governance bodies within the organization that advise the Board and promote active collaboration and effective dialogue among the Board, appropriate bodies of the Board, the Representative Assembly, and AOTA

Organizational Member

A category of AOTA membership for institutions or agencies that are interested in the profession or practice of occupational therapy (e.g., another professional health care organization)

Parliamentary Procedure

The rules contained in the current edition of *Modern Parliamentary Procedure* that govern the Association in all cases in which they are applicable and in which they are not inconsistent with the Bylaws and any special rules of order the Association may adopt

Postprofessional Program

An educational curriculum in occupational therapy that offers courses designed to enhance knowledge and skills beyond the basic entry level for persons who are already OTs

Pro Tem (Pro Tempore)

Temporarily; for the time being (e.g., a person who acts as a Chairperson for a group for a meeting)

RA

Representative Assembly

RACC

Representative Assembly Coordinating Council

RALT

Representative Assembly Leadership Team

Recorder

A person who sets down something in writing or other permanent form (e.g., the person who prepares and keeps the minutes of the Representative Assembly)

Representative

A member of the AOTA Representative Assembly

Representative Assembly

The body composed of representatives from identified constituencies (election areas) whose function is to legislate and establish professional policies and standards for the Association

SCB

Specialty Certification Board

Seated

In a position from which authority is exercised; also, the approval a person receives from the group authorizing participation in the conduct of business

SISs

Special Interest Sections

SISC

Special Interest Sections Council

Slate

A list of candidates, officers, and so forth to be considered for nomination, appointment, election, and the like

Special Interest Section

A group of members recognized by the Representative Assembly as having a mutual interest in an area of practice in occupational therapy

Standard Operating Procedure

Regular procedures or actions that are taken by a group to accomplish an activity, charge, or item of business. Standard operating procedures are recorded in written form and are referred to as SOPs.

Standing Advisory Committee

A permanent committee established in the Bylaws dealing with a designated function (e.g., elections, recognitions, finance). A committee is responsible for a specific area of information relevant to the Association and the Board.

State Affiliate

A professional organization that represents OTs, OTAs, and students in a state and that is recognized by the Association

Steering Committee

A selected group of persons charged to function as an organizing unit to conduct certain business for a larger group. The function of the Steering Committee is to expedite the work of a larger group.

Vacancy

An unoccupied position or office (e.g., the Presidency is vacant if the President resigns)

VLDC

Volunteer Leadership Development Committee

WFOT

World Federation of Occupational Therapists

WFOT Alternate Delegate

Representative of Internationally Based Practitioners in the Representative Assembly who may also serve in the position of WFOT Delegate in the event of an absence, resignation, removal, death, or disabling condition

WFOT Delegate

Representative from AOTA to the World Federation of Occupational Therapists

BPPC Reviewed: 9/7/03, 1/05, 1/07, 1/08, 9/10, 9/14

Adopted RA: 11/03, 5/05, 4/07, 11/10

Adopted BOD: 10/14

Academic Terminal Degree

Although there are doctoral-degree programs in occupational therapy and occupational science, currently it is customary for occupational therapy faculty to have a doctorate in related areas of science or social science, including but not limited to education, neuroscience, public health, psychology, policy, law, or sociology. Thus, a degree in any of these areas would be considered a terminal degree for occupational therapists in academia.

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for

The Commission on Education

René Padilla, PhD, OTR/L, FAOTA, *Chairperson (2007–2010)*

Adopted by the Representative Assembly 2008C4

Reviewed by the Commission on Education, 2013, with no changes

Andrea Bilics PhD, OTR, *Chairperson (2013–2016)*

Adopted by the Representative Assembly Coordinating Council for the Representative Assembly (2013)

Note. This revision replaces the 2008 document *Academic Terminal Degree*, previously published and copyrighted in 2008 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy*, 62, 704. <http://dx.doi.org/10.5014/ajot.62.6.704>

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Complex Environmental Modifications

The American Occupational Therapy Association (AOTA) asserts that the evaluation and provision of complex adaptations and modifications to environments where people complete daily life occupations is within the scope of occupational therapy practice. Occupational therapists and occupational therapy assistants¹ routinely work with individuals and populations who are at risk for limitations in occupational performance and participation as a result of obstacles within their home, work, school, or community environments.

AOTA further asserts that occupational therapy practitioners,² by virtue of their academic training, knowledge, and expertise, can provide solutions to challenges affecting occupational performance and participation in daily life activities of all types that affect individuals across the life course. Furthermore, occupational therapy practitioners are distinctly qualified to be members of interdisciplinary teams composed of professionals in fields such as architecture, construction, city planning, and disability services. Occupational therapy practitioners offer both high- and low-technology equipment options and suggestions for structural alterations, modifications, and space enhancements that provide clients across the life course with access, safety, and efficiency in function.

This document provides a description of complex environmental modifications (CEMs) and highlights the role of occupational therapy practitioners as providers of service within this area. It is intended for internal and external audiences and to inform consumers, health care providers, educators, payers, referral sources, and policymakers about the distinctive skill set and contributions that occupational therapy brings to CEMs. Occupational therapy practitioners recognize the influence of environments (physical and social) and contexts (cultural, personal, temporal, and virtual) on human performance and occupational participation (AOTA, 2014b); this paper focuses primarily on the physical environment.

Complex Environmental Modifications

CEMs are alterations, modifications, or creations of new spaces to meet the needs of an individual, family, group, or community to preserve or facilitate optimal participation in daily life. CEM interventions can include, but are not limited to, a combination of structural changes, assistive technologies (AT), and services. CEMs are differentiated from services in which more basic, simpler, low-tech solutions are adequate to improve function. Examples of more basic solutions may include a tub transfer bench, rug removal, and adapted door knobs.

In addition to the recognition that the modifications to environments can be complex (e.g., installation of home automation systems) is the understanding that the environment itself may offer complex challenges. For example, a complex modification is to create a fully accessible kitchen in a home that not only was built

¹Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. Occupational therapy assistants deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).

²When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

in the 1800s but also, because of its historical designation, requires the modifications to meet the guidelines set forth by the town's historic commission.³

Role of Occupational Therapy in Complex Environmental Modifications

As interdisciplinary team members, occupational therapy practitioners working in this area provide expertise in the core knowledge of human function and occupational participation, AT, and specialized products. In addition, occupational therapy practitioners bring a distinct perspective through their knowledge of human development, the impact of physical and cognitive changes through the life course, and knowledge of community resources. With advanced study, occupational therapy practitioners enhance their knowledge in the areas of construction, architecture, structural design, and legislative guidelines.

The occupational therapy perspective in the area of CEMs combines an understanding of the impact of the environment⁴ and context⁵ on a person's occupational performance.⁶ Occupational therapists conduct evaluations and provide consultation, and practitioners provide intervention, training, education, and advocacy to individuals and groups, caregivers, and employers to remove environmental barriers and support occupational performance.

The occupational therapy process involves completion of a comprehensive, client-focused evaluation of the person and the environment and the process of engagement from the perspective of occupational participation. On the basis of the results of the evaluation and in conjunction with the client, the occupational therapist identifies and recommends environmental modifications and AT with a focus on the outcomes of client safety, satisfaction, and participation in desired daily occupations. In addition, the occupational therapy practitioner may manage funding and installation of technologies and modifications as well as the training of clients in their use. Details of the occupational therapy process relevant to CEMs include

- *Evaluation:* Information gathering about the client's occupational performance within his or her physical and social environments and contexts to determine the impact of client factors,⁷ performance skills,⁸ performance patterns,⁹ and occupational participation;
- *Intervention:* Eliminating environmental barriers via a combination of environmental modifications, AT, specialized products, and resources; matching the complex environmental modification or AT with the client's current level of executive functioning to ensure successful occupational performance; and
- *Outcomes:* The results of the interventions, including increased performance, increased ease of use and adaptation of the environment or AT, decreased caregiver burden, and increased participation in daily

³Historic homes also engage another level of regulatory standards that are not within the scope of this document to address.

⁴"The term *environment* refers to the external physical and social conditions that surround the client and in which the client's daily life occupations occur" (AOTA, 2014b, p. S28). *Physical environment* refers to the "natural . . . and built . . . surroundings in which daily life occupations occur" (p. S8). The *social environment* is constructed by the "presence of, relationships with, and expectations of persons, groups, and populations with whom clients have contact" (p. S9).

⁵The term *context* refers to a variety of interrelated conditions that are within and surrounding the client that influence performance, including cultural, personal, temporal, and virtual contexts (AOTA, 2014b, p. S9).

⁶*Occupational performance* is the act of doing and accomplishing a selected action (performance skill), activity, or occupation (Fisher, 2009; Fisher & Griswold, 2014; Kielhofner, 2008) that results from the dynamic transaction among the client, the context and environment, and the activity (AOTA, 2014b, p. S43).

⁷*Client factors* are specific capacities, characteristics, or beliefs that reside within the individual and that influence performance in occupations (AOTA, 2014b).

⁸*Performance skills* are goal-directed actions that are observable as small units of engagement in daily life occupations. They are learned and developed over time and are situated in specific contexts and environments (Fisher & Griswold, 2014).

⁹*Performance patterns* are the habits, routines, roles, and rituals used in the process of engaging in occupations or activities that can support or hinder occupational performance (AOTA, 2014b).

life (Dooley & Hinojosa, 2004; Graff et al., 2006; Hendriks et al., 2008; Heywood, 2005; Mann, Ottenbacher, Fraas, Tomita, & Granger, 1999; Petersson, Kottorp, Bergstrom, & Lilja, 2009).

Examples of services provided by occupational therapy practitioners in the area of CEMs include

- Interventions that require knowledge of AT, environmental modifications, and community resources to ensure that the solutions will meet the client's immediate and future needs;
- Modifications that expand beyond consumer-grade and marketed adaptations such as grab bars, ramps, and AT found at retail and medical equipment stores;
- Modifications for clients with significant changes in function due to injury or disability or those with progressive or chronic conditions such as diabetes, asthma, and obesity;
- Consultation on projects requiring additional knowledge and experience such as remodeling and construction of new homes, work environments, and community spaces, including plan review;
- Consultation on projects that include a general contractor, designer, or architect or modifications requiring building permits; and
- Advocacy for the needs of clients requiring modifications to home and community environments through interfacing with government agencies, payment sources, and community planners.

Client-centered environmental modification interventions provided by an occupational therapy practitioner reduce functional challenges in performing daily living activities, minimize environmental barriers, and enhance perceived quality of life (Szanton et al., 2011). Evidence supports occupational therapy interventions to reduce falls (Campbell et al., 2005; Clemson et al., 2004; Davison, Bond, Dawson, Steen, & Kenny, 2005; Nikolaus & Bach, 2003), promote increased participation in activities of daily living (ADLs); Fänge & Iwarsson, 2005; Gitlin, Miller, & Boyce, 1999; Gitlin et al., 2006; Graff et al., 2006; Petersson et al., 2009; Stark, 2004; Stark, Landsbaum, Palmer, Somerville, & Morris, 2009), increase satisfaction in occupational performance (Graff, Vernooij-Dassen, Hoefnagels, Dekker, & de Witte, 2003; Petersson, Lilja, Hammel, & Kottorp, 2008; Stark et al., 2009), and promote safe performance of caregiving (Dooley & Hinojosa, 2004). Furthermore, occupational therapy interventions directed at the caregiver reduced decline in self-care of family members (Gitlin, Corcoran, Winter, Boyce, & Hauck, 2001), thus decreasing cost of care and delaying institutionalization (Wilson, Mitchell, Kemp, Adkins, & Mann, 2009), as well as increased perceived quality of life (Szanton et al., 2011).

Significance to Society

In 2001, the World Health Organization (WHO), in the *International Classification of Functioning, Disability and Health (ICF)*, described the ability of individuals to participate in life situations as a core component of addressing health and disability. According to the *ICF*, life situations in which participation occurs are identified as learning and applying knowledge; performing general tasks and demands; communication; mobility; self-care; domestic life; interpersonal interactions and relationships; and major life areas, including work, school, community, and social and civic life (Law, 2002; WHO, 2001). These areas of daily living and the view of the human as an occupational being whose level of ability is not a reflection of infirmity but of participation is found throughout the occupational therapy literature and is a grounding tenet of the *Occupational Therapy Practice Framework (AOTA, 2010a, 2014b; Wood et al., 2000)*.

Addressing concerns related to participation is the driving force behind the occupational therapy profession's focus on creating spaces for living, working, playing, sleeping, learning, addressing self-care needs, and being involved in the community that are accessible and provide ample opportunities for the level of participation desired by each individual. Occupational therapy practitioners provide services and recommend products to enable consumers and caregivers to live as independently and safely as possible while considering functional limitations and progressive issues of illness, disability, or age-related decline

(AOTA, 2014b; Siebert, Smallfield, & Stark, 2014). Occupational therapy services are provided across the spectrum of ages and settings, as well as during transition from one setting to another. There is a demand for services to be provided to consumers not only to assist with maintaining health and wellness but also to allow for successful aging in place and community participation. CEMs are one means of removing barriers to daily functioning and maintaining independence and quality of life for both consumers and their caregivers.

In addition, supporting older adults and persons with disabilities who wish to live independently and participate in their chosen communities (Bayer & Harper, 2000; Houser, Fox-Grage, & Ujvari, 2012; Lipman, 2012; Redfoot & Houser, 2010) is believed not only to enhance quality of life but also to contain health care costs. Occupational therapy practitioners consulting with clients, their caregivers, builders, designers, and other involved professionals can ensure the most appropriate, evidence-based, safe, and accessible residential design; choice of specialized products; and ergonomically appropriate installation from the design and building team.

Practitioner Qualifications, Professional Development, and Ethical Considerations

Occupational therapy practitioners providing CEMs must assess their own competency and ensure that they are able to safely and effectively recommend, obtain, and install appropriate modifications. To this end, occupational therapy practitioners must adhere to the *Occupational Therapy Code of Ethics (2015)* (AOTA, 2015) and the *Standards of Practice for Occupational Therapy* (AOTA, 2010b) and must abide by federal and state regulations to ensure their competencies as practitioners and the well-being of their clients.

Occupational therapy practitioners choosing to pursue CEM as an area of practice can gain advanced experience through mentoring opportunities, continuing education courses, and review of national and international professional publications on this topic. To address the complex needs and challenges facing clients, additional occupational therapy knowledge and training are needed in the following areas: environmental or functional evaluations, accessible building guidelines, universal design, AT and architectural products and their installation, ergonomic design, and advocacy.

Summary

The goal of occupational therapy is to promote health, well-being, and participation in life through engagement in occupation (AOTA, 2014b). Occupational therapy practitioners bring a distinct skill set to CEMs, addressing needs through a holistic and client-centered approach and providing environmental interventions that facilitate client safety, independence, and participation in daily life occupations within an environment. This skill set supports interprofessional collaboration for best client outcomes. Design, construction, architectural, city planning, and disability providers are increasingly aware of the benefits of working with occupational therapy practitioners. In addition, consumers are seeking the services of occupational therapy practitioners in building and renovating environments to increase accessibility, participation, independence, and safety.

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Enforcement Procedures for the Occupational Therapy Code of Ethics

1. Introduction

The principal purposes of the *Occupational Therapy Code of Ethics* (hereinafter referred to as the Code) are to help protect the public and to reinforce its confidence in the occupational therapy profession rather than to resolve private business, legal, or other disputes for which there are other more appropriate forums for resolution. The Code also is an aspirational document to guide occupational therapists, occupational therapy assistants, and occupational therapy students toward appropriate professional conduct in all aspects of their diverse professional and volunteer roles. It applies to any conduct that may affect the performance of occupational therapy as well as to behavior that an individual may do in another capacity that reflects negatively on the reputation of occupational therapy.

The *Enforcement Procedures for the Occupational Therapy Code of Ethics* have undergone a series of revisions by the Association's Ethics Commission (hereinafter referred to as the EC) since their initial adoption. This public document articulates the procedures that are followed by the EC as it carries out its duties to enforce the Code. A major goal of these *Enforcement Procedures* is to ensure objectivity and fundamental fairness to all individuals who may be parties in an ethics complaint. The *Enforcement Procedures* are used to help ensure compliance with the Code which delineates enforceable Principles and Standards of Conduct that apply to Association members.

Acceptance of Association membership commits individuals to adherence to the Code and cooperation with its *Enforcement Procedures*. These are established and maintained by the EC. The EC and Association's Ethics Office make the *Enforcement Procedures* public and available to members of the profession, state regulatory boards, consumers, and others for their use.

The EC urges particular attention to the following issues:

- 1.1. **Professional Responsibility**—All occupational therapy personnel have an obligation to maintain the Code of their profession and to promote and support these ethical standards among their colleagues. Each Association member must be alert to practices that undermine these standards and is obligated to take action that is appropriate in the circumstances. At the same time, members must carefully weigh their judgments as to potentially unethical practice to ensure that they are based on objective evaluation and not on personal bias or prejudice, inadequate information, or simply differences of professional viewpoint. It is recognized that individual occupational therapy personnel may not have the authority or ability to address or correct all situations of concern. Whenever feasible and appropriate, members should first pursue other corrective steps within the relevant institution or setting and discuss ethical concerns directly with the potential Respondent before resorting to the Association's ethics complaint process.
- 1.2. **Jurisdiction**—The Code applies to persons who are or were Association members at the time of the conduct in question. Later nonrenewal or relinquishment of membership does not affect Association jurisdiction. The *Enforcement Procedures* that shall be utilized in any complaint shall be those in effect at the time the complaint is initiated.

1.3. Disciplinary Actions/Sanctions (Pursuing a Complaint)—If the EC determines that unethical conduct has occurred, it may impose sanctions, including reprimand, censure, probation (with terms) suspension, or permanent revocation of Association membership. In all cases, except those involving only reprimand (and educative letters), the Association will report the conclusions and sanctions in its official publications and also will communicate to any appropriate persons or entities. If an individual is on either the Roster of Fellows (ROF) or the Roster of Honor (ROH), the EC Chairperson (via the EC Staff Liaison) shall notify the VLDC Chairperson and Association Executive Director (ED) of their membership suspension or revocation. That individual shall have their name removed from either the ROF or the ROH and no longer has the right to use the designated credential of FAOTA or ROH during the period of suspension or permanently, in the case of revocation.

The EC Chairperson shall also notify the Chairperson of the Board for Advanced and Specialty Certification (BASC) (via Association staff liaison, in writing) of final disciplinary actions from the EC in which an individual's membership has been suspended or revoked. These individuals are not eligible to apply for or renew certification.

The potential sanctions are defined as follows:

1.3.1. Reprimand—A formal expression of disapproval of conduct communicated privately by letter from the EC Chairperson that is nondisclosable and noncommunicative to other bodies (e.g., state regulatory boards [SRBs], National Board for Certification in Occupational Therapy® [NBCOT®]). Reprimand is not publicly reported.

1.3.2. Censure—A formal expression of disapproval that is publicly reported.

1.3.3. Probation of Membership Subject to Terms—Continued membership is conditional, depending on fulfillment of specified terms. Failure to meet terms will subject an Association member to any of the disciplinary actions or sanctions. Terms may include but are not limited to

- a. Remedial activity, applicable to the violation, with proof of satisfactory completion, by a specific date; and
- b. The corrected behavior which is expected to be maintained.

Probation is publicly reported.

1.3.4. Suspension—Removal of Association membership for a specified period of time. Suspension is publicly reported.

1.3.5. Revocation—Permanent denial of Association membership. Revocation is publicly reported.

1.4. Educative Letters—If the EC determines that the alleged conduct may or may not be a true breach of the Code but in any event does not warrant any of the sanctions set forth in Section 1.3. or is not completely in keeping with the aspirational nature of the Code or within the prevailing standards of practice or professionalism, the EC may send a private letter to educate the Respondent about relevant standards of practice and/or appropriate professional behavior. In addition, a different private educative letter, if appropriate, may be sent to the Complainant.

1.5. Advisory Opinions—The EC may issue general advisory opinions on ethical issues to inform and educate the Association membership. These opinions shall be publicized to the membership and are available in the *Reference Guide to the Occupational Therapy Code of Ethics* as well as on the Association website.

1.6. Rules of Evidence—The EC proceedings shall be conducted in accordance with fundamental fairness. However, formal rules of evidence that are used in legal proceedings do not apply to these

Enforcement Procedures. The Disciplinary Council (see Section 5) and the Appeal Panel (see Section 6) can consider any evidence that they deem appropriate and pertinent.

1.7. Confidentiality and Disclosure—The EC develops and adheres to strict rules of confidentiality in every aspect of its work. This requires that participants in the process refrain from any communication relating to the existence and subject matter of the complaint other than with those directly involved in the enforcement process. Maintaining confidentiality throughout the investigation and enforcement process of a formal ethics complaint is essential in order to ensure fairness to all parties involved. These rules of confidentiality pertain not only to the EC but also apply to others involved in the complaint process. Beginning with the EC Staff Liaison and support staff, strict rules of confidentiality are followed. These same rules of confidentiality apply to Complainants, Respondents and their attorneys, and witnesses involved with the EC's investigatory process. Due diligence must be exercised by everyone involved in the investigation to avoid compromising the confidential nature of the process. Any Association member who breaches these rules of confidentiality may become subject to an ethics complaint/investigatory process himself or herself. Non-Association members may lodge an ethics complaint against an Association member, and these individuals are still expected to adhere to the Association's confidentiality rules. The Association reserves the right to take appropriate action against non-Association members who violate confidentiality rules, including notification of their appropriate licensure boards.

1.7.1. Disclosure—When the EC investigates a complaint, it may request information from a variety of sources. The process of obtaining additional information is carefully executed in order to maintain confidentiality. The EC may request information from a variety of sources, including state licensing agencies, academic councils, courts, employers, and other persons and entities. It is within the EC's purview to determine what disclosures are appropriate for particular parties in order to effectively implement its investigatory obligations. Public sanctions by the EC, Disciplinary Council, or Appeal Panel will be publicized as provided in these *Enforcement Procedures*. Normally, the EC does not disclose information or documentation reviewed in the course of an investigation unless the EC determines that disclosure is necessary to obtain additional, relevant evidence or to administer the ethics process or is legally required.

Individuals who file a complaint (i.e., *Complainant*) and those who are the subject of one (i.e., *Respondent*) must not disclose to anyone outside of those involved in the complaint process their role in an ethics complaint. Disclosing this information in and of itself may jeopardize the ethics process and violate the rules of fundamental fairness by which all parties are protected. Disclosure of information related to any case under investigation by the EC is prohibited and, if done, will lead to repercussions as outlined in these *Enforcement Procedures* (see Section 2.2.3.).

2. Complaints

2.1. Interested Party Complaints

2.1.1. Complaints stating an alleged violation of the Code may originate from any individual, group, or entity within or outside the Association. All complaints must be in writing, signed by the Complainant(s), and submitted to the Ethics Office at the Association headquarters. Complainants must complete the Formal Statement of Complaint Form at the end of this document. All complaints shall identify the person against whom the complaint is directed (the Respondent), the ethical principles that the Complainant believes have been violated, and the key facts and date(s) of the alleged ethical violations. If lawfully available, supporting documentation should be attached. Hard-copy complaints must be sent to the address indicated on the complaint form.

Complaints that are emailed must be sent as a pdf attachment, marked "Confidential" with "Complaint" in the subject line to ethics@aota.org and must include the complaint form and supporting documentation.

2.1.2. Within 90 days of receipt of a complaint, the EC shall make a preliminary assessment of the complaint and decide whether it presents sufficient questions as to a potential ethics violation that an investigation is warranted in accordance with Section 3. Commencing an investigation does not imply a conclusion that an ethical violation has in fact occurred or any judgment as to the ultimate sanction, if any, that may be appropriate. In the event the EC determines at the completion of an investigation that the complaint does rise to the level of an ethical violation, the EC may issue a decision as set forth in Section 4 below. In the event the EC determines that the complaint does not rise to the level of an ethical violation, the EC may direct the parties to utilize other conflict resolution resources or authorities via an educative letter. This applies to all complaints, including those involving Association elected/ volunteer leadership related to their official roles.

2.2. Complaints Initiated by the EC

2.2.1. The EC itself may initiate a complaint (a *sua sponte* complaint) when it receives information from a governmental body, certification or similar body, public media, or other source indicating that a person subject to its jurisdiction may have committed acts that violate the Code. The Association will ordinarily act promptly after learning of the basis of a *sua sponte* complaint, but there is no specified time limit.

If the EC passes a motion to initiate a *sua sponte* complaint, the Association staff liaison to the EC will complete the Formal Statement of Complaint Form (at the end of this document) and will describe the nature of the factual allegations that led to the complaint and the manner in which the EC learned of the matter. The Complaint Form will be signed by the EC Chairperson on behalf of the EC. The form will be filed with the case material in the Association's Ethics Office.

2.2.2. De Jure Complaints—Where the source of a *sua sponte* complaint is the findings and conclusions of another official body, the EC classifies such *sua sponte* complaints as *de jure*. The procedure in such cases is addressed in Section 4.2.

2.2.3. The EC shall have the jurisdiction to investigate or sanction any matter or person for violations based on information learned in the course of investigating a complaint under Section 2.2.2.

2.3. Continuation of Complaint Process—If an Association member relinquishes membership, fails to renew membership, or fails to cooperate with the ethics investigation, the EC shall nevertheless continue to process the complaint, noting in its report the circumstances of the Respondent's action. Such actions shall not deprive the EC of jurisdiction. All correspondence related to the EC complaint process is in writing and sent by mail with signature and proof of date received. In the event that any written correspondence does not have delivery confirmation, the Association Ethics Office will make an attempt to search for an alternate physical or electronic address or make a second attempt to send to the original address. If the Respondent does not claim correspondence after two attempts to deliver, delivery cannot be confirmed or correspondence is returned to the Association as undeliverable, the EC shall consider that it has made good-faith effort and shall proceed with the ethics enforcement process.

3. EC Review and Investigations

3.1. Initial Action—The purpose of the preliminary review is to decide whether or not the information submitted with the complaint warrants opening the case. If in its preliminary review of the complaint the EC determines that an investigation is not warranted, the Complainant will be so notified.

3.2. Dismissal of Complaints—The EC may at any time dismiss a complaint for any of the following reasons:

3.2.1. Lack of Jurisdiction—The EC determines that it has no jurisdiction over the Respondent (e.g., a complaint against a person who is or was not an Association member at the time of the alleged incident or who has never been a member).

3.2.2. Absolute Time Limit/Not Timely Filed—The EC determines that the violation of the Code is alleged to have occurred more than 7 years prior to the filing of the complaint.

3.2.3. Subject to Jurisdiction of Another Authority—The EC determines that the complaint is based on matters that are within the authority of and are more properly dealt with by another governmental or nongovernmental body, such as an SRB, NBCOT®, an Association component other than the EC, an employer, educational institution, or a court.

3.2.4. No Ethics Violation—The EC finds that the complaint, even if proven, does not state a basis for action under the Code (e.g., simply accusing someone of being unpleasant or rude on an occasion).

3.2.5. Insufficient Evidence—The EC determines that there clearly would not be sufficient factual evidence to support a finding of an ethics violation.

3.2.6. Corrected Violation—The EC determines that any violation it might find already has been or is being corrected and that this is an adequate result in the given case.

3.2.7. Other Good Cause.

3.3. Investigator and EC (Avoidance of Conflict of Interest)—The investigator chosen shall not have a conflict of interest (i.e., shall never have had a substantial professional, personal, financial, business, or volunteer relationship with either the Complainant or the Respondent). In the event that the EC Staff Liaison has such a conflict, the EC Chairperson shall appoint an alternate investigator who has no conflict of interest. Any member of the EC with a possible conflict of interest must disclose and may be recused.

3.4. Investigation—If an investigation is deemed warranted, the EC Chairperson shall do the following within thirty (30) days: Appoint the EC Staff Liaison at the Association headquarters to investigate the complaint and notify the Respondent by mail (requiring signature and proof of date of receipt) that a complaint has been received and an investigation is being conducted. A copy of the complaint and supporting documentation shall be enclosed with this notification. The Complainant also will receive notification by mail (requiring signature and proof of date of receipt) that the complaint is being investigated.

3.4.1. Ordinarily, the Investigator will send questions formulated by the EC to be answered by the Complainant and/or the Respondent.

3.4.2. The Complainant shall be given thirty (30) days from receipt of the questions (if any) to respond in writing to the investigator.

3.4.3. The Respondent shall be given thirty (30) days from receipt of the questions to respond in writing to the Investigator.

3.4.4. The EC ordinarily will notify the Complainant of any substantive new evidence adverse to the Complainant's initial complaint that is discovered in the course of the ethics investigation and allow the Complainant to respond to such adverse evidence. In such cases, the Complainant will be given a copy of such evidence and will have fourteen (14) days in which to submit a written response. If the new evidence clearly shows that there has been no ethics violation, the

EC may terminate the proceeding. In addition, if the investigation includes questions for both the Respondent and the Complainant, the evidence submitted by each party in response to the investigatory questions shall be provided to the Respondent and available to the Complainant on request. The EC may request reasonable payment for copying expenses depending on the volume of material to be sent.

- 3.4.5. The Investigator, in consultation with the EC, may obtain evidence directly from third parties without permission from the Complainant or Respondent.
- 3.5. **Investigation Timeline**—The investigation will be completed within ninety (90) days after receipt of notification by the Respondent or his or her designee that an investigation is being conducted, unless the EC determines that special circumstances warrant additional time for the investigation. All timelines noted here can be extended for good cause at the discretion of the EC, including the EC's schedule and additional requests of the Respondent. The Respondent and the Complainant shall be notified in writing if a delay occurs or if the investigational process requires more time.
- 3.6. **Case Files**—The investigative files shall include the complaint and any documentation on which the EC relied in initiating the investigation.
- 3.7. **Cooperation by Respondent**—Every Association Respondent has a duty to cooperate reasonably with enforcement processes for the Code. Failure of the Respondent to participate and/or cooperate with the investigative process of the EC shall not prevent continuation of the ethics process, and this behavior itself may constitute a violation of the Code.
- 3.8. **Referral of Complaint**—The EC may at any time refer a matter to NBCOT®, the SRB, ACOTE®, or other recognized authorities for appropriate action. Despite such referral to an appropriate authority, the EC shall retain jurisdiction. EC action may be stayed for a reasonable period pending notification of a decision by that authority, at the discretion of the EC (and such delays will extend the time periods under these *Procedures*). A stay in conducting an investigation shall not constitute a waiver by the EC of jurisdiction over the matters. The EC shall provide written notice by mail (requiring signature and proof of date of receipt) to the Respondent and the Complainant of any such stay of action.

4. EC Review and Decision

4.1. Regular Complaint Process

- 4.1.1. **Decision**—If at the conclusion of the investigation the EC determines that the Respondent has engaged in conduct that constitutes a breach of the Code, the EC shall notify the Respondent and Complainant by mail with signature and proof of date received. The notice shall describe in sufficient detail the conduct that constitutes a violation of the Code and indicate the sanction that is being imposed in accordance with these *Enforcement Procedures*.
- 4.1.2. **Respondent's Response**—Within 30 days of notification of the EC's decision and sanction, if any, the Respondent shall
- 4.1.2.1. Accept the decision of the EC (as to both the ethics violation and the sanction) and waive any right to a Disciplinary Council hearing, or
- 4.1.2.2. Accept the decision that he/she committed unethical conduct but within thirty (30) days, submit to the EC a statement (with any supporting documentation) setting forth the reasons why any sanction should not be imposed or reasons why the sanction should be mitigated or reduced.

- 4.1.2.3. Advise the EC Chairperson in writing that he or she contests the EC's decision and sanction and requests a hearing before the Disciplinary Council.

Failure of the Respondent to take one of these actions within the time specified will be deemed to constitute acceptance of the decision and sanction. If the Respondent requests a Disciplinary Council hearing, it will be scheduled. If the Respondent does not request a Disciplinary Council hearing but accepts the decision, the EC will notify all relevant parties and implement the sanction. Correspondence with the Respondent will also indicate that public sanctions may have an impact on their ability to serve in Association positions, whether elected or appointed, for a designated period of time.

4.2. *De Jure* Complaint Process

- 4.2.1. The EC Staff Liaison will present to the EC any findings from external sources (as described above) that come to his or her attention and that may warrant *sua sponte* complaints pertaining to individuals who are or were Association members at the time of the alleged incident.
- 4.2.2. Because *de jure* complaints are based on the findings of fact or conclusions of another official body, the EC will decide whether or not to act based on such findings or conclusions and will not ordinarily initiate another investigation, absent clear and convincing evidence that such findings and conclusions were erroneous or not supported by substantial evidence. Based on the information presented by the EC Staff Liaison, the EC will determine whether the findings of the public body also are sufficient to demonstrate an egregious violation of the Code and therefore warrant taking disciplinary action.
- 4.2.3. If the EC decides that a breach of the Code has occurred, the EC Chairperson will notify the Respondent in writing of the violation and the disciplinary action that is being taken. Correspondence with the Respondent will also indicate that public sanctions may have an impact on their ability to serve in Association positions, whether elected or appointed, for a designated period of time. In response to the *de jure sua sponte* decision and sanction by the EC, the Respondent may
 - 4.2.3.1. Accept the decision of the EC (as to both the ethics violation and the sanction) based solely on the findings of fact and conclusions of the EC or the public body, and waive any right to a Disciplinary Council hearing;
 - 4.2.3.2. Accept the decision that the Respondent committed unethical conduct but within thirty (30) days submit to the EC a statement (with any supporting documentation) setting forth the reasons why any sanction should not be imposed or reasons why the sanction should be mitigated or reduced; or
 - 4.2.3.3. Within thirty (30) days, present information showing the findings of fact of the official body relied on by the EC to impose the sanction are clearly erroneous and request reconsideration by the EC. The EC may have the option of opening an investigation or modifying the sanction in the event they find clear and convincing evidence that the findings and the conclusions of the other body are erroneous.
- 4.2.4. In cases of *de jure* complaints, a Disciplinary Council hearing can later be requested (pursuant to Section 5 below) only if the Respondent has first exercised Options 4.2.3.2 or 4.2.3.3.
- 4.2.5. Respondents in an ethics case may utilize Options 4.2.3.2 or 4.2.3.3 (reconsideration) once in responding to the EC. Following one review of the additional information submitted by the Respondent, if the EC reaffirms its original sanction, the Respondent has the option of accepting the violation and proposed sanction or requesting a Disciplinary Council hearing. Repeated requests for reconsideration will not be accepted by the EC.

5. Disciplinary Council

5.1. Purpose—The purpose of the Disciplinary Council (hereinafter to be known as the Council) hearing is to provide the Respondent an opportunity to present evidence and witnesses to answer and refute the decision and/or sanction and to permit the EC Chairperson or designee to present evidence and witnesses in support of his or her decision. The Council shall consider the matters alleged in the complaint; the matters raised in defense as well as other relevant facts, ethical principles, and federal or state law, if applicable. The Council may question the parties concerned and determine ethical issues arising from the factual matters in the case even if those specific ethical issues were not raised by the Complainant. The Council also may choose to apply Principles or other language from the Code not originally identified by the EC. The Council may affirm the decision of the EC or reverse or modify it if it finds that the decision was clearly erroneous or a material departure from its written procedure.

5.2. Parties—The parties to a Council Hearing are the Respondent and the EC Chairperson.

5.3. Criteria and Process for Selection of Council Members

5.3.1. Criteria

5.3.1.1. Association Administrative Standard Operating Procedures (SOP) and Association Policy 2.6 shall be considered in the selection of qualified potential candidates for the Council, which shall be composed of qualified individuals and Association members drawn from a pool of candidates who meet the criteria outlined below. Members ideally will have some knowledge or experience in the areas of activity that are at issue in the case. They also will have experience in disciplinary hearings and/or general knowledge about ethics as demonstrated by education, presentations, and/or publications.

5.3.1.2. No conflict of interest may exist with either the Complainant or the Respondent (refer to Association Policy A.13—Conflict of Interest for guidance).

5.3.1.3. No individual may serve on the Council who is currently a member of the EC or the Board of Directors

5.3.1.4. No individual may serve on the Council who has previously been the subject of an ethics complaint that resulted in a public EC disciplinary action within the past three (3) years.

5.3.1.5. The public member on the Council shall have knowledge of the profession and ethical issues.

5.3.1.6. The public member shall not be an occupational therapist or occupational therapy assistant (practitioner, educator, or researcher.)

5.4. Criteria and Process for Selection of Council Chairperson

5.4.1. Criteria

5.4.1.1. Must have experience in analyzing/reviewing cases.

5.4.1.2. May be selected from the pool of candidates for the Council or a former EC member who has been off the EC for at least three (3) years.

5.4.1.3. The EC Chairperson shall not serve as the Council Chairperson.

5.4.2. Process

- 5.4.2.1. The Representative Assembly (RA) Speaker (in consultation with EC Staff Liaison) will select the Council Chairperson.
- 5.4.2.2. If the RA Speaker needs to be recused from this duty, the RA Vice Speaker will select the Council Chairperson.

5.5. Process

- 5.5.1. Potential candidates for the Council pool will be recruited through public postings in official publications and via the electronic forums. Association leadership will be encouraged to recruit qualified candidates. Potential members of the Council shall be interviewed to ascertain the following:
 - a. Willingness to serve on the Council and availability for a period of three (3) years and
 - b. Qualifications per criteria outlined in Section 5.3.1.
- 5.5.2. The President and EC Staff Liaison will maintain a pool of no fewer than six (6) and no more than twelve (12) qualified individuals.
- 5.5.3. The President, with input from the EC Staff Liaison, will select from the pool the members of each Council within thirty (30) days of notification by a Respondent that a Council is being requested.
- 5.5.4. Each Council shall be composed of three (3) Association members in good standing and a public member.
- 5.5.5. The EC Staff Liaison will remove anyone with a potential conflict of interest in a particular case from the potential Council pool.

5.6. Notification of Parties (EC Chairperson, Complainant, Respondent, Council Members)

- 5.6.1. The EC Staff Liaison shall schedule a hearing date in coordination with the Council Chairperson.
- 5.6.2. The Council (via the EC Staff Liaison) shall notify all parties at least forty-five (45) days prior to the hearing of the date, time, and place.
- 5.6.3. Case material will be sent to all parties and the Council members by national delivery service or mail with signature required and/or proof of date received.

5.7. Hearing Witnesses, Materials, and Evidence

- 5.7.1. Within thirty (30) days of notification of the hearing, the Respondent shall submit to the Council a written response to the decision and sanction, including a detailed statement as to the reasons that he or she is appealing the decision and a list of potential witnesses (if any) with a statement indicating the subject matter they will be addressing.
- 5.7.2. The Complainant before the Council also will submit a list of potential witnesses (if any) to the Council with a statement indicating the subject matter they will be addressing. Only under limited circumstances may the Council consider additional material evidence from the Respondent or the Complainant not presented or available prior to the issuance of their proposed sanction. Such new or additional evidence may be considered by the Council if the Council is satisfied that the Respondent or the Complainant has demonstrated the new evidence was previously unavailable and provided it is submitted to all parties in writing no later than fifteen (15) days prior to the hearing.
- 5.7.3. The Council Chairperson may permit testimony by conference call (at no expense to the participant), limit participation of witnesses in order to curtail repetitive testimony, or prescribe other

reasonable arrangements or limitations. The Respondent may elect to appear (at Respondent's own expense) and present testimony. If alternative technology options are available for the hearing, the Respondent, Council members, and EC Chairperson shall be so informed when the hearing arrangements are sent.

5.8. Counsel—The Respondent may be represented by legal counsel at his or her own expense. Association Legal Counsel shall advise and represent the Association at the hearing. Association Legal Counsel also may advise the Council regarding procedural matters to ensure fairness to all parties. All parties and the Association Legal Counsel (at the request of the EC or the Council) shall have the opportunity to question witnesses.

5.9. Hearing

5.9.1. The Council hearing shall be recorded by a professional transcription service or telephone recording transcribed for Council members and shall be limited to two (2) hours.

5.9.2. The Council Chairperson will conduct the hearing and does not vote.

5.9.3. Each person present shall be identified for the record, and the Council Chairperson will describe the procedures for the Council hearing. An oral affirmation of truthfulness will be requested from each participant who gives factual testimony in the Council hearing.

5.9.4. The Council Chairperson shall allow for questions.

5.9.5. The EC Chairperson shall present the ethics complaint, a summary of the evidence resulting from the investigation, and the EC decision and disciplinary action imposed against the Respondent.

5.9.6. The Respondent may present a defense to the decision and sanction after the EC presents its case.

5.9.7. Each party and/or his or her legal representative shall have the opportunity to call witnesses to present testimony and to question any witnesses including the EC Chairperson or his or her designee. The Council Chairperson shall be entitled to provide reasonable limits on the extent of any witnesses' testimony or any questioning.

5.9.8. The Council Chairperson may recess the hearing at any time.

5.9.9. The Council Chairperson shall call for final statements from each party before concluding the hearing.

5.9.10. Decisions of the Council will be by majority vote.

5.10. Disciplinary Council Decision

5.10.1. An official copy of the transcript shall be sent to each Council member, the EC Chairperson, the Association Legal Counsel, the EC Staff Liaison, and the Respondent and his or her counsel as soon as it is available from the transcription company.

5.10.2. The Council Chairperson shall work with the EC Staff Liaison and the Association Legal Counsel in preparing the text of the final decision.

5.10.3. The Council shall issue a decision in writing to the Association ED within thirty (30) days of receiving the written transcription of the hearing (unless special circumstances warrant additional time). The Council decision shall be based on the record and evidence presented and may affirm, modify, or reverse the decision of the EC, including increasing or decreasing the level of sanction or determining that no disciplinary action is warranted.

5.11. Action, Notification, and Timeline Adjustments

- 5.11.1. A copy of the Council's official decision and appeal process (Section 6) is sent to the Respondent, the EC Chairperson, and other appropriate parties within fifteen (15) business days via mail (with signature and proof of date received) after notification of the Association ED.
 - 5.11.2. The time limits specified in the *Enforcement Procedures for the Occupational Therapy Code of Ethics* may be extended by mutual consent of the Respondent, Complainant, and Council Chairperson for good cause by the Chairperson.
 - 5.11.3. Other features of the preceding *Enforcement Procedures* may be adjusted in particular cases in light of extraordinary circumstances, consistent with fundamental fairness.
- 5.12. **Appeal**—Within thirty (30) days after notification of the Council's decision, a Respondent upon whom a sanction was imposed may appeal the decision as provided in Section 6. Within thirty (30) days after notification of the Council's decision, the EC also may appeal the decision as provided in Section 6. If no appeal is filed within that time, the Association ED or EC Staff Liaison shall publish the decision in accordance with these procedures and make any other notifications deemed necessary.

6. Appeal Process

- 6.1. **Appeals**—Either the EC or the Respondent may appeal. Appeals shall be written, signed by the appealing party, and sent by mail requiring signature and proof of date of receipt to the Association ED in care of the Association Ethics Office. The grounds for the appeal shall be fully explained in this document. When an appeal is requested, the other party will be notified.
- 6.2. **Grounds for Appeal**—Appeals shall generally address only the issues, procedures, or sanctions that are part of the record before the Council. However, in the interest of fairness, the Appeal Panel may consider newly available evidence relating to the original complaint only under extraordinary circumstances.
- 6.3. **Composition and Leadership of Appeal Panel**—The Vice-President, Secretary, and Treasurer shall constitute the Appeal Panel. In the event of vacancies in these positions or the existence of a conflict of interest, the Vice President shall appoint replacements drawn from among the other Board of Directors members. If the entire Board has a conflict of interest, the Board Appeal process (Attachment C of EC SOP) shall be followed. The President shall not serve on the Appeal Panel. No individual may serve on the Council who has previously been the subject of an ethics complaint that resulted in a specific EC disciplinary action.

The Appeal Panel Chairperson will be selected by its members from among themselves.

- 6.4. **Appeal Process**—The Association ED shall forward any letter of appeal to the Appeal Panel within fifteen (15) business days of receipt. Within thirty (30) days after the Appeal Panel receives the appeal, the Panel shall determine whether a hearing is warranted. If the Panel decides that a hearing is warranted, timely notice for such hearing shall be given to the parties. Participants at the hearing shall be limited to the Respondent and legal counsel (if so desired), the EC Chairperson, the Council Chairperson, the Association Legal Counsel, or others approved in advance by the Appeal Panel as necessary to the proceedings.
- 6.5. **Decision**
 - 6.5.1. The Appeal Panel shall have the power to (a) affirm the decision; (b) modify the decision; or (c) reverse or remand to the EC, but only if there were procedural errors materially prejudicial to the outcome of the proceeding or if the Council decision was against the clear weight of the evidence.

6.5.2. Within thirty (30) days after receipt of the appeal if no hearing was granted, or within thirty (30) days after receipt of the transcript of an Appeal hearing if held, the Appeal Panel shall notify the Association ED of its decision. The Association ED shall promptly notify the Respondent, the original Complainant, appropriate Association bodies, and any other parties deemed appropriate (e.g., SRB, NBCOT®). For Association purposes, the decision of the Appeal Panel shall be final.

7. Notifications

All notifications referred to in these *Enforcement Procedures* shall be in writing and shall be delivered by national delivery service or mail with signature and proof of date received.

8. Records and Reports

At the completion of the enforcement process, the written records and reports that state the initial basis for the complaint, material evidence, and the disposition of the complaint shall be retained in the Association Ethics Office for a period of five (5) years.

9. Publication

Final decisions will be publicized only after any appeal process has been completed.

10. Modification

The Association reserves the right to (a) modify the time periods, procedures, or application of these *Enforcement Procedures* for good cause consistent with fundamental fairness in a given case and (b) modify its *Code* and/or these *Enforcement Procedures*, with such modifications to be applied only prospectively.

Adopted by the Representative Assembly 2015NovCO13 as Attachment A of the Standard Operating Procedures (SOP) of the Ethics Commission.

Reviewed by BPPC 1/04, 1/05, 9/06, 1/07, 9/09, 9/11, 9/13, 9/15

Adopted by RA 4/96, 5/04, 5/05, 11/06, 4/07, 11/09, 12/13

Revised by SEC 4/98, 4/00, 1/02, 1/04, 12/04, 9/06

Revised by EC 12/06, 2/07, 8/09, 9/13, 9/15

This document replaces the 2014 document *Enforcement Procedures for the Occupational Therapy Code of Ethics and Ethics Standards*, previously published and copyrighted in 2014 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy*, 68(Suppl. 3), S3–S15. <http://dx.doi.org/10.5014/ajot.2014.686S02>

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**AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
ETHICS COMMISSION**

*Formal Complaint of Alleged Violation of the
Occupational Therapy Code of Ethics*

If an investigation is deemed necessary, a copy of this form will be provided to the individual against whom the complaint is filed.

Date _____

Complainant: (Information regarding individual filing the complaint)

NAME _____

SIGNATURE _____

ADDRESS _____

TELEPHONE _____

E-MAIL ADDRESS _____

Respondent: (Information regarding individual against whom the complaint is directed)

NAME _____

SIGNATURE _____

ADDRESS _____

TELEPHONE _____

E-MAIL ADDRESS _____

1. **Summarize** in a written attachment the **facts and circumstances, including dates and events**, that support a violation of the *Occupational Therapy Code of Ethics* and this complaint. Include steps, if any, that have been taken to resolve this complaint before filing.

2. **Please sign and date all documents you have written and are submitting.** Do not include confidential documents such as patient or employment records.

3. If you have filed a complaint about this same matter with any other agency (e.g., NBCOT®; SRB; academic institution; any federal, state, or local official), indicate to whom it was submitted, the approximate date(s), and resolution if known.

I certify that the statements/information within this complaint are correct and truthful to the best of my knowledge and are submitted in good faith, not for resolution of private business, legal, or other disputes for which other appropriate forums exist.

Signature _____

Send completed form, with accompanying documentation, **IN AN ENVELOPE MARKED *CONFIDENTIAL*** to

Ethics Commission
American Occupational Therapy Association, Inc.
Attn: Ethics Program Manager/Ethics Office
4720 Montgomery Lane, Suite 200
Bethesda, MD 20814-3449

OR email all material in pdf format to
ethics@aota.org with "Complaint" in subject line

Office Use Only:

Membership Verified? Yes No

By: _____

Guidelines for Reentry Into the Field of Occupational Therapy

Purpose of the Guidelines

These guidelines are designed to assist occupational therapists and occupational therapy assistants who have left the field of occupational therapy for 24 months or more and have chosen to return to the profession and deliver occupational therapy services. The guidelines represent minimum recommendations only and are designed to support practitioners in meeting their ethical obligation to maintain high standards of competence.

It is expected that practitioners will identify and meet requirements outlined in applicable state and federal regulations, relevant workplace policies, the *Occupational Therapy Code of Ethics (2015)* (American Occupational Therapy Association [AOTA], 2015a), and continuing competence and professional development guidelines prior to reentering the field.

Clarification of Terms

Reentry—For the purpose of this document, reentering occupational therapists and occupational therapy assistants are individuals who

- Have practiced in the field of occupational therapy; and
- Have not engaged in the practice of occupational therapy (may include direct intervention, supervision, teaching, consultation, administration, case or care management, community programming, or research) for a minimum of 24 months; and
- Wish to return to the profession in the capacity of delivering occupational therapy services to clients.

Formal Learning—This term refers to any learning that has established goals and objectives that are measurable. It may include activities such as

- Attending workshops, seminars, lectures, and professional conferences;
- Auditing or participating in formal academic coursework;
- Participating in external self-study series (e.g., AOTA Self-Paced Clinical Courses); or
- Participating in independent distance learning, either synchronous or asynchronous (e.g., continuing education articles, video, audio, or online courses) with established goals and objectives that are measurable.

Supervised Service Delivery—For this document, *supervised service delivery* refers to provision of occupational therapy services under the supervision of a qualified occupational therapist. The *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2014a) state that

within the scope of occupational therapy practice, *supervision* is a process aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and development. [It is] a cooperative process in which two or more people participate in a joint effort to establish, maintain, and/or elevate a level of competence and performance. (p. S16)

Specific Guidelines for Reentry

Practitioners who are seeking reentry must abide by state licensure and practice regulations and any requirements established by the workplace. In addition, the following suggested guidelines are recommended:

1. Engage in a formalized process of self-assessment (e.g., self-assessment tools, such as AOTA's [2003] *Professional Development Tool*), and complete a professional development plan that addresses the *Standards for Continuing Competence* (AOTA, 2015b).
2. Attend a minimum of 10 hours of formal learning related to occupational therapy service delivery for each 12 consecutive months out of practice. At least 20 hours of the formal learning must have occurred within the past 24 months of re-entry.
3. Attain relevant updates to core knowledge of the profession of occupational therapy and the responsibilities of occupational therapy practitioners that are consistent with material found in AOTA official documents such as the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; AOTA, 2014b), the *Occupational Therapy Code of Ethics (2015)* (AOTA, 2015a), *Standards for Continuing Competence* (AOTA, 2015b), *Standards of Practice for Occupational Therapy* (AOTA, 2010), and *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2014a).
4. Complete of a minimum of 30 hours of documented supervised service delivery in occupational therapy, which is recommended for practitioners who have been out of practice for 3 or more years.
 - a. The supervised service delivery should be completed between the 12 months prior to anticipated reentry and the first 30 days of employment.
 - b. The reentering practitioner, in conjunction with the supervising occupational therapy practitioner(s), should establish specific goals and objectives for the 30 hours. Goals, objectives, and related assessment of performance may be developed or adapted from a variety of sources, including competency and performance review resources existing within the setting as well as AOTA resources such as the *Fieldwork Performance Evaluation for the Occupational Therapy Student*® forms (AOTA, 2002a, 2002b).
 - c. The supervised service delivery experience should focus on the area of practice to which the practitioner intends to return.
 - d. Supervised service delivery should occur with a practitioner at the same or greater professional level (i.e., an occupational therapist, not an occupational therapy assistant, supervises a returning therapist).
 - e. Supervision should be direct face-to-face contact, which may include observation, modeling, cotreatment, discussions, teaching, and instruction (AOTA, 2014a) and may be augmented by indirect methods such as electronic communications.

Ongoing Continuing Competence

Once practitioners have successfully returned to the delivery of occupational therapy services, they are encouraged to engage in activities that support them in their ongoing continuing competence, such as

- Seeking mentoring, consultation, or supervision—especially during the first year of return to practice;
- Engaging in relevant AOTA Special Interest Section forums to build a professional network and facilitate opportunities for practice guidance;
- Exploring relevant AOTA Board and Specialty Certifications and using the identified criteria as a blueprint for ongoing professional development; and
- Joining and becoming active in both AOTA and the state occupational therapy association to stay abreast of practice trends and increase opportunities for networking.

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Importance of Interprofessional Education in Occupational Therapy Curricula

The American Occupational Therapy Association (AOTA) asserts that entry-level occupational therapy curricula should include interprofessional education (IPE) in which students have opportunities to learn and apply the knowledge and skills necessary for interprofessional collaborative practice. To achieve the goals of improved health outcomes and client experiences, along with reduced health care costs, practitioners must be prepared to contribute to interprofessional care teams (Earnest & Brandt, 2014). In the 21st century, clients' health and well-being will benefit when occupational therapy students are taught firsthand that interprofessional collaborations are essential in the health care arena and community-based systems of care. The purposes of this position paper are to describe the history of IPE, to provide evidence for the benefits of including IPE in professional curricula, to define key concepts and core competencies associated with IPE, to address implications of including IPE in entry-level occupational therapy curricula, and to provide resources for faculty.

Background

History of Interprofessional Education

IPE is not a new concept in health professions education. It has been attempted, reported on, and discussed since the 1970s. In a 1972 Institute of Medicine (IOM) report titled *Report of a Conference: Educating for the Health Team*, Pellegrino wrote,

A major deterrent to fashion health care that is efficient, effective, comprehensive, and personalized is our lack of design for the *synergistic interrelationship* [emphasis added] of all who contribute to the patient's well-being. . . . We face a national challenge . . . the development of educational programs aimed at preparing future professionals for interprofessional collaboration. (p. 4)

In the 1st decade of the 21st century, the IOM issued two significant reports that reexamined the U.S. health care system and health professions education. The first of these reports, *To Err Is Human: Building Safer Health Systems* (IOM, 2000), focused on improving patient safety. The second report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001), also focused on quality-related issues and recommendations for innovative redesign to improve care. Together, these reports added urgency in the development of interprofessional educational programs and interprofessional collaborative health care practice across the country.

One outcome of these reports was the establishment of the IOM's Committee on the Health Professions Education Summit. The members of the committee met to discuss and develop strategies for better preparing health care professionals to practice in the 21st-century health system. Specifically, the committee addressed strategies for "restructuring clinical education to be consistent with the six national quality aims of . . . safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity . . . across the continuum of education for the allied health, medical, nursing, and pharmacy professions" (IOM, 2003, p. 20). National efforts in many arenas of health care professions education and practice have progressed and culminated in the 2012 establishment of the National Center for Interprofessional Practice and Education (2015) at the University of Minnesota. The need for integration and coordination of health

care delivery in dealing with the rising incidence of chronic diseases, the complexity of the health care system, and the use of technology in health care are the driving forces behind the current IPE movement (Page et al., 2009).

Interprofessional Education, Occupational Therapy, and Accreditation

Interprofessional education is defined as “occasions when students from two or more professions learn about, from, and with each other to improve collaboration and the quality of care” (Centre for the Advancement of Interprofessional Education [CAIPE], 2002). The ultimate goal of IPE is improving patient-centered care, a goal resonant with the core values of occupational therapy (AOTA, 2015). Client-centered practice focuses on the occupational needs of individuals, families, and communities to improve their health and well-being through participation in meaningful occupations (AOTA, 2014; Townsend, Brintell, & Staisey, 1990). Similarly, IPE focuses on the needs of individuals, families, and communities to improve their quality of care, health outcomes, and well-being (Barr & Low, 2011). Collaborating with clients and factoring their input into the decision-making process, a hallmark of client-centered care, is based on parity and inclusion. Similarly, in IPE all professions collaborate regardless of status and power. Just as client-centered occupational therapy values clients’ individuality regardless of their differences, IPE respects individuality and diversity within and between the professions. The unique identity, expertise, and contributions of individual professions are recognized and valued in IPE (Barr & Low, 2011).

Developing and incorporating standards for IPE and interprofessional care into accreditation and certification criteria is one way to ensure integration into curricula (Allison, 2007, p. 567). In actuality, the impetus for curriculum redesign to include IPE has in many fields been the accrediting bodies for the various professions and the insurance industry (Zorek & Raehl, 2013). Occupational therapy accreditation standards appear to align with this trend. The Preamble of the 2011 Accreditation Council for Occupational Therapy Education (ACOTE®) Educational Standards states that a graduate from an ACOTE-accredited doctoral-, master’s-, or associate-degree-level occupational therapy program must “be prepared to effectively communicate and work interprofessionally with those who provide care for individuals and/or populations in order to clarify each member’s responsibility in executing components of an intervention plan” (ACOTE, 2012, pp. S6–S8). This is the first time an educational standard specific to IPE and interprofessional practice has appeared in this document. In addition, ACOTE Standard B.5.21 states that students will be able to “effectively communicate, coordinate, and work interprofessionally with those who provide services to individuals, organizations, and/or populations in order to clarify each member’s responsibility in executing components of an intervention plan” (ACOTE, 2012, p. S48). Although ACOTE standards have only recently addressed IPE specifically, collaboration and communication with other professional team members and consumers in all phases of occupational therapy processes have been integral to the educational standards and the profession’s ethics standards (AOTA, 2015) for decades. Principle 6 of the *Occupational Therapy Code of Ethics (2015)* (AOTA, 2015) speaks to fidelity as it relates to interprofessional relationships. Occupational therapy personnel are specifically called to

promote collaborative actions and communication as a member of interprofessional teams to facilitate quality care and safety for clients [as well as] respect the practices, competencies, roles, and responsibilities of their own and other professionals to promote a collaborative environment reflective of interprofessional teams.

Key Concepts and Core Competencies

The definition of IPE has been expanded by the Institute of Medicine (2003), CAIPE (2002), and the World Health Organization (WHO) to “when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes” (WHO, 2010, p. 13). On the basis of this definition, students are required to interact with one another in learning activities

that are authentic and that require the complex problem solving that involves the knowledge and skills of multiple professions. Reflection on the experiences is a critical component to improve on the collaborative process. The overall goal is to develop *interprofessionality*, defined as

the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/ family/ population. . . . [It] involves continuous interaction and knowledge sharing between professionals, organized to solve or explore a variety of education and care issues all while seeking to optimize the patient's participation. . . . Interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working. (D'Amour & Oandasan, 2005, p. 9)

IPE is paramount to promoting effective interprofessional practice and collaboration. Multidisciplinary becomes interprofessional when team members transcend their separate disciplinary perspective and weave together their unique perspectives, methods, and practice to overcome problems and perform their work collaboratively (Klein, 1990). Pellegrino (1972) stated,

Each member of the team, while providing the group with the knowledge and skills of his or her disciplinary perspective, also strives to incorporate that perspective with those of others to create solutions to healthcare problems that transcend conventional discipline specific methods, procedures, and techniques. (p. 4)

Others who have written on the distinction between multidisciplinary and interprofessional practice have commented on the quality of communication and degree of collaboration between professional team members (Hirokawa, 1990) and the cohesive, collaborative decision making in team-oriented health care delivery (D'Amour & Oandasan, 2005).

The Interprofessional Education Collaborative (IPEC) published a report from an expert panel (IPEC Expert Panel, 2011) that is the landmark document for the delineation of core competencies for interprofessional practice and that guides a competency-based approach to IPE. This document describes four core competency areas for practice, the ultimate goal of which is to guide the development of interprofessional learning activities and "prepare all health professions students for *deliberatively working together*" (p. 3):

- Competency Domain 1: Values/Ethics for Interprofessional Practice
- Competency Domain 2: Roles/Responsibilities
- Competency Domain 3: Interprofessional Communication
- Competency Domain 4: Teams and Teamwork.

These core competencies for practice as applied to education can be effectively planned in education through a learning continuum of exposure → immersion → competency (as entry to practice), using tools of reflective learning and formative assessment (CAIPE, 2002).

Ultimately, IPE aims to create more effective systems of *interprofessional practice*, defined as a higher form of practice wherein health care professionals from different disciplines make up a team, unique to the individual client–patient, that works with the client to develop a unified decision (National Academies of Practice, 2012). IPP results in safer and more efficient delivery of health care (Guitard, Dubouloz, Savard, Metthé, & Brassat-Latulippe, 2010) as well as greater patient satisfaction (Howell, Wittman, & Bundy, 2012; Kent & Keating, 2013; Shiyanbola, Lammers, Randall, & Richards, 2012; Solomon & Risdon, 2011), thus validating the need to embed IPE into entry-level preparation for occupational therapy practitioners.

Assessing the Outcomes of Interprofessional Education

Positive outcomes associated with IPE have been documented at several levels from students to patient, client, and consumer. Assessments used in these studies have focused on measuring changes in attitudes, perceptions, behaviors, knowledge, skills, and abilities, although changes in student attitudes and percep-

tions are by far the most commonly assessed variables. In addition to positive changes in students' perception of health care teams and IPE, recent studies have noted that students who participate in IPE increase knowledge of their own professional roles, improve communication skills with people outside of their own profession, and develop critical skills necessary for working on interprofessional teams (Buff et al., 2014; Howell et al., 2012; Olson & Bialocerkowski, 2014; Solomon & Risdon, 2011). Some studies have noted that engagement in interprofessional learning may lead to health care providers who demonstrate higher levels of safety and more efficient delivery of medical care. Unfortunately, the literature that connects student participation in IPE and potential benefit to health service delivery or patient outcomes is limited (Knier, Stichler, Ferber, & Catterall, 2014; Shrader, Kern, Zoller, & Blue, 2013).

The Canadian Interprofessional Health Collaborative (CIHC) has published several interprofessional resources over the past few years, including an inventory of 128 IPE measurement tools (Lindqvist, Duncan, Shepstone, Watts, & Pearce, 2005). The majority of these assessments measure student attitudes (64 tools) versus knowledge, behavior, or patient or provider satisfaction. Of note, no psychometric information was found in 33% of the report's entries. Nevertheless, the IPE field's overall high regard for quantitative measurement is impressive and remains a focus for future studies.

The National Center for Interprofessional Practice and Education offers online access to a collection of assessments used for IPE and collaborative practice (IPECP) research (National Center for Interprofessional Practice and Education, 2013; available at <https://nexusipe.org/measurement-instruments>). The collection started with a review of the CIHC inventory but narrowed the assessments to those that focused on IPECP and variables specifically related to attitudes, behavior, knowledge, skills, abilities, organizational practice, patient satisfaction, and provider satisfaction. Table 1 outlines commonly used assessments organized using the National Center's outcome levels, all with adequate psychometrics for educational research.

Table 1. Commonly Used Outcome Measures in Interprofessional Education and Collaborative Practice

Name of Tool	Tool Description	Setting and Sample	Citation
Outcome Level 1: Attitudes			
Attitudes Toward Health Professionals Questionnaire (AHPQ)	20 items (1 for each profession) 2 components, caring and subservience, with visual analog scales	University in UK 160 students from 6 professional programs	Lindqvist et al. (2005)
Attitudes Toward Health Care Teams	3 subscales: Quality of Care/Process, Physician Centrality, and Cost of Care 20 items with 4-point Likert scales	Community and hospital settings in US 1,018 interdisciplinary geriatric health care teams	Heineman, Schmitt, Farrell, & Brallier (1999)
Attitudes Toward IP Learning in the Academic Setting	4 areas: campus resources and support, faculty, students, and curriculum/outcomes supporting IP learning 13 items with 5-point Likert scales	University in Canada 194 faculties from 4 health disciplines	Curran, Sharpe, & Forristall (2007)
Attitudes Toward Teamwork questionnaire (also applies to Outcome Levels 2 and 3)	Subscales: Orientation Toward Team Problem Solving, Problem-Solving Confidence, Team Preparedness, Attitude Toward Interdisciplinary Team, and Self-Efficacy 10 items each with 5- or 6-point Likert scales	University in US 410 alumni from 8 allied health disciplines	Lindqvist et al. (2005)
Group Environment Scale (GES)	10 subscales: Cohesion, Leader Support, Expressiveness, Independence, Task Orientation, Self-Discovery, Anger and Aggression, Order and Organization, Leader Control, and Innovation 9 items, each with true-false ratings	College in US 191 students	Salter & Junco (2007)

(Continued)

Table 1. Commonly Used Outcome Measures in Interprofessional Education and Collaborative Practice (cont.)

Name of Tool	Tool Description	Setting and Sample	Citation
Index of Interprofessional Team Collaboration for Expanded School Mental Health (IITC-ESMH) (also applies to Outcome Level 4)	4 subscales: Reflection on Process, Professional Flexibility, Newly Created Professional Activities, and Role Interdependence 26 items with 5-point Likert scales	Schools in US 436 members of IP health care teams	Mellin et al. (2010)
Professional Identity Scale	Strength of students' professional identity regarding readiness for IP learning 10 items with 5-point Likert scales	University in UK 933 students from various health disciplines	Hind et al. (2003)
Readiness for Interprofessional Learning Scale (RIPLS)	3 subscales: Teamwork and Collaboration, Negative and Positive Professional Identity, Roles and Responsibilities 19 items with 5-point Likert scales	University in UK 120 students from 8 health disciplines	Parsell & Bligh (1999)
Outcome Level 2: Knowledge, Skills, Abilities			
Interprofessional Delirium Knowledge Test (IDKT)	Delirium case study tool 4 areas: identification, causes, and management of delirium in terminally ill patients; psychosocial care of patient and family; roles of team members and contribution to patient care; and communication 5 open-ended questions scored with rubric	Palliative care unit in Canada 10 team members, volunteers, and students from 6 professions	Brajtman et al. (2008)
Attitudes Toward Teamwork questionnaire (also applies to Outcome Levels 1 and 3)	Subscales: Orientation Toward Team Problem Solving, Problem-Solving Confidence, Team Preparedness, Attitude Toward Interdisciplinary Team, and Self-Efficacy 10 items each with 5- or 6-point Likert scales	University in US 410 alumni from 8 allied health disciplines	Lindqvist et al. (2005)
Team Skills Scale (TSS)	17 items with 5-point Likert scales. Modified from original: 17 of the 20 items related interdisciplinary team skills were used. Remaining 3 attitudinal items examined individually.	Hospital in US 25 students from 4 disciplines	Robben et al. (2012)
Outcome Level 3: Behavior			
Attitudes Toward Teamwork questionnaire (also applies to Outcome Levels 1 and 2)	Subscales: Orientation Toward Team Problem Solving, Problem-Solving Confidence, Team Preparedness, Attitude Toward Interdisciplinary Team, and Self-Efficacy 10 items each with 5- or 6-point Likert scales	University in US 410 alumni from 8 allied health disciplines	Lindqvist et al. (2005)
Collaborative Practice Assessment Tool (CPAT)	8 domains: mission, meaningful purpose, goals; general relationships; team leadership; general role responsibilities and autonomy; communication and information exchange; community linkages and coordination of care; decision making and conflict management; and patient involvement. 57 items with 7-point Likert scales 3 open-ended questions on team's strengths, challenges, and help needed to improve collaborative practice	111 practice teams in Canada	Schroder et al. (2011)

(Continued)

Table 1. Commonly Used Outcome Measures in Interprofessional Education and Collaborative Practice (cont.)

Name of Tool	Tool Description	Setting and Sample	Citation
Interprofessional Collaboration Scale	Collaboration among multiple health professional groups 3 subscales: Communication, Accommodation, and Isolation (Nurse-Physician Relations Subscale of the Nursing Work Index and the subscales of the Attitudes Toward Health Care Teams Scale were used to measure the concurrent, convergent, and discriminant validity.)	Hospitals in Canada; number of sample not provided	Kenaszchuk, Reeves, Nicholas, & Zwarenstein (2010)
Outcome Level 4: Organizational Practice			
Index of Interprofessional Team Collaboration for Expanded School Mental Health (IITC-ESMH) (also applies to Outcome Level 1)	4 subscales: Reflection on Process, Professional Flexibility, Newly Created Professional Activities, and Role Interdependence 26 items with 5-point Likert scales	Schools in US 436 members of IP health care teams	Mellin et al. (2010)
Outcome Level 5: Patient Satisfaction			
Satisfaction With Treatment Team Planning Rating Scale (also applies to Outcome Level 6)	Patient satisfaction with treatment team planning 10 items with 4-point Likert scales	Inpatient psychiatric hospital in US 18 health professionals from 6 disciplines	Singh, Singh, Sabaawi, Myers, & Wahler (2006)
Outcome Level 6: Provider Satisfaction			
Satisfaction With Treatment Team Planning Rating Scale (also applies to Outcome Level 5)	Staff satisfaction with treatment team planning 10 items with 4-point Likert scales	Inpatient psychiatric hospital in US 18 health professionals from 6 disciplines	Singh et al. (2006)
Satisfaction Survey	Attitudes toward teamwork and teamwork abilities 12 items with 5-point Likert scales	University in Canada 137 professionals	Curran, Heath, Kearney, & Button (2010)

Note. IP = interprofessional.

Source. Arthur et al., 2012.

Designing, Implementing, and Sustaining Interprofessional Education

It is of the highest importance that occupational therapy educators teach students to build their interprofessional toolkit during their educational journey. This toolkit includes building trust, open communication, mutual respect, and professionalism, as well as the skills required for effective teamwork: conflict resolution, negotiation, and empathy. Creating an atmosphere and culture within occupational therapy curricula that emphasize being a team player and being client focused is well supported through IPE. When students demonstrate effective collaborative reciprocity within the educational environment, best practices of interprofessionalism in occupational therapy will follow.

As Greer and Clay (2010) asserted, "Developing and sustaining IPE requires a mammoth effort that incorporates institutional support, leadership, and shared vision and which transverses multiple divisions, units, schools, or colleges within and among educational systems" (p. 224). Once the goal of IPE is established, best methods for implementing the experience must be identified. It is important to assess the level of understanding of faculty, staff, and administration who are interested in collaborating in the IPE effort. Occupational therapy faculty initiating or supporting IPE activities may need to provide educational programming to ensure that everyone understands the importance of and reasons to engage in this educational component. This may be accomplished through campus workshops, webinars, reading groups, and attendance at a national conference on IPE.

The next step is to assess the strengths and opportunities both within and external to the institution that are in place to support one's efforts. These can range from students and alumni in the community or settings in which interprofessional collaboration and practice exist to resources within the division or the university at large. Perhaps the institution has an office or advisory board that can assist in community outreach. Figure 1 displays important factors to consider at all levels of the institution when planning to implement IPE as well as suggested resources.

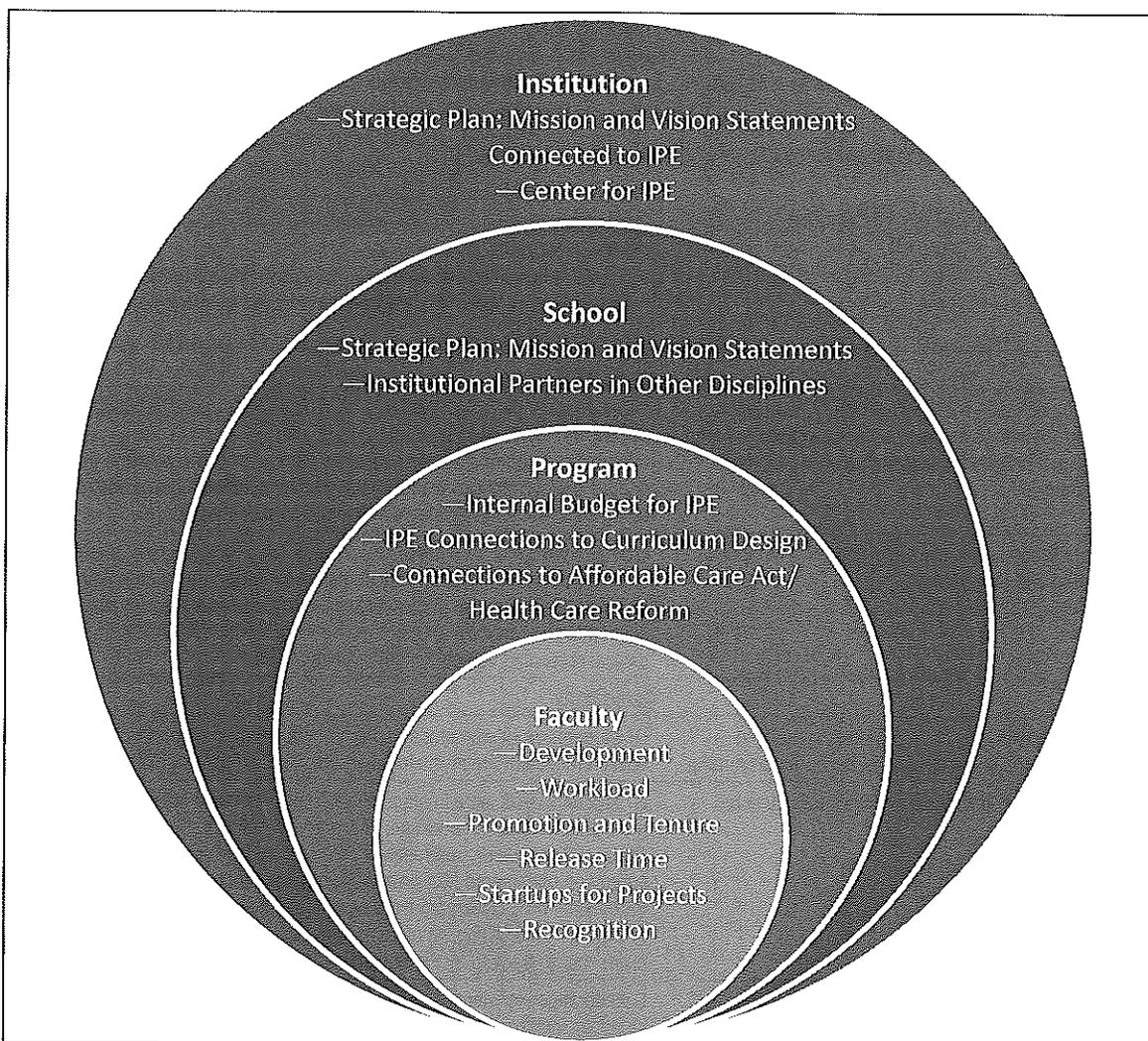


Figure 1. Institutional considerations and resources.

Note. IPE = interprofessional education.

A typical hierarchy of ease in implementation is to begin at the classroom level, then in-service learning and Level I fieldwork, and then campuswide experiences; however, depending on the balance of support available and the goals of the initiative, faculty may find a Level I fieldwork experience easier to carry out than a classroom experience. Level II fieldwork is certainly a place where students can put their interprofessional skills to the test, and it is recommended that all Level II fieldwork experiences have at least one assignment related to IPE and practice. Table 2 provides examples of IPE activities at all levels from classroom to community.

Table 2. Models of Interprofessional Education

Activity	Description
	Institution
Universitywide faculty IPE institute--training	IP faculty training about campuswide IP initiatives; engagement of faculty on IP teams to develop universitywide IP activities and new programs.
IPE Day	<p>Planned by representative group of faculty from several disciplines (e.g., medicine, nursing, OT, pharmacy, physician assistant, physical therapy, social work). Each member has a coordinating responsibility: space, food, handouts, scheduling faculty facilitators, and so forth.</p> <p>Students from several disciplines are assigned to IP groups that meet in several classrooms across the campus and engage in activities addressing IP core competencies at the appropriate level. Faculty facilitators meet over lunch to receive instructions, and 2 or more (from different disciplines) are assigned to each room. Social activity with refreshments follows.</p> <p><i>Examples:</i> Introduction to each discipline's educational curricula and scope of practice; case-study discussion emphasizing each profession's contributions and role.</p>
	Classroom
OT faculty coteach with faculty from other professions; faculty jointly create and foster a collaborative learning environment or activity for students from 2 or more professions	OT students engage with students from other professions to conduct interviews with family and caregivers of people who have chronic conditions. The team of students considers the role of caregivers and how various professions can work collaboratively to assist patients and their caregivers with long-term and ongoing health care issues.
Sharing Knowledge and Skills: OTAs and PTAs: Adaptive Equipment and Gait Training	OTA students and PTA students teach each other. OTA students share, and provide simulations for, various pieces of adaptive equipment and explain their purpose(s) in daily activities. PTA students present case scenarios and rationale for gait training to increase problem solving and clinical reasoning behind the gait training process.
	Community
Service learning with 2 or more professions working together to engage in community-based programming	OT students work with students from dental medicine to develop school-based oral health programs for children with multiple disabilities.
Student-run free medical-therapy clinics for uninsured patients	OT students participate in student-run free clinics with other health professions including medicine, pharmacy, nursing, and physical therapy. These clinics provide free medical care and therapy services to uninsured and underserved patients while offering students an opportunity to translate their classroom learning directly to patient care in the form of experiential learning. As of 2014, 146 student-run free clinics are in existence, as tracked by the Society of Student-Run Free Clinics.
Cultivating Partnerships in the Garden: An IP Service Learning Experience; Quincy Gardening Club and OTA Students	<p>Collaborative experiences between OTA and PTA, English, and forestry students, including</p> <ul style="list-style-type: none"> • Modifications to gardening tools and garden terrain • Accessibility with raised garden beds • Restructuring of gardening tasks • Exploration of current market for adapted garden tools • Documentary of collaborative experience.

(Continued)

Table 2. Models of Interprofessional Education (cont.)

Activity	Description
Adaptive Equipment Project: An IP Learning Experience	<p>Collaborative experience between OTA and engineering students, including</p> <ul style="list-style-type: none"> • Creation of a piece of adaptive equipment intended for individuals with disabilities • Communication between students with different backgrounds and goals • Education of faculty, staff, and student body as well as the community.
Fieldwork—Level I	
<p>Introduction to IP Collaborative Education and Practice</p> <p><i>Learning outcomes:</i></p> <ul style="list-style-type: none"> • Understand the importance of good teamwork for the client's health and well-being. • Learn about another team professional's roles and job tasks. 	<p>Students ask fieldwork educator to assist in seeking out a non-OT professional at the fieldwork site. Student shadows the professional for 30 minutes and conducts a 15-minute interview based on the following:</p> <ul style="list-style-type: none"> • Describe what you do during a typical day. • What is the best part of being a _____? • How do you see yourself working in tandem with OT practitioners? • How important is it to be a team player for the health and well-being of your clients? <p>Student writes a reflection on</p> <ul style="list-style-type: none"> • Whether, during the observation of the professional, he or she saw the professional use therapeutic use of self while communicating with clients. Explain. • What he or she learned about the professional's role in the care of clients and as a team member.
<p>Synthesis and Application of IP Collaborative Education and Practice</p> <p><i>Learning outcomes:</i></p> <ul style="list-style-type: none"> • Assess own IP collaborative practices, and use knowledge to effectively engage with peers. • Appraise the benefits and constraints on IP teamwork. • Actively engage with at least 1 other professional to ensure quality client care during the fieldwork experience. 	<p>Students read the IPEC Expert Panel's (2011) <i>Core Competencies for IP Collaborative Practice</i> before fieldwork. Students write a descriptive narrative about client care in relation to the following IP competencies:</p> <ul style="list-style-type: none"> • Values/Ethics for IP Practice: Develop a trusting relationship with other team members • Roles/Responsibilities: Communicate one's roles and responsibilities • IP Communication: Listen actively, and encourage ideas and opinions of other team members • Teams and Teamwork: Share accountability with other professions.

(Continued)

Table 2. Models of Interprofessional Education (cont.)

Activity	Description
Fieldwork—Level II	
IP Collaborative Practice based on Educational Experiences <i>Learning outcomes:</i> <ul style="list-style-type: none"> • Effectively communicate and work IPly with those who provide services to individuals and groups to clarify each member's responsibility in executing an intervention plan. 	On the basis of Level II fieldwork experiences, students write descriptive narratives of the following: <ul style="list-style-type: none"> • Identify non-OT professionals encountered on a frequent basis. • Discuss the level of collaboration between the above-named professionals and the OT staff during coordination of client care. • Discuss the format and frequency of communication between the OT staff and non-OT professionals as it relates to coordination of client care. • Discuss your level of confidence in effectively communicating with non-OT professionals as it relates to coordination of client care and explaining the basic tenets of OT. • Discuss a specific incident in which you directly collaborated or communicated with a non-OT professional in regard to client care or explanation of OT services. • List a specific component of a client's intervention plan that requires team collaboration.

Note. IP = interprofessional; IPE = interprofessional education; IPEC = Interprofessional Education Collaborative; OT = occupational therapy; OTA = occupational therapy assistant; PTA = physical therapy assistant.

Ways to ensure that IPE initiatives are sustainable include meeting with administration to discuss the stakes for IPE, which may include enhanced professional skills for graduates, improved standards of education, and opportunities for emergent practice and scholarship for faculty across the campus and within the community. One of the most productive means of ensuring the sustainability of IPE is to build a goal into the program's strategic plan in which each component of the educational experience has a measurable goal, identified strengths, and key stakeholders. Greer and Clay (2010) described a useful peer-reviewed instrument for assessing IPE in health care institutions that provides detailed insight into requirements for successfully implementing and sustaining IPE.

Ethical Considerations for Occupational Therapy Education and Practice

It is the professional and ethical responsibility of occupational therapy educators to provide students with opportunities to work and learn collaboratively during their professional education. Without opportunities to learn collaboratively as students, it is unlikely that occupational therapy practitioners will effectively work collaboratively in practice settings. Practice that is truly collaborative is aligned with health care reform efforts to benefit consumers with improved care and client experiences at reduced costs (IOM, 2003).

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Occupational Therapy Code of Ethics (2015)

Preamble

The 2015 *Occupational Therapy Code of Ethics* (Code) of the American Occupational Therapy Association (AOTA) is designed to reflect the dynamic nature of the profession, the evolving health care environment, and emerging technologies that can present potential ethical concerns in research, education, and practice. AOTA members are committed to promoting inclusion, participation, safety, and well-being for all recipients in various stages of life, health, and illness and to empowering all beneficiaries of service to meet their occupational needs. Recipients of services may be individuals, groups, families, organizations, communities, or populations (AOTA, 2014b).

The Code is an AOTA Official Document and a public statement tailored to address the most prevalent ethical concerns of the occupational therapy profession. It outlines Standards of Conduct the public can expect from those in the profession. It should be applied to all areas of occupational therapy and shared with relevant stakeholders to promote ethical conduct.

The Code serves two purposes:

1. It provides aspirational Core Values that guide members toward ethical courses of action in professional and volunteer roles.
2. It delineates enforceable Principles and Standards of Conduct that apply to AOTA members.

Whereas the Code helps guide and define decision-making parameters, ethical action goes beyond rote compliance with these Principles and is a manifestation of moral character and mindful reflection. It is a commitment to benefit others, to virtuous practice of artistry and science, to genuinely good behaviors, and to noble acts of courage. Recognizing and resolving ethical issues is a systematic process that includes analyzing the complex dynamics of situations, weighing consequences, making reasoned decisions, taking action, and reflecting on outcomes. Occupational therapy personnel, including students in occupational therapy programs, are expected to abide by the Principles and Standards of Conduct within this Code. Personnel roles include clinicians (e.g., direct service, consultation, administration); educators; researchers; entrepreneurs; business owners; and those in elected, appointed, or other professional volunteer service.

The process for addressing ethics violations by AOTA members (and associate members, where applicable) is outlined in the Code's Enforcement Procedures (AOTA, 2014a).

Although the Code can be used in conjunction with licensure board regulations and laws that guide standards of practice, the Code is meant to be a free-standing document, guiding ethical dimensions of professional behavior, responsibility, practice, and decision making. This Code is not exhaustive; that is, the Principles and Standards of Conduct cannot address every possible situation. Therefore, before making complex ethical decisions that require further expertise, occupational therapy personnel should seek out resources to assist in resolving ethical issues not addressed in this document. Resources can include, but are not limited to, ethics committees, ethics officers, the AOTA Ethics Commission or Ethics Program Manager, or an ethics consultant.

Core Values

The profession is grounded in seven long-standing Core Values: (1) Altruism, (2) Equality, (3) Freedom, (4) Justice, (5) Dignity, (6) Truth, and (7) Prudence. *Altruism* involves demonstrating concern for the welfare of others. *Equality* refers to treating all people impartially and free of bias. *Freedom* and personal choice are paramount in a profession in which the values and desires of the client guide our interventions. *Justice* expresses a state in which diverse communities are inclusive; diverse communities are organized and structured such that all members can function, flourish, and live a satisfactory life. Occupational therapy personnel, by virtue of the specific nature of the practice of occupational therapy, have a vested interest in addressing unjust inequities that limit opportunities for participation in society (Braveman & Bass-Haugen, 2009).

Inherent in the practice of occupational therapy is the promotion and preservation of the individuality and *Dignity* of the client by treating him or her with respect in all interactions. In all situations, occupational therapy personnel must provide accurate information in oral, written, and electronic forms (*Truth*). Occupational therapy personnel use their clinical and ethical reasoning skills, sound judgment, and reflection to make decisions in professional and volunteer roles (*Prudence*).

The seven Core Values provide a foundation to guide occupational therapy personnel in their interactions with others. Although the Core Values are not themselves enforceable standards, they should be considered when determining the most ethical course of action.

Principles and Standards of Conduct

The Principles and Standards of Conduct that are enforceable for professional behavior include (1) Beneficence, (2) Nonmaleficence, (3) Autonomy, (4) Justice, (5) Veracity, and (6) Fidelity. Reflection on the historical foundations of occupational therapy and related professions resulted in the inclusion of Principles that are consistently referenced as a guideline for ethical decision making.

BENEFICENCE

Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services.

Beneficence includes all forms of action intended to benefit other persons. The term *beneficence* connotes acts of mercy, kindness, and charity (Beauchamp & Childress, 2013). Beneficence requires taking action by helping others, in other words, by promoting good, by preventing harm, and by removing harm. Examples of beneficence include protecting and defending the rights of others, preventing harm from occurring to others, removing conditions that will cause harm to others, helping persons with disabilities, and rescuing persons in danger (Beauchamp & Childress, 2013).

RELATED STANDARDS OF CONDUCT

Occupational therapy personnel shall

- A. Provide appropriate evaluation and a plan of intervention for recipients of occupational therapy services specific to their needs.
- B. Reevaluate and reassess recipients of service in a timely manner to determine whether goals are being achieved and whether intervention plans should be revised.
- C. Use, to the extent possible, evaluation, planning, intervention techniques, assessments, and therapeutic equipment that are evidence based, current, and within the recognized scope of occupational therapy practice.

- D. Ensure that all duties delegated to other occupational therapy personnel are congruent with credentials, qualifications, experience, competency, and scope of practice with respect to service delivery, supervision, fieldwork education, and research.
- E. Provide occupational therapy services, including education and training, that are within each practitioner's level of competence and scope of practice.
- F. Take steps (e.g., continuing education, research, supervision, training) to ensure proficiency, use careful judgment, and weigh potential for harm when generally recognized standards do not exist in emerging technology or areas of practice.
- G. Maintain competency by ongoing participation in education relevant to one's practice area.
- H. Terminate occupational therapy services in collaboration with the service recipient or responsible party when the services are no longer beneficial.
- I. Refer to other providers when indicated by the needs of the client.
- J. Conduct and disseminate research in accordance with currently accepted ethical guidelines and standards for the protection of research participants, including determination of potential risks and benefits.

NONMALEFICENCE

Principle 2. Occupational therapy personnel shall refrain from actions that cause harm.

Nonmaleficence "obligates us to abstain from causing harm to others" (Beauchamp & Childress, 2013, p. 150). The Principle of *Nonmaleficence* also includes an obligation to not impose risks of harm even if the potential risk is without malicious or harmful intent. This Principle often is examined under the context of due care. The standard of *due care* "requires that the goals pursued justify the risks that must be imposed to achieve those goals" (Beauchamp & Childress, 2013, p. 154). For example, in occupational therapy practice, this standard applies to situations in which the client might feel pain from a treatment intervention; however, the acute pain is justified by potential longitudinal, evidence-based benefits of the treatment.

RELATED STANDARDS OF CONDUCT

Occupational therapy personnel shall

- A. Avoid inflicting harm or injury to recipients of occupational therapy services, students, research participants, or employees.
- B. Avoid abandoning the service recipient by facilitating appropriate transitions when unable to provide services for any reason.
- C. Recognize and take appropriate action to remedy personal problems and limitations that might cause harm to recipients of service, colleagues, students, research participants, or others.
- D. Avoid any undue influences that may impair practice and compromise the ability to safely and competently provide occupational therapy services, education, or research.
- E. Address impaired practice and, when necessary, report it to the appropriate authorities.
- F. Avoid dual relationships, conflicts of interest, and situations in which a practitioner, educator, student, researcher, or employer is unable to maintain clear professional boundaries or objectivity.
- G. Avoid engaging in sexual activity with a recipient of service, including the client's family or significant other, student, research participant, or employee, while a professional relationship exists.

- H. Avoid compromising the rights or well-being of others based on arbitrary directives (e.g., unrealistic productivity expectations, falsification of documentation, inaccurate coding) by exercising professional judgment and critical analysis.
- I. Avoid exploiting any relationship established as an occupational therapy clinician, educator, or researcher to further one's own physical, emotional, financial, political, or business interests at the expense of recipients of services, students, research participants, employees, or colleagues.
- J. Avoid bartering for services when there is the potential for exploitation and conflict of interest.

AUTONOMY

Principle 3. Occupational therapy personnel shall respect the right of the individual to self-determination, privacy, confidentiality, and consent.

The Principle of *Autonomy* expresses the concept that practitioners have a duty to treat the client according to the client's desires, within the bounds of accepted standards of care, and to protect the client's confidential information. Often, respect for Autonomy is referred to as the *self-determination principle*. However, respecting a person's autonomy goes beyond acknowledging an individual as a mere agent and also acknowledges a person's right "to hold views, to make choices, and to take actions based on [his or her] values and beliefs" (Beauchamp & Childress, 2013, p. 106). Individuals have the right to make a determination regarding care decisions that directly affect their lives. In the event that a person lacks decision-making capacity, his or her autonomy should be respected through involvement of an authorized agent or surrogate decision maker.

RELATED STANDARDS OF CONDUCT

Occupational therapy personnel shall

- A. Respect and honor the expressed wishes of recipients of service.
- B. Fully disclose the benefits, risks, and potential outcomes of any intervention; the personnel who will be providing the intervention; and any reasonable alternatives to the proposed intervention.
- C. Obtain consent after disclosing appropriate information and answering any questions posed by the recipient of service or research participant to ensure voluntariness.
- D. Establish a collaborative relationship with recipients of service and relevant stakeholders to promote shared decision making.
- E. Respect the client's right to refuse occupational therapy services temporarily or permanently, even when that refusal has potential to result in poor outcomes.
- F. Refrain from threatening, coercing, or deceiving clients to promote compliance with occupational therapy recommendations.
- G. Respect a research participant's right to withdraw from a research study without penalty.
- H. Maintain the confidentiality of all verbal, written, electronic, augmentative, and nonverbal communications, in compliance with applicable laws, including all aspects of privacy laws and exceptions thereto (e.g., Health Insurance Portability and Accountability Act [Pub. L. 104–191], Family Educational Rights and Privacy Act [Pub. L. 93–380]).
- I. Display responsible conduct and discretion when engaging in social networking, including but not limited to refraining from posting protected health information.

- J. Facilitate comprehension and address barriers to communication (e.g., aphasia; differences in language, literacy, culture) with the recipient of service (or responsible party), student, or research participant.

JUSTICE

Principle 4. Occupational therapy personnel shall promote fairness and objectivity in the provision of occupational therapy services.

The Principle of *Justice* relates to the fair, equitable, and appropriate treatment of persons (Beauchamp & Childress, 2013). Occupational therapy personnel should relate in a respectful, fair, and impartial manner to individuals and groups with whom they interact. They should also respect the applicable laws and standards related to their area of practice. Justice requires the impartial consideration and consistent following of rules to generate unbiased decisions and promote fairness. As occupational therapy personnel, we work to uphold a society in which all individuals have an equitable opportunity to achieve occupational engagement as an essential component of their life.

RELATED STANDARDS OF CONDUCT

Occupational therapy personnel shall

- A. Respond to requests for occupational therapy services (e.g., a referral) in a timely manner as determined by law, regulation, or policy.
- B. Assist those in need of occupational therapy services in securing access through available means.
- C. Address barriers in access to occupational therapy services by offering or referring clients to financial aid, charity care, or pro bono services within the parameters of organizational policies.
- D. Advocate for changes to systems and policies that are discriminatory or unfairly limit or prevent access to occupational therapy services.
- E. Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy.
- F. Inform employers, employees, colleagues, students, and researchers of applicable policies, laws, and Official Documents.
- G. Hold requisite credentials for the occupational therapy services they provide in academic, research, physical, or virtual work settings.
- H. Provide appropriate supervision in accordance with AOTA Official Documents and relevant laws, regulations, policies, procedures, standards, and guidelines.
- I. Obtain all necessary approvals prior to initiating research activities.
- J. Refrain from accepting gifts that would unduly influence the therapeutic relationship or have the potential to blur professional boundaries, and adhere to employer policies when offered gifts.
- K. Report to appropriate authorities any acts in practice, education, and research that are unethical or illegal.
- L. Collaborate with employers to formulate policies and procedures in compliance with legal, regulatory, and ethical standards and work to resolve any conflicts or inconsistencies.
- M. Bill and collect fees legally and justly in a manner that is fair, reasonable, and commensurate with services delivered.

- N. Ensure compliance with relevant laws, and promote transparency when participating in a business arrangement as owner, stockholder, partner, or employee.
- O. Ensure that documentation for reimbursement purposes is done in accordance with applicable laws, guidelines, and regulations.
- P. Refrain from participating in any action resulting in unauthorized access to educational content or exams (including but not limited to sharing test questions, unauthorized use of or access to content or codes, or selling access or authorization codes).

VERACITY

Principle 5. Occupational therapy personnel shall provide comprehensive, accurate, and objective information when representing the profession.

Veracity is based on the virtues of truthfulness, candor, and honesty. The Principle of *Veracity* refers to comprehensive, accurate, and objective transmission of information and includes fostering understanding of such information (Beauchamp & Childress, 2013). Veracity is based on respect owed to others, including but not limited to recipients of service, colleagues, students, researchers, and research participants.

In communicating with others, occupational therapy personnel implicitly promise to be truthful and not deceptive. When entering into a therapeutic or research relationship, the recipient of service or research participant has a right to accurate information. In addition, transmission of information is incomplete without also ensuring that the recipient or participant understands the information provided.

Concepts of veracity must be carefully balanced with other potentially competing ethical principles, cultural beliefs, and organizational policies. Veracity ultimately is valued as a means to establish trust and strengthen professional relationships. Therefore, adherence to the Principle of Veracity also requires thoughtful analysis of how full disclosure of information may affect outcomes.

RELATED STANDARDS OF CONDUCT

Occupational therapy personnel shall

- A. Represent credentials, qualifications, education, experience, training, roles, duties, competence, contributions, and findings accurately in all forms of communication.
- B. Refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, misleading, or unfair statements or claims.
- C. Record and report in an accurate and timely manner and in accordance with applicable regulations all information related to professional or academic documentation and activities.
- D. Identify and fully disclose to all appropriate persons errors or adverse events that compromise the safety of service recipients.
- E. Ensure that all marketing and advertising are truthful, accurate, and carefully presented to avoid misleading recipients of service, research participants, or the public.
- F. Describe the type and duration of occupational therapy services accurately in professional contracts, including the duties and responsibilities of all involved parties.
- G. Be honest, fair, accurate, respectful, and timely in gathering and reporting fact-based information regarding employee job performance and student performance.
- H. Give credit and recognition when using the ideas and work of others in written, oral, or electronic media (i.e., do not plagiarize).

- I. Provide students with access to accurate information regarding educational requirements and academic policies and procedures relative to the occupational therapy program or educational institution.
- J. Maintain privacy and truthfulness when using telecommunication in the delivery of occupational therapy services.

FIDELITY

Principle 6. Occupational therapy personnel shall treat clients, colleagues, and other professionals with respect, fairness, discretion, and integrity.

The Principle of Fidelity comes from the Latin root *fidelis*, meaning loyal. *Fidelity* refers to the duty one has to keep a commitment once it is made (Veatch, Haddad, & English, 2010). In the health professions, this commitment refers to promises made between a provider and a client or patient based on an expectation of loyalty, staying with the client or patient in a time of need, and compliance with a code of ethics. These promises can be implied or explicit. The duty to disclose information that is potentially meaningful in making decisions is one obligation of the moral contract between provider and client or patient (Veatch et al., 2010).

Whereas respecting Fidelity requires occupational therapy personnel to meet the client's reasonable expectations, the Principle also addresses maintaining respectful collegial and organizational relationships (Purtilo & Doherty, 2011). Professional relationships are greatly influenced by the complexity of the environment in which occupational therapy personnel work. Practitioners, educators, and researchers alike must consistently balance their duties to service recipients, students, research participants, and other professionals as well as to organizations that may influence decision making and professional practice.

RELATED STANDARDS OF CONDUCT

Occupational therapy personnel shall

- A. Preserve, respect, and safeguard private information about employees, colleagues, and students unless otherwise mandated or permitted by relevant laws.
- B. Address incompetent, disruptive, unethical, illegal, or impaired practice that jeopardizes the safety or well-being of others and team effectiveness.
- C. Avoid conflicts of interest or conflicts of commitment in employment, volunteer roles, or research.
- D. Avoid using one's position (employee or volunteer) or knowledge gained from that position in such a manner as to give rise to real or perceived conflict of interest among the person, the employer, other AOTA members, or other organizations.
- E. Be diligent stewards of human, financial, and material resources of their employers, and refrain from exploiting these resources for personal gain.
- F. Refrain from verbal, physical, emotional, or sexual harassment of peers or colleagues.
- G. Refrain from communication that is derogatory, intimidating, or disrespectful and that unduly discourages others from participating in professional dialogue.
- H. Promote collaborative actions and communication as a member of interprofessional teams to facilitate quality care and safety for clients.
- I. Respect the practices, competencies, roles, and responsibilities of their own and other professions to promote a collaborative environment reflective of interprofessional teams.
- J. Use conflict resolution and internal and alternative dispute resolution resources as needed to resolve organizational and interpersonal conflicts, as well as perceived institutional ethics violations.

- K. Abide by policies, procedures, and protocols when serving or acting on behalf of a professional organization or employer to fully and accurately represent the organization's official and authorized positions.
- L. Refrain from actions that reduce the public's trust in occupational therapy.
- M. Self-identify when personal, cultural, or religious values preclude, or are anticipated to negatively affect, the professional relationship or provision of services, while adhering to organizational policies when requesting an exemption from service to an individual or group on the basis of conflict of conscience.

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Occupational Therapy for Children and Youth Using Sensory Integration Theory and Methods in School-Based Practice

The American Occupational Therapy Association (AOTA) recognizes that occupational therapists and occupational therapy assistants¹ working within public school settings may provide intervention to students in general and special education programs. When the processing and integrating of sensory information interferes with a child's performance in school activities, occupational therapy practitioners² may use sensory-based interventions or a sensory integration (SI) approach (Ayres, 1972a) to support the child's ability to participate in his or her educational program. Evidence to support SI and sensory processing interventions can be found in Watling, Koenig, Davies, and Schaaf (2011) and also in Dunn (2014). Occupational therapy practitioners working in schools use evidence-based sensory-based interventions or a SI approach when sensory-related issues are identified and affect a child's ability to benefit from his or her education.

Studies have identified atypical sensory reactivity within the general population of between 5% and 16.5% (Ahn, Miller, Milberger, & McIntosh, 2004; Ben-Sasson, Carter, & Briggs-Gowan, 2009). The incidence of sensory modulation disorders increases to 35% in a Head Start sample, with 45% of those children showing extreme differences in underresponsive or seeking behaviors (Reynolds, Shepherd, & Lane, 2008). In a study of children with autism spectrum disorder, approximately 95% of the sample demonstrated some degree of sensory processing dysfunction (Tomchek & Dunn, 2007). Given that sensory reactivity is only one of the several patterns of sensory integrative deficits (Parham & Mailloux, 2010), estimates of school-age children with all types of sensory difficulties who require occupational therapy may be even higher. The research suggests that sensory-based interventions may be necessary for these students to participate in school.

Federal and State Mandates for Occupational Therapy Practitioners Working in Public Education

Occupational therapy practitioners working in schools, including preschools, are required to follow federal and state education laws and regulations as well as professional licensure regulations and guidelines. In addition, occupational therapy practitioners are guided by the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; AOTA, 2014b), the *Occupational Therapy Code of Ethics* (2015) (AOTA, 2015), and *Standards of Practice for Occupational Therapy* (AOTA, 2010). The *Framework* promotes occupation-based, client-centered, contextual, and evidence-based services. The scope of occupational therapy evaluation and intervention in the school setting includes areas that affect the child's "learning and participation in the context of educational activities, routines, and environments" (AOTA, 2011, p. S49).

¹Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. Occupational therapy assistants deliver safe and effective occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).

²When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

Specific to public schools are parameters established by federal laws, including the No Child Left Behind Act of 2001 (NCLB; Pub. L. 107–110); the Individuals With Disabilities Education Improvement Act of 2004 (IDEA 2004; Pub. L. 108–446); and Section 504 of the Rehabilitation Act of 1973, as amended (Pub. L. 93–112, Pub. L. 99–506), mandating a child’s right to a free, appropriate public education (FAPE) that includes occupational therapy as a related service. NCLB focuses on improving education for all children, requiring schools to use “effective methods and instructional strategies that are based on scientifically based research” (§ 1114(b)(1)(B)(ii)) and to demonstrate “adequate yearly progress” as measured by annual statewide assessment of student learning.

IDEA establishes the rights of children with disabilities to receive a FAPE in the least restrictive environment (LRE) and reinforces the need for effective instructional practices within special education. A child meeting the eligibility criteria for one of the disability categories identified in IDEA 2004, and also demonstrating a need for specialized instruction, is entitled to special education and related services. The individualized education program (IEP) must contain a statement of special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practical, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided to enable the child to attain the annual goals, to be involved in and make progress in the general education curriculum, and to be educated and participate with other children (§300.320(a)(4)).

The LRE mandate within IDEA requires that children with disabilities be educated within the general education environment unless “the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily” (§300.114(a)(2)). The IEP must identify the extent to which the child will not participate with other children in the regular classroom and other activities within the educational environment (§300.114(a)(5)), and state departments of education must report to the Office of Special Education Programs the amount of time the child is removed from the classroom (IDEA 2004).

Under IDEA, each state must establish rules and regulations for determining eligibility for special education on the basis of the federal code. Local education agencies (LEAs) have some discretion regarding the provision of services so long as they meet the minimum requirements mandated by the federal and state education agencies. Many state and LEAs provide early intervening services (EIS) under IDEA 2004, which authorizes multitiered systems of support (e.g., Response to Intervention, positive behavior interventions and supports; §1413(f)).

Under EIS, occupational therapy practitioners working in public schools may provide professional development to educators to support the delivery of scientifically based instruction or interventions and, if state professional regulations allow, evaluations, services, and supports to general education children to increase their performance in general education. This encourages occupational therapy practitioners to provide systems (i.e., schoolwide) and team approaches as well as, possibly, individual services to enhance general education performance. For example, an occupational therapist may provide professional development based on SI theory and methods to general education teachers regarding ways to modify or adapt the environment and context to support participation and engagement in the classroom or on the playground.

Under Section 504 of the Rehabilitation Act of 1973, children who are not eligible for specially designed instruction under IDEA but who need supports and accommodations for equal access may be determined by the school district to be eligible for a 504 plan, which identifies the accommodations, modifications, and services needed. Occupational therapy practitioners may be participants in the development and implementation of the 504 plan.

Application of Sensory Integration Theory and Methods in Schools

Clinical and Professional Reasoning

Occupational therapy is provided toward the aim of affording opportunities for full participation in every-day activities and occupations in which individuals choose to engage (Christiansen & Townsend, 2010). The imperative when working in schools is to provide occupational therapy for the purpose of meeting the child's specific needs to support his or her ability to access the curriculum and benefit from his or her education in the LRE. As members of the IEP team, occupational therapists rely on the results of the evaluation to determine the child's needs, to establish goals, and to make recommendations to the IEP team regarding the types and intensity of occupational therapy services the child requires to benefit from the educational program. Through accurate functional baseline data, measurable goals, and data collection to monitor a child's successful participation in the natural environment, occupational therapy practitioners provide accountability for a child's progress in occupational therapy intervention as it relates to education.

Clinical reasoning based on professional training, evidence, and expertise guides the occupational therapist's selection and use of one or more theories on SI (Boyt Schell & Schell, 2008; Burke, 2001; Dunn, 2013; Parham, 1987; Schaaf & Smith Roley, 2006). The child's ability to adapt, organize, and integrate sensory information in school environments and activities is important for performance (Watling et al., 2011).

Evaluation

Occupational therapists evaluate a child's school performance by using "a variety of assessment tools and strategies to gather relevant functional, developmental and academic information including information provided by the parent" (IDEA 2004, § 614(b)(2)(A)). Multiple data sources are used during the evaluation, including review of pertinent medical and educational information; interviews with teachers, parents, and the child; observations in natural settings; and various assessments (Coster & Frolek Clark, 2013).

When referrals or observations suggest sensory, motor, and praxis issues, the occupational therapy evaluation includes assessment of these areas (AOTA, 2014b; Lane, Smith Roley, & Champagne, 2013; Stewart, 2010; Watling et al., 2011). Assessments may include direct observation of the child's performance in a variety of tasks to analyze the demands of the activities (e.g., objects and their properties, space, sequencing, timing), social and physical characteristics of the environments, and effectiveness of the child's performance skills and patterns in those activities and environments. The occupational therapist conducts assessments of sensory and neuromotor functions through observations in various environments and analyzes play performance and functional participation of the child in response to the setting's demands (Blanche, 2002; Blanche, Bodison, Chang, & Reinoso, 2012; Knox, 2008; Lane et al., 2013; Schaaf & Smith Roley, 2006; Skard & Bundy, 2008; Watling et al., 2011; Wilson, Pollock, Kaplan, & Law, 1994). Interventions are then designed on the basis of data analysis, with a focus on assisting the child to benefit from his or her educational program (Schaaf & Blanche, 2012). Several structured screenings and assessments have been developed to assess the child's sensory, motor, and praxis abilities:

- The DeGangi-Berk Test of Sensory Integration (DeGangi & Berk, 1983) is a preschool screening focused on sensory-based postural and motor functions.
- The Sensory Integration and Praxis Tests (SIPT; Ayres, 1989) is a standardized performance measure used to identify sensory integrative dysfunction related to learning and behavior. The SIPT is a series of 17 individual tests that provide information on visual perception; visual-motor and fine motor performance; construction; tactile discrimination; tactile sensitivity; kinaesthesia; vestibular functions, including postrotary nystagmus and balance; bilateral motor control; and praxis.
- The Sensory Processing Measure: Home Form (Parham & Ecker, 2007); Sensory Processing Measure: Main Classroom and School Environments Form (Miller-Kuhaneck, Herry, & Glennon, 2007);

Sensory Processing Measure–Preschool: Home Form (Parham & Ecker, 2010); and Sensory Processing Measure–Preschool: Main Classroom and School Environments Form (Miller-Kuhaneck, Henry, & Glennon, 2010) are integrated systems of rating scales that enable assessment on the basis of parent and educational staff report of sensory processing issues, planning and ideas, and social participation in preschool through elementary school-age children.

- The Sensory Profile 2 (Dunn, 2014) includes infant, toddler, child, and school rating forms, and the Adolescent/Adult Sensory Profile (Brown & Dunn, 2002) consists of standardized questionnaires that focus on the student’s sensory processing performance patterns within the natural context.

Intervention

Although the scope of occupational therapy services expands far beyond the use of SI methods, if one or more types of SI and praxis deficits are revealed during the evaluation, the use of SI methods is appropriate (Table 1). Occupational therapy practitioners with this focus may use a continuum of intervention approaches and types to enhance the child’s ability to be educated and participate in daily occupations with other children. Services may be provided individually (e.g., providing one-on-one intervention to remediate vestibular–ocular difficulties affecting visual tracking and handwriting), through consultation and collaboration with groups (e.g., offering staff in-services on sensory regulatory strategies), or through education and training (e.g., establishing an awareness and understanding of sensory needs addressed through occupational therapy; AOTA, 2014b).

Table 1. Occupational Therapy Approaches in Schools Using SI Theory and Methods

Occupational Therapy Approach	Examples of Pathways to Outcomes
Create and promote health and participation.	<ul style="list-style-type: none"> • Create a class for parents or educational staff to teach the relationships among sensory processing, learning, and behavior. • Promote increased physical activity for students to improve physical and mental health as well as cognitive and social performance. • Support installation of various equipment available at schools and public playgrounds to promote diversity in sensory play experiences. • Design sensory-enriched classrooms with various seating options as well as opportunities for tactile, movement, and proprioceptive experiences throughout the day.
Establish or restore performance skills and performance patterns.	<ul style="list-style-type: none"> • Provide controlled sensory input through activities that require increasingly complex adaptive responses to novel activity to support ability to access Common Core curriculum standards and participate in classroom activities. • Design activities rich in tactile, vestibular, and proprioceptive information that increase academic, physical, and social performance skills. • Facilitate development of appropriate SI and motor planning skills needed for organizing materials, completing tasks within an appropriate time frame, and adapting to transitions. • Establish or restore SI and praxis needed for physical, social, and object play.
Maintain student ability to engage in and cope with school-related activities.	<ul style="list-style-type: none"> • Structure the sensory environment to meet the student’s needs, such as reducing sensory distractions and improving the ergonomic comfort of the chair and desk. • Teach sensory self-regulation strategies for academic achievement, social–emotional well-being, physiological homeostasis, positive behavior, and motor performance in play. • Maintain ability to organize behavior by providing scheduled sensory breaks and sensory accommodations, such as changing the size, maneuverability, comfort, and location of the seat and desk. • Maintain peer relationships by supporting and compensating for motor planning needs in age-appropriate games and sports. • Maintain student productivity by providing compensation techniques for sensory and motor planning deficits using study carrels, visual timers, weighted vests, alternate seating arrangements, modified writing tools, and paper and other assistive technology.

(Continued)

Table 1. Occupational Therapy Approaches in Schools Using SI Theory and Methods (cont.)

Occupational Therapy Approach	Examples of Pathways to Outcomes
Modify activity to help student compensate for sensory, motor, and praxis deficits.	<ul style="list-style-type: none"> • Through collaborative consultation with education staff and parents, develop strategies for modifying the sensory, motor, or praxis demands of assignments to increase student productivity. • Support student participation in general curriculum by modifying sensory and motor planning demands of the activity. • Structure or modify the environment to support the student's sensory, motor, motor planning, and self-regulatory capacities and needs.
Prevent barriers to participation and improve safety.	<ul style="list-style-type: none"> • Prevent inattention, poor posture, and restlessness when sitting for prolonged periods by modifying seating options, allowing sensory breaks, and allowing the student to work in various positions. • Prevent social isolation by providing motor planning and social strategies to participate with peers. • Prevent socially inappropriate behaviors and behavioral distress or disruption by detecting and meeting sensory and self-regulatory needs. • Prevent injury by providing ergonomic seating and safety strategies for students whose nervous systems have reduced registration of sensory information. • Prevent barriers to child participation by increasing the understanding of the school district staff regarding the role that SI and praxis play in influencing learning and behavior.

Note. SI = sensory integration.

Collaboration with school staff and IEP team members provides opportunities for education and training to increase their understanding of the contribution of SI and praxis to participation at school. Collaboration allows the occupational therapy practitioner to advocate for accommodations and modifications that will assist the child's school performance and to model services that enhance participation in physical and social play. Adaptation of the school environment according to children's sensory, motor, and praxis needs has been consistently recognized in the professional literature as a way to support their successful participation. It may include increasing the number of activity breaks and ensuring that all children have access to recess (Pellegrini, 2005). As teachers, administrators, and paraprofessionals better understand sensory-related behaviors, they can implement suggested evidence-based sensory strategies, embedding them in the classroom routine to improve children's ability to learn (Prizant, Wetherby, Rubin, & Laurent, 2003). Table 2 provides case examples of school-based occupational therapy interventions with a preschool child, an elementary school child, and a middle school child.

Table 2. Case Examples Using SI Theory in Schools

The following vignettes are outlined relative to the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; AOTA, 2014b) to illustrate occupational therapy using SI theory and methods in schools.

Case 1. Natasha: Preschool-Age Child

Evaluation

Referral: Natasha is a 3-year-old child enrolled in a special education preschool. The IEP team recommended an OT evaluation because Natasha has difficulty with classroom transitions and social interactions.

Occupational Profile

Natasha's family and educational team are seeking OT services because of her difficulty with transitioning and coping in the classroom. Natasha is sensitive to noise; she cries and clings to the aide in the classroom. She performs well at skilled tasks. Additional information was gathered from her medical, developmental, educational, and occupational histories. The priorities listed by the teacher and parents include social interactions (i.e., friendships) and performance within the flow of the classroom (i.e., transitioning).

Analysis of Occupational Performance

Interview Data	Observation Data	Test Data
<ul style="list-style-type: none"> • Speech-language therapist report: Natasha's receptive language is below 	<ul style="list-style-type: none"> • Natasha prefers to sit alone or next to an adult. 	<ul style="list-style-type: none"> • Evaluation of sensory processing using Infant/Toddler Sensory Profile (Dunn, 2002)

(Continued)

Table 2. Case Examples Using SI Theory in Schools (cont.)

<p>average and decreases when there is noise in the room.</p> <ul style="list-style-type: none"> • <i>Teacher report:</i> Natasha has difficulty adapting to the flow of classroom activities. She needs an exceptional amount of attention from adults to stay calm. She is able to cognitively perform the tasks but is overwhelmed with the noise and movement in the room. • <i>Parent report:</i> The mother is concerned about Natasha's unhappiness at school and inability to play and make friends. 	<ul style="list-style-type: none"> • Natasha needs extra cues to pay attention. Although physically capable, she does not complete a fine motor preschool activity without adult direction. • She does not initiate social interaction with other children and becomes irritable when children come near her. • She cries when entering the lunchroom or when a group of noisy children run past her during recess. • She does not like to go to lunch and refuses to eat anything but chips. 	<ul style="list-style-type: none"> • DeGangi–Berk Test of Sensory Integration (DeGangi & Berk, 1983) • Postrotary Nystagmus Test (Ayres, 1989; Mailloux et al., 2014) • Structured clinical observations (Blanche, 2002) • Evaluation of play skills using Knox Preschool Play Scale (Knox, 2008).
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Intervention Examples

<i>IEP Goals</i>	<i>OT Intervention Plan and Goals</i>	<i>OT Intervention Process and Strategies</i>
<p><i>Natasha:</i></p> <ul style="list-style-type: none"> • Will transition between classroom activities independently 4 of 5 transitions for 3 days. • Will sustain adult-facilitated interaction with her peers during free play for 5 minutes during a 15-minute observation 4 of 5 free play periods. • Will carry out verbal instructions with visual cues 4 of 5 opportunities with 80% accuracy. 	<p>OT is to be provided within the classroom setting during routine activities. Natasha's response to intervention in relation to learning, behavior, and adjustment to preschool will be monitored closely for progress and signs of a disorder in SI. Changes to service delivery may be recommended to the IEP team as needed.</p> <p><i>OT Goals:</i> Natasha</p> <ul style="list-style-type: none"> • Will regulate her responses to environmental stimuli to remain calm during routine class transitions. • Will self-regulate her responses to tactile stimuli to sit next to several peers and focus on the activity during playground and eating activities. • Will motor plan her body movements to engage in preschool play. • Will improve her spatial location of sound relative to the position of her body in the classroom with and without background noise. 	<p>The OT practitioner will facilitate and enhance performance through the following therapeutic activities:</p> <p><i>Client level:</i></p> <ul style="list-style-type: none"> • Increase sensory modulation through the use of heavy work activities. • Improve vestibular spatial body awareness through moving on swings and locating visual and auditory targets. • Improve adaptive responses and motor planning to increase competence when faced with dynamic activities and in her overall repertoire of play skills. <p><i>Activity level:</i></p> <ul style="list-style-type: none"> • Increase texture and weight of materials used during class activities. • Use visual cues for improved independence during familiar sequences and routines. <p><i>Environment level:</i></p> <ul style="list-style-type: none"> • Before class, Natasha will arrive early and will enter classroom prior to other children to gradually adjust to the increased noise and pace of the day. • Natasha will receive visual cues and tangible transition prompts, such as a visual schedule, to provide advance notice of classroom activity changes. • Natasha will be provided with a variety of seating options during circle time, such as a bean bag chair, rocking chair, ball chair, or cube seat. • Seating will be arranged near an adult.

Outcomes

Outcomes were reported by members of the IEP team.

Performance Skills

- Improvement noted in all skill areas—motor, process, and social skills.

(Continued)

Table 2. Case Examples Using SI Theory in Schools (cont.)

Performance Patterns

- Easier transitions
- Increased attention
- New friendships
- Sustained participation during classroom activities without withdrawing
- Teacher and parent satisfaction that Natasha is able to participate in her preschool program and appears happier at school.

Participation

- Improved self-regulation and adaptation in the preschool routine.

Case 2. Billy: Elementary School–Age Student

Evaluation

Referral: Billy is a 7-year-old student in a general education classroom environment. The IEP team requested an OT evaluation because of Billy's poor handwriting, aggressive behavior, difficulty completing work, and diagnosis of developmental coordination disorder.

Occupational Profile

Billy's guardians and educational team requested an OT evaluation because of his difficulty with writing, aggressive behavior, and a medical diagnosis of developmental coordination disorder. Information was obtained from Billy's medical, developmental, educational, and occupational histories. Billy receives speech therapy and specialized academic instruction from a resource specialist. He was referred to OT because of increasing aggressive behavior, difficulty beginning and completing work that was modified for his level of ability, and disorganized handwriting with almost no spacing between words. Billy has difficulty with play and social participation on the playground. He has poorly established habits and routines of organizing his belongings and self-care at school, often appearing disheveled. Parental and IEP team priorities include improving Billy's ability to meet the Common Core Standards (through handwriting and work completion) and ability to play more effectively with his peers.

Analysis of Occupational Performance

<i>Interview Data</i>	<i>Test Data</i>
<p><i>Teacher report:</i></p> <ul style="list-style-type: none"> • Billy has above-average academic ability but completes fewer than half of his assignments in the proper amount of time. • Billy does not interact with his peers. • Billy has expressed the concern that as the demands of school increase, he is going to fall further and further behind. • Billy has poor use of his hands for tasks, such as opening his lunch containers and managing classroom tools. • Billy's writing is illegible. <p><i>Parent report:</i></p> <ul style="list-style-type: none"> • Billy has no friends. • Billy has difficulty comprehending simple verbal instructions. • Billy has unusual habits and rituals. • Billy has poorly established patterns of daily activities, such as getting ready to go to bed or mealtimes. 	<ul style="list-style-type: none"> • Sensory Integration and Praxis Tests (Ayres, 1989) and clinical observation results were as follows: <ul style="list-style-type: none"> ○ Visual–perception tests within normal limits ○ Visual–motor tests 1–2 standard deviations below the mean ○ Visual construction test scores in the high-average range ○ Poor bilateral motor control ○ Poor oral praxis and postural praxis ○ Poor tactile discrimination ○ Poor posture and eye control ○ Decreased prone extension and supine flexion. • Sensory Processing Measure–Home Form (Parham & Ecker, 2007) revealed definite differences in social participation, movement, tactile functions, body awareness, and ideas and planning. • Sensory Processing Measure–Main Classroom and Social Environments Form (Miller-Kuhaneck, Henry, & Glennon, 2007) revealed definite differences in response to movement and body awareness; Billy is easily overwhelmed with auditory and visual activity in the environment. • Classroom handwriting portfolio was compared with peers and revealed a discrepancy.

Intervention Examples

<i>IEP Goals</i>	<i>OT Intervention Plan and Goals</i>	<i>OT Intervention Process and Strategies</i>
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(Continued)

Table 2. Case Examples Using SI Theory in Schools (cont.)

<p><i>Billy:</i></p> <ul style="list-style-type: none"> • Will be able to write 3 legible sentences in his journal during a 20-minute writing period 4 of 5 opportunities. • Will stay on topic and remain in his seat for the duration of a 15-minute social studies lesson 4 of 5 opportunities. • Will participate appropriately in a structured playground activity with 1 other child without leaving the activity or arguing with the child for 10 minutes during the recess or lunch break 2 of 3 opportunities. <p>OT is recommended to improve visual–motor control and overall attention.</p> <p>OT is to be provided in a specially equipped environment, and consultation is to be provided to the IEP team members.</p> <p><i>OT Goals: Billy</i></p> <ul style="list-style-type: none"> • Will organize visual–motor information to write legible words. • Will organize somatosensory input from his body to imitate and follow visual directions during structured playground activities. • Will remain comfortably seated and regulate his attention during instruction to remain focused and on task during social studies. • Will confidently access playground equipment and perform in recess and physical education games with peers. 	<p>OT is recommended to improve visual–motor control and overall attention.</p> <p>OT is to be provided in a specially equipped environment, and consultation is to be provided to the IEP team members.</p> <p><i>OT Goals: Billy</i></p> <ul style="list-style-type: none"> • Will organize visual–motor information to write legible words. • Will organize somatosensory input from his body to imitate and follow visual directions during structured playground activities. • Will remain comfortably seated and regulate his attention during instruction to remain focused and on task during social studies. • Will confidently access playground equipment and perform in recess and physical education games with peers. 	<p>The OT practitioner will facilitate adaptive responses through provision of sensory and motor challenges through the following interventions:</p> <p><i>Client level:</i></p> <ul style="list-style-type: none"> • Use weight-bearing and heavy work activities to increase strength of Billy's trunk and upper extremities. • Increase Billy's exploration of multiple textures, sizes, and shapes to improve sensitivity and stereognosis in his hands. <p><i>Activity level:</i></p> <ul style="list-style-type: none"> • Instruct teacher in kinesthetic and visual support method to reteach fundamentals of handwriting. • Use weighted pencils, pencil grips, and paper with highlighted areas. • Allow Billy to do some of his work while standing, ball-sitting, or lying on his stomach. <p><i>Environment level:</i></p> <ul style="list-style-type: none"> • Provide written text to copy rather than copying from blackboard. • Provide written instructions and pictures of daily sequences of activities with times and locations. • Allow structured time for movement throughout the day as needed.
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Outcomes

Outcomes were reported by members of the IEP team.

Occupational Performance

- Improved writing and language arts skills.
- Increased ADL and functional independence.
- Improved social participation.
- Independent engagement in structured activities.
- Improved participation and organization of behavior in daily routines.

Case 3. John: Middle School–Age Student

Evaluation

Referral: John is 12 years old and has just entered middle school. The IEP team requested an OT evaluation because John cannot organize his belongings and schedule or find his way around the middle school campus. He is experiencing high anxiety and refusing to go to school. Although psychoeducational assessments reveal adequate cognitive abilities, the IEP team members report escalating concerns related to John's ability to academically and physically keep up with his peers.

(Continued)

Table 2. Case Examples Using SI Theory in Schools (cont.)

<i>Occupational Profile</i>		
<p>John's family and the educational team requested an OT evaluation because of his difficulty finding his way around his school and resulting anxiety and depression. Additional information from John's medical, developmental, educational, and occupational histories was reviewed. Team priorities include increasing John's confidence and independence in performing school curriculum activities and ability to navigate around school without getting lost.</p>		
<i>Analysis of Occupational Performance</i>		
<i>Interview Data</i>	<i>Data From Record Review</i>	<i>Test Data</i>
<p><i>Parent report:</i></p> <ul style="list-style-type: none"> • John gets lost easily. • John works best in a self-contained classroom with group transitions; however, the middle school is not structured this way. • John demonstrates poor spatial abilities, such as when he needs to align numbers in math. • John talks his way out of anything he finds difficult. <p><i>John's self-report:</i></p> <ul style="list-style-type: none"> • He has anxiety attacks. • He feels sick during rides in the car to school. • He feels stupid. • He wants to be home schooled. • He spends most of his day in sedentary activities. • He cannot tolerate backward movement of his head. • He cannot play desired team sports at the skill level of his peers and as a result feels rejected and humiliated by other children. 	<p>The elementary school file indicates that John performed well in academics but rarely finished written work on time in a legible or organized manner. He was well behaved and liked by peers.</p> <ul style="list-style-type: none"> • John's teacher notes that John does not volunteer for classroom errands on the school grounds unless he could go with a peer. • John often lost his completed assignments in the classroom, later to be found in his messy desk or in unlikely places in the classroom. 	<ul style="list-style-type: none"> • Below age level on VMI visual-motor integration and visual perception (Beery, Buktenica, & Beery, 2010). • Within normal limits on VMI fine motor coordination in tracing precision (Beery et al., 2010). • Poor 2- and 3-dimensional construction ability. • Poor balance with eyes closed. • Self-reports of dizziness on playground swings. • Poor disassociation of his head, neck, and body. • Excessive talking to avoid performing during the evaluation observation. • Inability to locate familiar landmarks (e.g., office).
Intervention Examples		
<i>IEP Goals</i>	<i>OT Intervention Plan and Goals.</i>	<i>OT Intervention Process and Strategies</i>
<p><i>John:</i></p> <ul style="list-style-type: none"> • Will arrive at all of his classes independently and on time for 2 weeks. • Will attend school 8 of 10 days with low levels of anxiety, as noted by self-report. • Will show increased tolerance for bus rides as reported by John, parent, and bus driver 4 of 5 days. • Will identify age-appropriate leisure time options that are within his ability and interest level, such as individually oriented community sports and lessons (e.g., karate, yoga, swimming, chess, arts and crafts). • Will explore junior high extracurricular activities and clubs. 	<p>OT is recommended in the school setting.</p> <p><i>OT Goals: John</i></p> <ul style="list-style-type: none"> • Will identify 1 strategy of 3 options (i.e., map, written sequence, self-instruction) that works best for him to get to familiar places. • Will identify, select, and participate in leisure and extracurricular physical activities. • Will learn to identify antecedents to periods of increased anxiety and use relaxation techniques to remain calm when transitioning from home to school and between classes. 	<p>The OT practitioner will facilitate and enhance performance through the following interventions:</p> <p><i>Client level:</i></p> <ul style="list-style-type: none"> • Develop various strategies for John to practice to improve his awareness of the geography of the campus. • Provide strategies to help John become aware of and identify his own sensory strengths, sensitivities, and preferences. • Increase proprioceptive heavy work activities to improve John's sense of his body in space. • Educate John to avoid intense vestibular activities.

(Continued)

Table 2. Case Examples Using SI Theory in Schools (cont.)

		<p><i>Activity level:</i></p> <ul style="list-style-type: none"> • Provide cues, landmarks, and signs that John can record as he walks to class. • Enroll John in extracurricular activities such as karate, yoga, swimming, or rock climbing. <p><i>Environment level:</i></p> <ul style="list-style-type: none"> • Pair John initially with a peer to walk to class. • Make a list of visual details as landmarks, take pictures, or put room numbers on an index card, color-coded for each of John's classes, to enable him to get to different classes.
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Outcomes

Outcomes were reported by members of the IEP team.

Participation

- Improved confidence in his own ability to adapt to and meet the everyday spatial demands of school activities, greatly reducing stress at school.
- Increased self-awareness and self-determination in seeking advice to devise strategies to compensate in situations that are uncomfortable or intimidating.
- Improved ability to arrive at class on time.
- Independence in finishing and finding 75% of his assignments.
- Decreased resistance to going to school.
- Increased initiation of participation in leisure activities with peers, such as school clubs.

Client Satisfaction

- Confidence in travelling between classes without assistance.
- Increased parent-reported happiness at home and at school.
- Cessation of reports of depression or anxiety.

Note. ADL = activity of daily living; AOTA = American Occupational Therapy Association; IEP = individualized education program; OT = occupational therapy; SI = sensory integration; VMI = Beery–Buktenica Developmental Test of Visual–Motor Integration.

Occupational therapy services provided to support a child with sensory processing differences may be delivered within multiple contexts that include the variety of educational environments and routines. Two types of commonly applied occupational therapy interventions for children with sensory processing and SI challenges in school-based practice include (1) occupational therapy using sensory-based interventions and (2) occupational therapy using an SI approach.

Occupational Therapy Using Sensory-Based Interventions

Sensory-based interventions focus on how sensory input within the school environment affects student participation (Foster & Cox, 2013). Occupational therapy practitioners use sensory-based interventions to address specific sensory needs related to sensory modulation or sensory discrimination (Watling et al., 2011). Sensory-based interventions used in school settings commonly involve the application of Dunn’s (2013) model that organizes sensory processing into four basic patterns of behavioral responses (“seekers,” “avoiders,” “bystanders,” and “sensors”), which depend on individuals’ thresholds for sensory input and whether they use active or passive strategies to support self-regulation. Using this strengths-based model,

the occupational therapy practitioner designs interventions that consider the sensory needs of the students and teachers within the context (i.e., authentic activity settings and routines). Interventions may include helping school personnel consider sensory processing patterns or factors when addressing student concerns, implementing daily routines that incorporate sensory-based activities, and modifying the environment to match students' sensory needs and support participation. Self-regulation strategies may be taught using the Alert Program (Williams & Shellenberger, 1994) and Zones of Regulation (Kuypers, 2011).

Provision of occupational therapy using sensory-based interventions often involves the use of sensory accommodations or strategies such as the use of mobile-seating options or fidget toys to address single-sensory systems. Some sensory strategies, such as the use of dynamic seating and strategies to increase attention, have shown promising results (Bagatell, Mirigliani, Patterson, Reyes, & Test, 2010; Fertel-Daly, Bedell, & Hinojosa, 2001; Schilling & Schwartz, 2004; Schilling, Washington, Billingsley, & Deitz, 2003). It is important to communicate to the educational team that these strategies must be used within the overall context of an occupational therapy intervention plan. Sensory-based strategies without the oversight of an occupational therapist do not constitute occupational therapy.

Occupational Therapy Using a Sensory Integrative Approach

Occupational therapy using a sensory integrative approach is grounded in the work of A. Jean Ayres, PhD, OTR, and identified by the trademarked term *Ayres Sensory Integration*® (ASI; Fertel-Daly et al., 2001). ASI represents a

- Well-developed theory grounded in basic and applied science (Berthoz, 2002; Berthoz & Petit, 2008; Head, 1920; Sherrington, 1906, 1940; Stein, 2012);
- Model of practice (Ayres, 1972a, 1972b, 1979);
- Set of standardized, structured and unstructured assessments (Ayres, 1989; Blanche, 2002; Davies & Tucker, 2010; Mailloux et al., 2011; Mulligan, 1998; Watling et al., 2011); and
- Replicable intervention, with evidence of its effectiveness (Pfeiffer, Koenig, Kinnealey, Sheppard, & Henderson, 2011; Schaaf et al., 2014; Smith Roley, Mailloux, Miller-Kuhaneck, & Glennon, 2007; Watling et al., 2011).

For school-based practice, difficulties in sensory integration and praxis are predictive of academic achievement in elementary school children (Parham, 1998). A compendium of evidence in SI can be found in Watling and colleagues (2011).

The use of ASI requires additional knowledge and skills, such as administering and interpreting the SIPT (Ayres, 1989). Occupational therapy practitioners gain expertise through workshops, publications, mentoring, pediatric study groups, and postgraduate studies. To ensure implementation of ASI with fidelity, intervention is provided by a skilled occupational therapy practitioner who is guided by the interpretation of a thorough assessment and who provides services within a therapeutically designed setting with appropriate space and equipment. This method relies on interactions between the therapist and child in a sensory-rich environment and uses a collaborative and playful approach, with attention to the child's successful adaptation to a variety of novel challenges, including sensory reactivity, sensory-perceptual and postural skills, and praxis. Collaboration with caregivers is essential, as are the one-to-one interactions with the child (Parham et al., 2011).

Therapy services that support participation in the LRE frequently occur in natural school spaces (e.g., classroom, playground, gym, cafeteria). Provision of SI methods, such as moving through space (e.g., climbing in, over, and under large equipment; swinging on equipment; playing with toys and structures graded for specific needs), may be essential to meet the IEP goals for some children and can be provided on a school campus.

The choice of interventions is guided by the best available research regarding the effectiveness of the intervention related to the identified goals for the child. The efficacy of occupational therapy's use of SI and sensory processing has been investigated by numerous researchers during the past 35 years. The outcome of occupational therapy using SI methods is to improve function in various daily occupations (Ayres, 1979; Bundy, Lane, & Murray, 2002; Dunn, 2001; Parham & Mailloux, 2010; Smith Roley, Blanche, & Schaaf, 2001; Watling et al., 2011). Recent studies adhering to fidelity in ASI intervention have shown promising results (Fazlioglu & Baran, 2008; Pfeiffer et al., 2011; Smith, Press, Koenig, & Kinnealey, 2005). Research supporting the use of SI methods can be found in *Occupational Therapy Practice Guidelines for Children and Adolescents With Challenges in Sensory Processing and Sensory Integration* (Watling et al., 2011). Selected studies supporting projected educational outcomes, by OT focus area, are provided in Table 3.

Table 3. Occupational Therapy Service Continuum Focus Areas, Projected Outcomes, and Research Support for School-Based Practice Using SI Theory and Methods

This table provides samples of studies supporting various SI theory and methods and outcomes in school-based practice. It is not an exhaustive list of the available evidence.

OT Focus Area	Projected Educational Outcomes	Examples of Resources and Evidence
Participation in education Emotional regulation, sensory-perceptual, motor, praxis, and cognitive skills	Students will access general education curriculum and attend to classroom instruction for longer periods of time prior to identification for special education eligibility and formal OT evaluation.	Schilling et al. (2003)
School readiness for education participation Play and leisure Communication and social skills	Students access general education standards and learn adaptive behavior and social skills.	Jarrett & Maxwell (2000) Pellegrini & Smith (1993, 1998)
Self-regulation, including the development of emotional regulation, cognitive, and sensory-perceptual skills	Students build sensory self-awareness and self-regulatory strategies to increase focus of attention and completion of schoolwork.	Wells, Chasnoff, Schmidt, Telford, & Schwartz (2012)
Attention and on-task behavior to improve participation in education	Students increase on-task behavior through classroom modifications, sensory strategies, sensory breaks, and sensory diets integrated into the school routine.	Kinnealey et al. (2012) VandenBerg (2001)
Cognitive, sensory-perceptual, and motor and praxis skills that enhance academic learning	Academic scores are improved through SI methods focusing on eliciting adaptive responses during OT. Gains in language comprehension and on expressive language measures are noted after OT using SI methods.	Ayres (1972a) Ayres & Mailloux (1981)
Sensory functions and sensory-perceptual skills influencing readiness to learn Adaptation	Individuals with hyperresponsiveness such as tactile defensiveness and gravitational insecurity responded better to intervention than those with underresponsiveness or who failed to orient to sensory input.	Ayres & Tickle (1980)
Cognitive, sensory-perceptual, and motor and praxis skills that enhance academic learning and communication and social skills	Following SI intervention, children with decreased cognitive function showed improved spontaneous language, indicating that vestibular activities are effective nonverbal strategies for increasing spontaneous language.	Magrun, Ottenbacher, McCue, & Keefe (1981)
Participation in ADLs and ability to engage in a variety of functional activities	Group who received SI intervention showed reduced self-stimulating behaviors that interfere with participation in functional activities. Study compared an SI approach with tabletop activities in children with pervasive developmental disorder and mental retardation.	Smith, Press, Koenig, & Kinnealey (2005)

(Continued)

Table 3. Occupational Therapy Service Continuum Focus Areas, Projected Outcomes, and Research Support for School-Based Practice Using SI Theory and Methods (cont.)

OT Focus Area	Projected Educational Outcomes	Examples of Resources and Evidence
Sensory-perceptual and fine motor skills affecting penmanship and handwriting	Using sensory strategies via classroom consultation and direct intervention related to sensory processing improve visual-motor skills, which support penmanship and writing skills.	Hall & Case-Smith (2007)
Participation in play and leisure, including curiosity and independent learning	SI approaches improve play and interactions with others and with toys and other objects, as well as tolerance for vestibular and proprioceptive sensations, and lead to greater sensory exploration of the environment. Sensory exploration improves as a key feature of independent learning intervention when OT with a SI approach is used to address symptoms related to learning disorders.	Schaaf, Merrill, & Kinsella (1987)
Reading	Smooth eye pursuits, which are important in developing reading skills, improved in this study, which demonstrated a reduction in the number of saccades for the intervention cohort and reduced time necessary to accomplish smooth pursuits.	Horowitz, Oosterveld, & Adrichem (1993)
Academic skills Motor skills	SI intervention methods prove equally as effective as tutoring in improving academic and motor skills, with maintenance of gains in motor skills development. This randomized clinical trial compared OT using SI with tutoring to improve academic and motor skills. Although the SI group did not make greater gains in the initial study, at follow-up 2 years later, only the SI group maintained their gross motor skills.	Wilson, Kaplan, Fellowes, Gruchy, & Faris (1992)
Emotional regulation skills resulting in positive behavior Health and wellness Quality of life	A decrease in disruptive behaviors is noted with improved speech, play, attention, and social dialogue. This single-case study of 2 children demonstrated improvements in social interaction, approach to novel activities, response to affection, and response to movement.	Linderman & Stewart (1999)
Self-advocacy and parent advocacy Quality of life	Parents report increased ability to advocate for their child on the basis of improved understanding of their child's behavior and validation of their parenting efforts. At the clinic site, waiting room interactions allowed parents time to share experiences and resources with others and expand their understanding of their children.	Cohn (2001) Cohn, Miller, & Tickle-Degnen (2000)
Positive behavior Increased engagement Independent work	SI supports behavior in preschool-aged child, including increased engagement, decreased aggression, less need for intense teacher direction, and decreased mouthing of objects. Using a single-case-study design, researchers found that the child benefited from classic ASI, affecting his preschool performance.	Roberts, King-Thomas, & Boccia (2007)
Participation at school	SI supports occupational performance and behavior in a school-age child, improving participation at school, at home, and in the community. Using a single-case-study design, the researchers found that the child benefited from classic ASI, which affected his occupational performance and behavior.	Schaaf & Nightlinger (2007)

(Continued)

Table 3. Occupational Therapy Service Continuum Focus Areas, Projected Outcomes, and Research Support for School-Based Practice Using SI Theory and Methods (cont.)

OT Focus Area	Projected Educational Outcomes	Examples of Resources and Evidence
Play Learning	Research suggests that learning is enhanced by emotion, spontaneity, and play, which are the essential ingredients in a SI approach used within OT. Physiological data show increased cortical blood volume during performance of novel integration activities in a spontaneous, playful manner.	Peyton, Bass, Burke, & Frank (2005)
Occupational performance in educational settings observed via academic achievement	Measures of SI in elementary students are significantly related to school achievement concurrently and predictively over a 4-year period, even when controlling for intelligence. A particularly strong link between praxis and math achievement is evident.	Parham (1998)

Note. This table provides examples of studies supporting SI theory, methods, and outcomes in school-based practice. It is not an exhaustive list of the available evidence. ADLs = activities of daily living; ASI = Ayres Sensory Integration®; OT = occupational therapy; SI = sensory integration.

Through accurate functional baseline data, measurable student goals, and data collection to monitor a child’s successful participation in the natural environment, occupational therapy practitioners provide accountability for a child’s progress in occupational therapy intervention as it relates to education. Goal attainment scaling is a promising method providing practitioners with the possibility of measuring achievement toward customized, participation-based goals (Mailloux et al., 2007).

Summary

AOTA recognizes SI as one of several theories and methods used by occupational therapists and occupational therapy assistants working with children in public and private schools. Regardless of the theories and methods used, occupational therapy practitioners work within the framework of occupational therapy toward the desired outcome of enhancing a person’s ability to participate in life through engagement in everyday activities (AOTA, 2014b). When children demonstrate sensory, motor, or praxis deficits that interfere with their ability to access the general education curriculum, occupational therapy using an SI approach is appropriate.

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Occupational Therapy's Perspective on the Use of Environments and Contexts to Facilitate Health, Well-Being, and Participation in Occupations

Introduction

Occupational therapy practitioners¹ view human performance as a transactive relationship among the client (people, groups, or populations), the client's occupations (daily life activities), and environments and contexts. *Environments* are the external physical and social aspects that surround clients while they engage in an occupation. *Contexts* are the cultural, personal, temporal, and virtual aspects of this engagement; some contexts are external to the client (e.g., virtual), some are internal to the client (e.g., personal), and some may have both external features and internalized beliefs and values (e.g., cultural; American Occupational Therapy Association [AOTA], 2014b).

Using their expertise in analyzing these complex and reciprocal relationships, occupational therapy practitioners make recommendations to structure, modify, or adapt the environment and context to enhance and support performance. Both environment and context influence clients' success in desired occupations and are therefore critical aspects of any occupational therapy assessment, intervention, and outcome. This assumption is consistent with current education and health care laws and policies, which stipulate that assessment and intervention by providers take place in the natural and least restrictive environments (LREs) that support the client's successful participation. Table 1 reviews key legislation and court cases related to occupational therapy intervention and how they apply to practice.

Purpose

The purpose of this document is to articulate AOTA's position regarding how, across all areas of practice, occupational therapy practitioners select, create, and use environments and contexts to support clients as they achieve health, well-being, and participation in desired occupations.

Occupational Therapy Process

Occupational therapy practitioners collaborate with clients to identify both strengths and barriers to health, well-being, and participation. As part of this process, practitioners consider a variety of environmental and contextual factors to inform the clinical reasoning process that guides client evaluation, intervention, and targeting of outcomes.

Occupational therapy practitioners analyze the environment and context to understand how these elements can best support learning and performance. Solutions are then generated to reduce identified barriers or build on supports through modifications and adaptations.

¹When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006). *Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).

Table 1. Legislation and Court Cases Related to Occupational Therapy Practice

Federal Law, Court Case, or Movement	Key Constructs	Application to Occupational Therapy Practice
Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93–112)	<ul style="list-style-type: none"> • The Rehabilitation Act of 1973 is a civil rights law that states that no person may, on the basis of his or her disability, be “excluded from the participation in, or denied the benefits of . . . any program or activity receiving Federal financial assistance” (29 U.S.C. § 794(a). • In educational settings, this law requires that schools ensure equal educational opportunities for students with a qualifying disability through the provision of special education services, related services, modifications, or accommodations. 	<ul style="list-style-type: none"> • Occupational therapy services can be used in any program funded with federal funds to ensure equal access for people with disabilities. • In educational settings, occupational therapy practitioners can participate in developing a student plan under Section 504, help suggest and implement needed modifications and accommodations, and provide related services.
No Child Left Behind Act of 2001 (NCLB; Pub. L. 107–110)	<ul style="list-style-type: none"> • NCLB is the most recent reauthorization of the Elementary and Secondary Education Act of 1965 (Pub. L. 89–313). • It expands accountability standards for schools receiving federal funding. • It includes children with disabilities in the accountability models developed to gauge student and school success. 	<ul style="list-style-type: none"> • NCLB created increased motivation for schools to use all existing resources to improve the achievement of all students. • It created broader opportunities for occupational therapy to be used by schools to benefit students with and without disabilities.
Individuals With Disabilities Education Improvement Act of 2004 (IDEA; Pub. L. 108–446)	<ul style="list-style-type: none"> • IDEA is the law governing how early intervention services for children ages birth–3 years are provided; it addresses the provision of special education and related services to students ages 3–21. • The purpose of IDEA Part B for students ages 3–21 is “to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living” (34 C.F.R. 300.1[a]). • The purpose of IDEA Part C for children ages birth–3 years and their families is to enhance and expand states’ capacity to provide early intervention services and to help maintain, implement, and coordinate interagency services for early intervention with children ages 0–3 years. • Of note, IDEA requires that “removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes cannot be achieved satisfactorily” (34 C.F.R. 300.114[a][ii]). 	<ul style="list-style-type: none"> • IDEA identified occupational therapy as a related service for eligible children under Part B for school-age children. • It established occupational therapy as a primary service provider for children age birth–3 years under Part C. • Under both programs, occupational therapy practitioners participate in evaluation and implementation, including analyzing and adjusting the context of and environment for learning and participation in school.

(Continued)

Table 1. Legislation and Court Cases Related to Occupational Therapy Practice (cont.)

Federal Law, Court Case, or Movement	Key Constructs	Application to Occupational Therapy Practice
Social Security Amendments of 1965 (Medicare and Medicaid; Pub. L. 89-97)	<ul style="list-style-type: none">• These amendments established a national public health care program, Medicare, to meet the needs of older Americans and people with disabilities (Social Security Disability Insurance) who qualify for services on the basis of disability status and a sufficient work history.• They established an optional state-federal program to provide health and rehabilitation services for low-income people and certain people with disabilities.	<ul style="list-style-type: none">• The amendments created a system of health care financing and insurance for older Americans and for people who would otherwise not have health and other services.• It created a steady funding stream for health care, including occupational therapy.• Social, community, and individual supports can in some circumstances be paid for by Medicare.• Medicaid has many options for coverage of occupational therapy, including programs that provide community and home-based supports for long-term care.
Older Americans Act of 1965 (OAA; Pub. L. 89-73)	<ul style="list-style-type: none">• The OAA created a network of local and state entities, many called Area Agencies on Aging (AAAs), that are funded through OAA resources.• Programs and services are focused on older people to plan and care for their lifelong needs.• The goal of these programs is to keep older adults living independently in their own homes.• A broad range of services are covered, based on local needs, and may address nutrition, caregiver support, community safety, and fall prevention.	<ul style="list-style-type: none">• The OAA provides flexible funding options that support community health and social services programs for older adults, which may include occupational therapy.• It increased focus and emphasis on community-based living resources and the promotion of aging in place.
Omnibus Budget Reconciliation Act of 1987 (Federal Nursing Home Reform Act; Pub. L. 100-203)	<ul style="list-style-type: none">• This act created a set of national minimum standards of care and a bill of rights for people living in certified nursing facilities.• It requires nursing homes to develop individualized care plans for residents that focus on maintaining or improving the ability to walk, bathe, and complete other ADLs to the maximum extent possible.• The act requires nursing homes to develop individualized care plans for residents and training of paraprofessional staff.• It protects residents' right to be free of unnecessary and inappropriate physical and chemical restraints.	<ul style="list-style-type: none">• This act created requirements as well as opportunities for occupational therapy practitioners to facilitate optimum function, attention to mental health, and maximum participation. Occupational therapy practitioners' care plans and interventions in nursing facilities, whether funded through Medicare or Medicaid, should be targeted to these goals.• Occupational therapy practitioners may address environmental modifications and adaptations needed for maximum performance and safety, both in personal environments (e.g., wheelchairs, beds) as well as bedrooms, bathrooms, and common areas.
Americans With Disabilities Act of 1990 (ADA; Pub. L. 101-336)	<ul style="list-style-type: none">• The ADA built on previous civil rights legislation targeted at protecting the rights and enhancing participation of other minorities.• It provides a clear mandate to end discrimination against people with disabilities in all areas of life.• The ADA includes 5 titles that address employment, state and local government services, transportation, public accommodations (i.e., public places and services), and telecommunications.	<ul style="list-style-type: none">• The ADA supports initiatives and interventions, including occupational therapy expertise, that promote function and participation for people with disabilities across the lifespan.• Occupational therapy practitioners can support the end of discrimination through their knowledge of independent living, accessibility, environmental modifications, supported employment, competence-based evaluation for employment, and implementation of reasonable accommodations in all settings.

(Continued)

Table 1. Legislation and Court Cases Related to Occupational Therapy Practice (cont.)

Federal Law, Court Case, or Movement	Key Constructs	Application to Occupational Therapy Practice
Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978 (Pub. L. 95-602)	<ul style="list-style-type: none"> • These amendments provide federal funding in cooperation with states to establish a national network of consumer-run community facilities and services. • Independent living centers now exist across the country. • The amendments advocate for the removal of architectural and transportation barriers that prevent people with disabilities from sharing fully in all aspects of society. 	<ul style="list-style-type: none"> • The amendments support provision of occupational therapy evaluation and intervention in the natural environments in which people live, work, and play to help people adapt to the realities of their physical, social, attitudinal, and political contexts. • Intervention includes consultation, program development, and advocacy with teachers in schools, supervisors in jobs, citizens' organizations, local governments, businesses, local media, and advocacy organizations.
<i>Olmstead v. L.C.</i> (1999)	<ul style="list-style-type: none"> • In a 6-3 ruling by the U.S. Supreme Court against the state of Georgia, this case affirmed the right of people with disabilities whose living situation is supported by state or federal funds to live in their community. • The ruling requires states to place people with mental disabilities in community settings rather than in institutions if at all possible. • It dictates that community placement must be appropriate; that the transfer from institutional care to a less restrictive setting is not opposed by the affected person; and that the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities. 	<ul style="list-style-type: none"> • <i>Olmstead v. L.C.</i> established the precedent for the enforcement of a federal mandate for services to be provided in the LRE and in settings of choice for people with disabilities. • The case created opportunities for occupational therapy practitioners to design accommodations, interventions, and related services to support community living for people with disabilities.

Note. ADLs = activities of daily living; LRE = least restrictive environment.

Practitioners can recommend environmental and contextual modifications and adaptations such as those in the following examples:

- *Physical environment:* Improving accessibility of kitchens (lowering counter height and creating open floor plan) for clients using wheelchairs who want to engage in the occupation of cooking. Adding visual cues in the home environment to structure homemaking tasks to increase safety and organization for people with cognitive limitations.
- *Social environment:* Encouraging a student on the autism spectrum to connect with a peer mentor to attend various activities on campus, including sporting events.
- *Personal context:* Educating older adults on community mobility options.
- *Temporal context:* Consulting with a newly retired business executive about volunteer options involving financial planning and entrepreneurship.
- *Virtual context:* Collaborating with classroom teachers to provide appropriate technology.

Occupational therapy practitioners also recognize that specific interventions may need to begin outside the natural setting in which performance takes place and be completed in a setting in which components of occupations or underlying factors and skills can be targeted. For example, during inpatient rehabilitation, an adult with a spinal cord injury would practice community mobility in a simulated community environment in the rehabilitation facility to enable independent shopping on discharge to home.

Ultimately, interventions occurring in natural or modified environments support clients where they live, work, or play and wherever occupations take place (e.g., homes, classrooms, playgrounds, work, recreation or community centers). Providing appropriate intervention in the most appropriate environment is consistent with the values and purpose of occupational therapy. Practitioners also realize that many additional factors, such as limited financial, organizational, and personnel resources and the complexity of the client's condition, may inform various service delivery options. For example, although the most natural environment in which to address cooking difficulties for a client who is experiencing poststroke weakness in one arm may be the home, the client's medical status may dictate that training occur in a subacute rehabilitation facility.

Providing opportunities for all members of society to engage in health-promoting occupations through flexibility in the analysis of the environment and context in which clients thrive is essential. Table 2 provides additional examples of how occupational therapy practitioners use and modify the context and the environment to support health and participation in occupations.

Table 2. Case Studies

Case Description	Contextual and Environmental Focus of Occupational Therapy Service Delivery	Examples of Occupational Therapy Interventions Addressing Specific Environments and Contexts	Research Evidence and Related Resources Guiding Practice
<p>A 15-month-old boy was born at 29 weeks' gestation. He has had difficulty sitting up, particularly during feeding, and achieving other developmental milestones. He is living at home with his family.</p>	<p>The focus of intervention is to support the entire family in sustaining their family life while addressing the child's developmental needs. Intervention is provided in the home with an emphasis on how to adapt the natural environment to support the child's occupational performance and development.</p>	<ul style="list-style-type: none"> • After discharge from the NICU, provide direct intervention in the child's home to promote safety and establish the child's developmental skills. • Collaborate with the family to structure and modify the physical and social environments in the home to support occupational performance. • Educate the caregiver in developmental principles, positioning, and activities to facilitate feeding and development. • Consult with family and other members of the transdisciplinary team to support family goals. 	<ul style="list-style-type: none"> • Performing everyday activities in the natural setting provides reinforcement and support to achieve and enhance performance and competence (Dunst et al., 2001; Dunst, Trivette, Hamby, & Bruder, 2006). • Helping families accommodate to the demands of daily life with a child with developmental delays helps them develop appropriate and sustainable routines congruent with the family's values and the child's developmental needs (Keogh, Bernheimer, Gallimore, & Weisner, 1998).
<p>A 3-year-old girl with social and emotional regulation challenges attends a center-based preschool program.</p>	<p>The focus of intervention is to provide early childhood services in an inclusive classroom to enhance the child's opportunities for play with peers in naturally occurring situations that arise in the classroom. Occupational therapy intervention is integrated into the classroom activities.</p>	<ul style="list-style-type: none"> • Structure play groups to promote peer social interaction skills. • Direct intervention with the child and parents to promote self-regulation and establish routines to facilitate the child's transitions throughout the day. • Consult with the early childhood team to analyze the demands of the preschool class and make recommendations for adaptations to support performance. 	<p><i>Additional Resources</i> Frolek Clark & Kingsley (2013) Kingsley & Mailloux (2013)</p> <ul style="list-style-type: none"> • Center-based early intervention services have a positive effect on children's social functioning (Blok, Fukkink, Gebhardt, & Leseman, 2005). • Preschoolers with disabilities perform as well, if not better, when placed in quality inclusive classroom settings and play groups (Bailey, Aytch, Odom, Symons, & Wolery, 1999; Odom, 2000). • Parents of children with disabilities commonly report that they perceive inclusive classroom practices as contributing to their child's

(Continued)

Table 2. Case Studies (cont.)

Case Description	Contextual and Environmental Focus of Occupational Therapy Service Delivery	Examples of Occupational Therapy Interventions Addressing Specific Environments and Contexts	Research Evidence and Related Resources Guiding Practice
<p>A 7-year-old student with cognitive, motor, and speech delays participates in a special day class in a public school. He has difficulty processing sensory information, interacting with peers, focusing on academic tasks, using his hands for tasks, and maneuvering on equipment on the playground.</p>	<p>Guided by the child's needs, the IEP team, which includes the occupational therapist and the parents, determines that the child is having difficulty participating with typically developing peers and would benefit from a special day class for students with behavioral challenges. Although such placements are viewed as more restrictive, the regular classroom environment is currently overwhelming for the child.</p> <p>The goal of the tailored environment is to provide the structure necessary for the child to learn specific skills for participation in a less restrictive environment in the future.</p>	<ul style="list-style-type: none"> • Educate the IEP team about the effect of the environment on sensory processing and the relationship to behavior in a school setting. • Consult with the IEP team and teachers to structure, adapt, and modify the classroom and playground environments so that the child has opportunities to meet sensory needs by participating in vestibular, tactile, and proprioceptive activities throughout the school day. • Collaborate with the student to help him establish strategies and routines for sensory regulation, emotional and behavioral deescalation, and appropriate coping skills. • Develop a peer buddy system to promote appropriate social interactions with modeling and role-play during social group. • Provide direct intervention to facilitate integration of sensory systems in an environment rich in sensory experiences and equipment. 	<p>self-esteem, confidence, and happiness as well as reshaping their own expectations of their child's ability to develop and learn with others (Buysse, Skinner, & Grant, 2001).</p> <p><i>Additional Resources</i> Case-Smith (2013) Frolek Clark & Kingsley (2013) Kingsley & Mailloux (2013)</p> <ul style="list-style-type: none"> • The student may attend to classroom instruction for longer periods of time when sensory needs are addressed (Schilling, Washington, Billingsley, & Deitz, 2003). • Teaching children self-regulation strategies (a cognitive approach to manage sensory needs) helps them manage their behavior (Barnes, Vogel, Beck, Schoenfeld, & Owen, 2008; Vaughn et al., 2003). • Supporting a school-age child's occupational performance and behavior improves participation in school (Schaaf & Nightlinger, 2007). • Suspended equipment and opportunities to carefully monitor various and safe sensory experiences is a hallmark of sensory integration intervention. These opportunities may only be available in a carefully designed environment (Parham et al., 2007). <p><i>Additional Resource</i> Watling, Koenig, Davies, & Schaaf (2011)</p>
<p>A 28-year-old man with schizoaffective disorder lives alone. He has difficulty organizing his daily routines to manage his medications. He was recently admitted to the hospital because of an acute exacerbation of his illness. He wants to be discharged home.</p>	<p>The intervention focuses on developing medication routines to help the client return to his apartment. If he is unable to manage his medications, he might need to move to a group home with more structured supervision.</p> <p>By analyzing the social and physical environment in the client's home and community, the occupational therapy practitioner can identify external cues and resources to optimize the client's occupational performance.</p>	<ul style="list-style-type: none"> • Educate the medical team and case manager about performance deficits that affect medication routines. • Request that a pharmacist or nurse teach the client how to read labels and practice filling his medication box correctly. • Advocate for reminder calls for refills from the pharmacy or another entity. • Teach the client skills to establish habits and routines that support medication management, such as regular 	<p>Environmental supports are more likely to improve functional behavior for people with schizoaffective disorder when the supports are customized for the person and situated in the person's home (Velligan et al., 2000, 2006).</p> <p><i>Additional Resources</i> Arbesman & Logsdon (2011) Brown (2012) Siebert, Smallfield, & Stark (2014)</p>

(Continued)

Table 2. Case Studies (cont.)

Case Description	Contextual and Environmental Focus of Occupational Therapy Service Delivery	Examples of Occupational Therapy Interventions Addressing Specific Environments and Contexts	Research Evidence and Related Resources Guiding Practice
<p>Clients living in a shelter for homeless people want to meet basic needs, remain safe, and reduce the potential for harm.</p>	<p>Using a consultative model, the intervention focuses on modifying the physical and social environments to promote safety and meet the clients' basic needs.</p>	<p>sleep-wake times, use of an alarm clock and calendar to track when to take and refill medication, and storage of medication in a consistent location (e.g., on a nightstand).</p> <ul style="list-style-type: none"> • Provide visual cues such as a list of medications with pictures and their purpose or reminder signs. • Establish a connection with mental health support groups. 	<p>Life skills interventions have the potential to support the complex needs of people situated in the homeless context (Helfrich, Aviles, Badiani, Walens, & Sabol, 2006).</p>
<p>A 52-year-old successful businessman had a right middle cerebral artery stroke 1 year ago, resulting in left-sided weakness and decreased balance. He lives at home and has tried to return to his job as a financial consultant but has struggled to maintain his productivity at work.</p>	<p>Because this client may not regain all performance skills, intervention focuses on designing environmental modifications in the home, work, and community settings that will support his health and participation in occupations.</p>	<ul style="list-style-type: none"> • Adapt activity demands for participation in necessary and desired occupations. • Modify the home environment to optimize safety and reduce the impact of weakness and fatigue (Fänge & Iwarsson, 2005; Stark, 2004; Stearns et al., 2000). • Consult with the employer to modify the work environment by using assistive technology to change the task demands. • Set up an ergonomically advantageous setting by adjusting work routines and schedule to support work performance (Whiteneck, Gerhardt, & Cusick, 2004). • Consult with community agencies regarding access (e.g., transportation, public bathrooms, timing of cross-walk lights, safe railings). 	<ul style="list-style-type: none"> • Specific strategies are effective in improving performance skills and participation in roles and routines after stroke (Ma & Trombly, 2002; Trombly & Ma, 2002). • Occupational therapists evaluate contextual factors of the work environment (e.g., work tasks, routines, tools, equipment) and use this information to plan interventions that facilitate work performance (AOTA, 2011). • Occupational therapy practitioners consult with community agencies, business owners, and building contractors, among others, to create environments that promote occupational performance for all (AOTA, 2000).

Additional Resources
 Wolf, Chuh, Floyd, McInnes, & Williams (2015)
 Wolf, Chuh, McInnes, & Williams (2013)

(Continued)

Table 2. Case Studies (cont.)

Case Description	Contextual and Environmental Focus of Occupational Therapy Service Delivery	Examples of Occupational Therapy Interventions Addressing Specific Environments and Contexts	Research Evidence and Related Resources Guiding Practice
<p>Older adults residing in an assisted-living facility are at high risk for loss of balance and falls.</p>	<p>The focus of intervention is to maintain the clients' occupational engagement through a multifactorial approach that includes elements such as strength and balance training; education; modifying activity demands; and creating a safe and supportive environment, including falls prevention.</p>	<ul style="list-style-type: none"> • Consult with facility administrators, architects, and facility staff to design an environment that <ul style="list-style-type: none"> ○ Reflects a noninstitutional character, ○ Eliminates barriers to physical mobility, ○ Provides lighting without glare, and ○ Clusters small activity areas together. 	<ul style="list-style-type: none"> • The design of the social and physical environment influences the function and well-being of older adults (Day, Carreon, & Stump, 2000). • Occupational therapy practitioners advocate for and contribute to the creation of an environment in which the demands do not exceed the client's capabilities (Cooper & Day, 2003). • Occupational therapy practitioners identify and modify environmental barriers (Davison, Bond, Dawson, Steen, & Kenny, 2005).
<p><i>Additional Resource</i> Siebert et al. (2014)</p>			
<p>A 74-year-old woman with Alzheimer's disease lives in an apartment in the inner city with her husband of 45 years. She has become lethargic and no longer initiates activities. Her husband now does all the shopping, cooking, and cleaning. He is overwhelmed with the demands of caregiving.</p>	<p>The Intervention focuses on supporting the caregiver's and the care recipient's health and participation in desired occupations and activities and enabling them to remain in their home as they age.</p>	<ul style="list-style-type: none"> • Educate the caregiver about the disease process and the impact of the environment on the care recipient's occupational performance. • Recommend modifications to the home environment to manage daily care activities. • Provide emotional support and information on coping strategies and stress management to caregivers. • Facilitate use of community and family support. • Provide support and education on the uses of adaptive equipment in the home. 	<ul style="list-style-type: none"> • People with dementia or Alzheimer's disease can live at home, remaining in their roles and contexts for a longer period of time, if given enough support from caregivers (Haley & Bailey, 1999). • An in-home skills training and environmental adaptation program (Gitlin et al., 2003) improves the quality of life for both the caregiver and the care recipient with fewer declines in the care recipient's occupational performance and less need for caregiving (Gitlin, Hauck, Dennis, & Winter, 2005). • Home-based occupational therapy is effective and cost-efficient for community-dwelling older adults and their caregivers (Graff et al., 2008). • People with Alzheimer's disease perform better at home than in unfamiliar environments; it is harder for them to adapt to new environments (Hoppes, Davis, & Thompson, 2003).
<p><i>Additional Resources</i> Padilla (2011) Schaber (2010)</p>			

Note. ADLs = activities of daily living; AOTA = American Occupational Therapy Association; IEP = individualized education program; NICU = neonatal intensive care unit.

Summary

Occupational therapy practitioners work with a wide variety of clients across the lifespan. The goal of occupational therapy is to facilitate achievement of health, well-being, and participation in life through engagement in occupation (AOTA, 2014b). Practitioners consider current educational and health care laws and policies as they make recommendations to modify, adapt, or change environments and contexts to support or improve occupational performance. On the basis of theory, evidence, knowledge, client preferences and values, and occupational performance, they assess the intervention settings and the environmental and contextual factors influencing clients' occupational performance. In their interventions and recommendations, practitioners focus on selecting and using environments and contexts that are congruent with clients' needs and maximize participation in daily life occupations. Practitioners' expertise is essential to support clients' health and participation in meaningful occupations.

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Philosophy of Occupational Therapy Education

Preamble

Occupational therapy education prepares occupational therapy practitioners to address the occupational needs of individuals, groups, communities, and populations. The education process includes academic and fieldwork components. The philosophy of occupational therapy education parallels the philosophy of occupational therapy yet remains distinctly concerned with beliefs about knowledge, learning, and teaching.

What are the fundamental beliefs of occupational therapy education?

Students are viewed as occupational beings who are in dynamic transaction with the learning context and the teaching–learning process. The learning context includes the curriculum and pedagogy and conveys a perspective and belief system that includes a view of humans as occupational beings, occupation as a health determinant, and participation as a fundamental right. Education promotes clinical reasoning and the integration of professional values, theories, evidence, ethics, and skills. This approach will prepare practitioners to collaborate with clients to achieve health, well-being, and participation in life through engagement in occupation (American Occupational Therapy Association, 2014). Occupational therapy education is the process by which practitioners acquire their professional identity.

What are the values within occupational therapy education?

Enacting the above beliefs to facilitate the development of a sound reasoning process that is client centered, occupation based, and theory driven while encouraging the use of best evidence and outcomes data to inform the teaching learning experience may include supporting

- Active and diverse learning within and beyond the classroom environment;
- A collaborative process that builds on prior knowledge and experience;
- Continuous professional judgment, evaluation, and self-reflection; and
- Lifelong learning.

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Scope of Occupational Therapy Services for Individuals With Autism Spectrum Disorder Across the Life Course

The primary purpose of this paper is to define the role of occupational therapy and the scope of occupational therapy services available for individuals with autism spectrum disorder (ASD) to persons outside of the occupational therapy profession. In addition, this document is intended to clarify the role of occupational therapy with this population for occupational therapists and occupational therapy assistants.

Background

The American Occupational Therapy Association (AOTA; 2014c) strongly supports the right of all individuals to “have the same opportunities to participate in the naturally occurring activities of society” (p. S23). Occupational therapy practitioners¹ work collaboratively with individuals on the autism spectrum, their families, other professionals, organizations, and community members in multiple contexts to advocate for and provide a range of needed resources and services that support the individuals’ ability to participate fully in life (Case-Smith & Arbesman, 2008; Kuhaneck, Madonna, Novak, & Pearson, 2015; Tanner, Hand, O’Toole, & Lane, 2015; Watling & Hauer, 2015a; Weaver, 2015). According to a study conducted by the Interactive Autism Network (2011), occupational therapy ranks second to speech–language pathology as the most frequently provided services for individuals with autism throughout the United States.

Prevalence data suggest that ASD currently affects approximately 1 in 68 children (Centers for Disease Control and Prevention, 2014), and the World Health Organization (WHO; 2013) estimates the prevalence of ASD to be 1 in 160 individuals worldwide. Other estimates of ASD diagnoses in the United States have suggested that these rates might be higher, with as many as 2% of children ages 6–17 years having a parent-reported diagnosis (Blumberg et al., 2013). These figures reflect a dramatic increase in the number of individuals living with ASD in the United States over the past 20 years.

ASD is the diagnosis used in the *Diagnostic and Statistical Manual of Mental Disorders (DSM; 5th ed., American Psychiatric Association [APA], 2013)* to describe a cluster of symptoms that range in type and severity and include (1) “persistent deficits in social communication and social interaction” and (2) “restricted, repetitive patterns of behavior, interests or activities” (p. 31). This diagnostic category combines a range of disorders, including autistic disorder, Asperger disorder, and pervasive developmental disorder—not otherwise specified, which were identified as separate diagnoses in the previous edition of the *DSM (4th ed., text rev., APA, 2000)*.

Rather than using the term *autism spectrum disorder*, the Individuals With Disabilities Education Improvement Act of 2004 (IDEA; Pub. L. 108–446) uses the term *autism* as a disability category under which children might be eligible for special education and related services. IDEA regulations define *autism* as “a developmental disability significantly affecting verbal and nonverbal communication and social interaction generally evident before age 3 that adversely affects a child’s educational performance.” Other charac-

¹The term *occupational therapy practitioner* refers to both occupational therapists and occupational therapy assistants (AOTA, 2013a). *Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).

teristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences (§300.8[c][1][i]).

Under Part B of IDEA, occupational therapy is a related service; under Part C, occupational therapy is a primary service. Thus, occupational therapy must be provided to children with autism if those services will help the child benefit from special education (§602[26][A]). Because educational classification and identification criteria vary considerably from state to state, readers are referred to specific state policies and requirements.

Occupational Therapy Domain and Process

Occupations are daily life activities that are “central to a client’s . . . identity and sense of competence and have a particular meaning and value to that client” (AOTA, 2014b, p. S5). Occupational therapy services focus on “achieving health, well-being, and participation in life through engagement in occupation” (AOTA, 2014b, p. S4). Occupations are categorized into activities of daily living, instrumental activities of daily living (IADLs), rest and sleep, education, work, play, leisure, and social participation within their natural and daily contexts. Consistent with all occupational therapy intervention, the focus of services for individuals with ASD is determined by the client’s specific goals and priorities for participation. Given that individuals with ASD may experience complex challenges, including social–communication difficulties, collaboration with key individuals such as family members, caregivers, and educators is important for determining goals and priorities. Some examples of occupations (daily life activities) that may be challenging for individuals with ASD and that can be addressed by occupational therapy practitioners are included in Table 1.

The process of client-centered occupational therapy service delivery includes evaluation and intervention to achieve targeted outcomes using occupations to promote health, well-being, and participation in life (AOTA, 2014b). Services can be provided to the client at the person, group, and population levels and may include direct service, consultation, education, and advocacy to support the person, family members, health professionals, educational staff, and community agencies.

At the person and group levels, collaboration with family, caregivers, educators, and other team members is essential for understanding the daily life experiences of individuals with ASD and those with whom they interact. At the systems level, services may focus on educating staff and designing programs and environments for individuals or groups that are served by an organization to be more socially inclusive for persons on the autism spectrum. At the population level, occupational therapy practitioners may engage in education, consultation, and advocacy initiatives with communities or ASD consumer groups.

Evaluation

The evaluation process is designed to provide an understanding of the client’s occupational profile and performance. This process includes an analysis of the client’s strengths and challenges related to occupations, performance skills, performance patterns, body functions and body structures, and activity demands. Evaluation is comprehensive and tailored to the concerns of the specific client, organization, or population. Information collected through interviews, structured observations, and standardized assessments guides occupational therapy services.

Because the literature shows that individuals with ASD may have difficulties in areas of occupation such as self-care; IADLs; sleep; functional and pretend play; leisure pursuits; social participation; education and work performance; and performance skills, performance patterns, and client factors such as sensory integration and modulation, self-regulation, praxis, and motor imitation, occupational therapy evaluations conducted at the individual level should assess these areas (Baranek, 2002; Case-Smith & Bryan, 1999;

Foster & Cox, 2013; Johnson & Myers, 2007; Kientz & Dunn, 1997; Libby, Powell, Messer, & Jordan, 1998; Rutherford & Rogers, 2003; Shattuck et al., 2007; Tomchek & Case-Smith, 2009; Watson, Baranek, & DiLavore, 2003; Zaks, 2006). At the group level, the evaluation process may focus on analyzing the program structure, resources, and services that support individuals on the autism spectrum to engage in desired occupations. At the population level, the evaluation process may focus on collaborating with ASD consumer groups to identify their capacities and needs to support societal participation. Recent book chapters and practice guidelines have been developed to inform the practice of occupational therapy related to ASD and include comprehensive chapters on the evaluation process (Boyt Schell, Gillen, & Scaffa, 2014; Case-Smith & O'Brien 2015; Foster & Cox, 2013; Tomchek & Case-Smith, 2009; Watling, 2010).

Intervention

Occupational therapy intervention is based on the results of the evaluation and is implemented to foster occupational engagement and social participation by attending to the transactions among the client, the activity, and the environment. The goal of intervention is to promote engagement in and performance of daily activities, personal satisfaction, adaptation, health and wellness, role competence, quality of life, and occupational justice for individuals with ASD within the contexts of their families and communities.

At the individual level, the intervention may emphasize social engagement and participation, include strategies to improve adaptive behaviors and occupational performance, and support family priorities. Some research has demonstrated the effectiveness of occupational therapy interventions for children and adolescents with ASD that lead to improvement in self-care and play (Tanner et al., 2015; Weaver, 2015). These interventions include the use of activities that promote social interaction, problem solving, and pivotal behaviors (e.g., joint attention, initiative, persistence, executive functioning, cooperation) and address specific skill acquisition (Tanner et al., 2015). Effective interventions also address contextual factors such as structure, consistency of routine, sensory environments that optimize attention and arousal, and caregiver skills that contribute to occupational performance.

Research indicates that the occupational therapy intervention process should be individualized, intensive, and comprehensive; include the family; and facilitate active engagement of the individual (see Tomchek & Case-Smith, 2009). The literature provides additional support for the use of developmental and behavioral approaches to intervention, particularly for young children (Callahan, Henson, & Cowan, 2008; Dawson et al., 2010; National Autism Center [NAC], 2015; Rogers & Vismara, 2008). Environmental modification to address problem behaviors also has been shown to be effective (Horner, Carr, Strain, Todd, & Reed, 2002), and emerging evidence shows that families of children with ASD can be supported through telehealth and other online communication technologies (AOTA, 2013b; Gibbs & Toth-Cohen, 2011; Vismara, McCormick, Young, Nadhan, & Monlux, 2013).

At the systems level, interventions could include recommendations for educational and policy initiatives, participation on a transition team, provision of staff education, and development of new programs. At the population level, emphasis may be on inclusion and advocacy initiatives.

Outcomes

Targeting outcomes of service is an integral part of the occupational therapy process. Outcomes describe what clients can achieve through occupational therapy intervention and are important for determining future actions. Targeting outcomes involves monitoring the client's responses to intervention, reevaluating and modifying the intervention plan, and measuring intervention success through outcomes that are important to the client within the dynamic physical and social environments and cultural contexts where functioning occurs. Progress is noted through improvement in the client's occupational performance, adaptation, participation in desired activities, satisfaction, role competence, health and wellness, and quality of life and through prevention of further difficulties and facilitation of effective transitions.

Occupational therapy practice for individuals with ASD is consistent with the WHO's (2013) action agenda for ASD and the National Research Council's (2001) recommended practices for educating individuals with ASD. Occupational therapy practitioners also use established interventions as identified by the NAC (2015). Table 2 provides case examples that reflect a range of occupational therapy evaluation and intervention services for individuals with ASD at the individual, group, and population levels across the lifespan.

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Table 1. Examples of Potentially Challenging Areas of Occupation for Individuals With ASD

Occupation	Example
ADLs	Participating in daily self-care routines such as showering, toileting, and dressing; accepting a healthy variety of foods during mealtime; tolerating the sensory aspects of grooming activities
IADLs	Accessing the community by driving or using public transportation; managing finances; running a household; planning and preparing healthful, balanced meals
Rest and sleep	Achieving a calm state to rest, preparing for sleep, developing routines and rituals that support sleep, participating in and achieving restful sleep
Education	Engaging in formal education activities such as reading, writing, and math; accessing academic curricula; organizing and using school tools and materials; participating in various school environments and activities such as cafeteria, playground, and gym; identifying and pursuing informal educational interests and needs
Work	Identifying and pursuing employment options, seeking and acquiring employment, sequencing job tasks, developing effective job performance and interaction skills, exploring and participating in volunteer work
Play	Identifying a range of play interests, exploring and participating in a variety of play activities, developing interactive play skills
Leisure	Exploring and participating in community recreational leisure activities, developing leisure skills and interests
Social participation	Developing peer friendships, interacting appropriately with others, engaging in community-based social activities and outings, understanding social nuances and maintaining appropriate behavior, participating in family gatherings and rituals

Note. ADLs = activities of daily living; ASD = autism spectrum disorder; IADLs = instrumental activities of daily living.

Table 2. Case Examples of Occupational Therapy Evaluation and Intervention Services for Individuals With ASD

Client Description	Evaluation	Intervention
<p>Kamau, age 2 1/2 years, has autism. His language consists of single-word utterances. He has an intense interest in a few objects such as wheels and mobiles.</p> <p>His mother's primary concerns are his limited social interaction, delayed pretend play, hyperactive behaviors, and picky eating.</p> <p>Kamau also is receiving speech therapy services and an applied behavioral analysis program at home through the state early intervention program.</p>	<p>Develop occupational profile of play behaviors, family interactions, and food preferences through parent interview.</p> <p>Gather clinical observations of behavior, self-regulation, and parent-child interaction during free play and interactive parent-child play.</p> <p>Conduct structured observation of parent-child interaction during play and while Kamau is eating.</p> <p>Administer Toddler Sensory Profile-2 (Dunn, 2014); Bayley Scales of Infant and Toddler Development (Bayley, 2006); and Pediatric Evaluation of Disability Inventory, Self-Care Scale (Haley, Coster, Ludlow, Haltiwanger, & Andrellos, 1992).</p>	<p>Provide weekly occupational therapy in the home setting with mother present to help Kamau establish self-regulation, social engagement, and pretend play skills (Greenspan & Wieder, 1997; Kasari, Freeman, & Paparella, 2006; Mahoney & Perales, 2005; Salt et al., 2001).</p> <p>Use sensory integration methods (Watling & Hauer, 2015c); behavioral strategies, including positive reinforcement; and reciprocal play to improve social interaction.</p> <p>Collaborate with the SLP regarding Kamau's intervention program, and arrange cotreatment sessions to promote social interaction.</p> <p>Collaborate with the behavioral therapist (Cohen, Amerine-Dickens, & Smith, 2006; Smith, Groen, & Wynn, 2000) to integrate sensory and behavioral strategies helpful in modulating Kamau's behavior.</p> <p>Provide parent training related to sensory processing and behavior management strategies and social participation (NAC, 2015).</p> <p>Provide parent consultation to improve the family's mealtime routine and the variety of foods Kamau eats (Horner et al., 2002; Ledford & Gast, 2006).</p>

(Continued)

Table 2. Case Examples of Occupational Therapy Evaluation and Intervention Services for Individuals With ASD (cont.)

Client Description	Evaluation	Intervention
<p>Heang, age 4 years, has autism and attends an inclusive preschool through her school district.</p> <p>Her parents have sought individualized occupational therapy services from an outpatient clinic.</p> <p>Heang uses only a few basic gestures to communicate.</p> <p>She primarily engages in solitary sensory-motor exploration of her environment and does not yet spontaneously play beside other children or with toys.</p> <p>She has frequent tantrums and screams particularly when there are changes in the environment or when she is being directed toward a specific task.</p>	<p>Develop an occupational profile of behavior and self-regulation in play through parent and teacher interview.</p> <p>Conduct clinical observations of behavior, self-regulation, parent-child and teacher-child interaction, and play skills.</p> <p>Administer the Sensory Profile-2 (Dunn, 2014) and the Miller Function and Participation Scales (Miller, 2006).</p>	<p>Provide weekly occupational therapy in a clinical setting with the parent present.</p> <p>Consult with preschool team, including teacher and SLP.</p> <p>Provide interventions to improve self-regulation to allow for socially appropriate behavior (Greenspan & Wieder, 1997; Kasari et al., 2006; Mahoney & Perales, 2005; NAC, 2015; Salt et al., 2001, 2002).</p> <p>Incorporate sensory integration techniques (Baranek, 2002; Watling & Hauer, 2015a, 2015b, 2015c); visual supports for structure (NAC, 2015; Ozonoff & Cathcart, 1998) and communication; and behavioral strategies, including positive reinforcement, redirection, elimination of antecedents to her tantrums, and reinforcement of her positive behaviors (Horner et al., 2002; NAC, 2015; Rogers & Vismara, 2008).</p> <p>Educate parents on how to recognize when Heang is becoming overaroused, and implement both positive behavior (Horner et al., 2002) and sensory-based strategies to help her modulate her arousal (Baranek, 2002; Watling & Hauer, 2015a).</p>
<p>Jorge, age 6 years, is a kindergartener with a diagnosis of PDD-NOS.</p> <p>He demonstrates minimal social initiation with peers, although he interacts better with adults.</p> <p>When peers initiate interaction, Jorge withdraws or responds aggressively.</p> <p>He needs direct adult supervision to manage his school materials and complete school tasks.</p>	<p>Develop an occupational profile of play, work-reward routine, and behavior regulation through parent and teacher interview.</p> <p>Conduct structured clinical observations of classroom behavior, social-communication skills, parent-child interaction, and play skills.</p> <p>Administer Sensory Profile-2 (Dunn, 2014) and School Function Assessment (Cognitive/Behavior Scales; Coster, Deeney, Haltiwanger, & Haley, 1998).</p> <p>Conduct formal functional behavior analysis of aggressive behaviors.</p>	<p>Provide occupational therapy services within the school setting (Case-Smith & Weaver, 2015a; Weaver, 2015).</p> <p>Collaborate with teacher to implement structured teaching methods based on TEACCH (Ozonoff & Cathcart, 1998; Paneral, Ferrante, & Zingale, 2002) and a visual schedule in the classroom (Ganz, 2007).</p> <p>Implement positive behavior supports (Horner et al., 2002; NAC, 2015) and a sensory diet, including strategies for self-regulation based on the functional analysis of aggressive behaviors (Borrero & Borrero, 2008).</p> <p>Develop and implement Social Stories (NAC, 2015; Reynhout & Carter, 2006) before challenging school situations (e.g., standing in line, assemblies, fire drills) to encourage appropriate behavior.</p> <p>Develop peer buddies and modeling program to build social-communication skills during naturally occurring play activities (Harper, Symon, & Frea, 2008; NAC, 2015).</p> <p>Consult with the classroom teacher and family to promote generalization of strategies across home and school settings.</p>
<p>The local museum of science is interested in making the museum more accessible to individuals with ASD.</p> <p>The museum hosts school classes daily and specialized weekend learning programs.</p>	<p>Develop an occupational profile of supports and inhibitors to engagement in museum activities through observation of museum patrons of various ages interacting with museum exhibits.</p> <p>Complete structured observation of behavioral, sensory, and social demands of the museum, including structure, timing, and transitions of docent-led groups; signage; "way-finding" materials; and universal design features of physical space.</p>	<p>Provide an educational presentation to museum education staff about the characteristics associated with ASD and strategies for supporting informal learning.</p> <p>Consult with museum staff to develop a Social Story (Gray, 2010) to be placed on the museum website for families to use before visiting the museum.</p> <p>Consult with museum staff to develop an after-school program for adolescents with ASD.</p>

(Continued)

Table 2. Case Examples of Occupational Therapy Evaluation and Intervention Services for Individuals With ASD (cont.)

Client Description	Evaluation	Intervention
	Conduct focus groups at the museum with parents who have children with ASD to elicit their recommendations for improving accessibility.	
<p>T. J., age 21 years, is a young man with high-functioning autism.</p> <p>T. J. currently is enrolled in a junior college and is having difficulty finding a needed part-time job. He lives independently in an apartment.</p> <p>T. J. presents with poor grooming and hygiene skills and pragmatic language deficits. He has several interests but spends most of his free time reading about antique cars. His interest in cars has led to distractibility during driving and resulted in a minor auto accident and a traffic citation for failing to stop at a stop sign.</p>	<p>Develop an occupational profile of ADL and IADL performance, leisure activities, and driving behaviors through personal interview about his concerns and his interests.</p> <p>Conduct structured observation of role playing a job interview.</p> <p>Administer the Scales of Independent Behavior-Revised (Bruininks, Woodcock, Weatherman, & Hill, 1997) and Occupational Self Assessment (Baron, Kielhofner, Iyenger, Goldhammer, & Wolenski, 2006).</p> <p>Develop an occupational profile for behavior regulation and interpersonal relatedness through interview.</p>	<p>Initially provide occupational therapy weekly in the clinic, then in the community (Case-Smith & Weaver, 2015a; Weaver, 2015).</p> <p>Provide direct intervention to address grooming and hygiene needs through the use of a step-by-step self-monitoring system.</p> <p>Consult with the Division of Vocational Rehabilitation to assist in the employment search.</p> <p>Use role playing, video self-modeling, and collaborative problem solving to address social communication and pragmatic language needs related to the interview process and interaction with coworkers (Case-Smith & Weaver, 2015b; Weaver, 2015).</p> <p>Initiate job coaching to allow T. J. to learn and master job functions and to problem solve when needed.</p> <p>Refer to an occupational therapy DRS to assess driving safety and provide interventions to improve executive functioning and focused attention during driving (Clas-sen, Monahan, & Wang, 2013).</p> <p>Facilitate T. J.'s enrollment in an existing on-campus support group of other college students with Asperger disorder.</p>
<p>Sanjaya, age 34 years, has Asperger disorder.</p> <p>He lives in an apartment with his wife and contributes to the family income through an online business.</p> <p>Sanjaya has challenges with arousal regulation and coping skills, difficulty with body space awareness, and difficulty reading and sending body language signals that affect his social participation.</p> <p>Sanjaya has tactile defensiveness, which leads to difficulties with intimacy.</p>	<p>Administer the Adolescent/Adult Sensory Profile (Brown & Dunn, 2002) and the COPM (Law et al., 2014).</p>	<p>Initially provide occupational therapy services in the OT's office to address Sanjaya's poor processing of tactile, vestibular, and proprioceptive input.</p> <p>Develop a sensory diet for Sanjaya to implement daily in his natural environment (Dunn, Cox, Foster, Mische-Lawson, & Tanquary, 2012; Watling & Hauer, 2015a).</p> <p>Consult with and train Sanjaya and his wife in the Alert Program (Williams & Shellenberger, 1996) to recognize when his arousal level is high and to provide a language to aid in their communication.</p> <p>Perform video analysis (Bellini & Akullian, 2007) and role playing to help develop an awareness of nonverbal communication through facial expression and body language and to practice pragmatic skills.</p> <p>Train Sanjaya and his wife in the use of massage to provide deep tactile pressure and proprioceptive input to diminish tactile defensiveness.</p>

(Continued)

Table 2. Case Examples of Occupational Therapy Evaluation and Intervention Services for Individuals With ASD (cont.)

Client Description	Evaluation	Intervention
<p>Martina, age 47 years, has autism and has recently transitioned from her parent's home to a group home with 24-hour supervision due to her parents' declining ability to care for her.</p> <p>Martina works at a local library where she sorts and reshelves books.</p> <p>She has funding for services through the Department of Developmental Disabilities and a small amount of private resources.</p> <p>Martina becomes anxious when her routine is disturbed, demands are placed on her, or her desires are not granted. She enjoys leisure activities with her parents, but her parents are worried about her making friends and joining activities with peers at the group home.</p> <p>Her parents have arranged for contract occupational therapy services to facilitate her transition to the group home, with a focus on establishing routines for self-care and household chores, understanding and using transportation services to and from work, and participation in leisure activities with peers at the group home.</p>	<p>Develop an occupational profile through observation of and interview with Martina and her parents.</p> <p>Administer the COPM (Law et al., 2014), Adolescent/Adult Sensory Profile (Brown & Dunn, 2002), and Test of Grocery Shopping Skills (Brown, Rempfer, & Hamera, 2009).</p> <p>Conduct clinical observations of behavior during leisure, self-care, cooking, laundry, and cleaning tasks and of path finding and skills for using public transportation.</p>	<p>Provide occupational therapy services in the group home to help Martina organize her belongings; establish a routine for daily self-care and weekly household tasks; and ensure her success in using the available microwave oven, washer, dryer, and vacuum (Weaver, 2015).</p> <p>Work with Martina in using public transportation to get to and from work each day. Coach Martina in how to follow a picture sequence on her smart phone to help her follow her walking route, identify where to get off the bus, and know what to do if the bus is late.</p> <p>Teach residential program staff to implement educational strategies, such as forward and backward chaining, visual supports, and environmental structure to support success during intervention (Horner et al., 2002; Hwang & Hughes, 2000; NAC, 2015) and during everyday activities.</p> <p>Conduct staff training regarding environmental accommodations and environmental supports.</p> <p>Collaborate with group home staff to identify leisure activity choices that match the interests Martina and her parents identified during the occupational profile. Coach Martina in how to engage with peers during leisure activities and provide Social Stories, scripts, and role-playing opportunities to help her learn new routines and what to do and say (Tanner et al., 2015).</p>

Note. ADL = activity of daily living; ASD = autism spectrum disorder; COPM = Canadian Occupational Performance Measure; DRS = driving rehabilitation specialist; IADL = instrumental activity of daily living; NAC = National Autism Center; OT = occupational therapist; PDD-NOS = pervasive developmental disorder, not otherwise specified; SLP = speech-language pathologist; TEACCH = Treatment and Education of Autistic and Related Communication Handicapped Children.

Standards for Continuing Competence

Continuing competence is a process involving the examination of current competence and the development of capacity for the future. It is a component of ongoing professional development and lifelong learning. Continuing competence is a dynamic and multidimensional process in which the occupational therapist and occupational therapy assistant develop and maintain the knowledge, performance skills, interpersonal abilities, critical reasoning, and ethical reasoning skills necessary to perform current and future roles and responsibilities within the profession. The pursuit of continuing competence advances the occupational therapy practitioner and the profession. Continuing competence is maintained through self-assessment of the practitioner's capacities in the core of occupational therapy, which reflects knowledge of the domain of the profession and the process used in service delivery.

Occupational therapists and occupational therapy assistants use the following standards to assess, maintain, and document continuing competence. Basic to these standards is the belief that all occupational therapists and occupational therapy assistants share core values and knowledge, guiding actions within their roles and responsibilities. The core of occupational therapy involves "the therapeutic use of everyday activities (occupations) with individuals or groups for the purpose of enhancing or enabling participation in roles, habits, and routines in home, school, workplace, community, and other settings" (American Occupational Therapy Association [AOTA], 2014, p. S1).

Standard 1. Knowledge

Occupational therapists and occupational therapy assistants shall demonstrate understanding and integration of the information required for the multiple roles and responsibilities they assume. The individual must demonstrate

- Mastery of the core of the practice and profession of occupational therapy as it is applied in the multiple responsibilities assumed;
- Expertise in client-centered occupational therapy practice and related primary responsibilities;
- Integration of relevant evidence, literature, and epidemiological data related to primary responsibilities and to the consumer population(s) served by occupational therapy;
- Integration of current AOTA documents and legislative, legal, and regulatory requirements into occupation- and evidence-based practice; and
- The ability to seek new knowledge to meet client needs as well as the demands of a dynamic profession.

Standard 2. Critical Reasoning

Occupational therapists and occupational therapy assistants shall use reasoning processes to make sound judgments and decisions. The individual must demonstrate

- Deductive and inductive reasoning in making decisions specific to roles and responsibilities;

- Problem-solving skills necessary to carry out responsibilities;
- The ability to analyze occupational performance as influenced by client and environmental factors;
- The ability to reflect on one's own practice of occupational therapy;
- Management and synthesis of information from a variety of sources in support of making decisions;
- Application of evidence, research findings, and outcome data in making decisions; and
- The ability to assess previous assumptions against new evidence and revise decision-making processes.

Standard 3. Interpersonal Skills

Occupational therapists and occupational therapy assistants shall develop and maintain their professional relationships with others within the context of their roles and responsibilities. The individual must demonstrate

- Use of effective communication methods that match the abilities, personal factors, learning styles, and therapeutic needs of consumers and others;
- Cultural competence through effective interaction with people from diverse backgrounds;
- Integration of feedback from clients, supervisors, and colleagues to modify one's professional behavior and therapeutic use of self;
- Collaboration with clients, families, significant others, and professionals to attain optimal consumer outcomes; and
- The ability to develop, sustain, and refine interprofessional and team relationships to meet identified outcomes.

Standard 4. Performance Skills

Occupational therapists and occupational therapy assistants shall demonstrate the expertise, proficiencies, and abilities to competently fulfill their roles and responsibilities by employing the art and science of occupational therapy in the delivery of services. The individual must demonstrate expertise in

- Practice grounded in the core of occupational therapy;
- The therapeutic use of self, the therapeutic use of client-centered occupations and activities, the consultation process, and the education process to bring about change (AOTA, 2014);
- Integrating current evidence-based practice techniques and technologies;
- Updating performance based on current evidence-based literature with consideration given to client interest and practitioner judgment; and
- Using quality improvement processes that prevent practice error and optimize client outcomes.

Standard 5. Ethical Practice

Occupational therapists and occupational therapy assistants shall identify, analyze, and clarify ethical issues or dilemmas to make responsible decisions within the changing context of their roles and responsibilities. The individual must demonstrate in practice

- Understanding and adherence to the *Occupational Therapy Code of Ethics (2015)* (AOTA, 2015), other relevant codes of ethics, and applicable laws and regulations;

- The use of ethical principles and the profession's core values to understand complex situations;
- The integrity to make and defend decisions based on ethical reasoning; and
- Integration of varying perspectives in the ethics of clinical practice.

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Standards of Practice for Occupational Therapy

This document defines minimum standards for the practice of occupational therapy. The *practice of occupational therapy* means the therapeutic use of occupations (everyday life activities) with persons, groups, and populations for the purpose of participation in roles and situations in the home, school, workplace, community, or other settings.

Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life (American Occupational Therapy Association [AOTA], 2011). The overarching goal of occupational therapy is to support people in participation in life through engagement in occupation for “habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non-disability-related needs” (AOTA, 2014b, p. S1).

The *Standards of Practice for Occupational Therapy* are requirements for occupational therapists and occupational therapy assistants for the delivery of occupational therapy services. *The Reference Manual of the Official Documents of the American Occupational Therapy Association, Inc.* (AOTA, 2015b) contains documents that clarify and support occupational therapy practice, as do various issues of the *American Journal of Occupational Therapy*. These documents are reviewed and updated on an ongoing basis for their applicability.

Education, Examination, and Licensure Requirements

All occupational therapists and occupational therapy assistants must practice under federal and state laws. To practice as an occupational therapist, the individual must

- Have graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE[®]) or predecessor organizations;
- Have successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE or predecessor organizations;
- Have passed the entry-level examination for occupational therapists approved by the state occupational therapy regulatory board or agency; and
- Fulfill state requirements for licensure, certification, or registration. Internationally educated occupational therapists must complete occupational therapy education programs (including fieldwork requirements) that are deemed comparable (by the credentialing body recognized by the state occupational therapy regulatory board or agency) to entry-level occupational therapy education programs in the United States.

To practice as an occupational therapy assistant, the individual must

- Have graduated from an occupational therapy assistant program accredited by ACOTE or predecessor organizations;
- Have successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapy assistants that is accredited by ACOTE or predecessor organizations;
- Have passed the entry-level examination for occupational therapy assistants approved by the state occupational therapy regulatory board or agency; and
- Fulfill state requirements for licensure, certification, or registration.

Definitions

The following definitions are used in this document. All definitions are retrieved from the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2014b) unless noted otherwise:

- *Activities*: Actions designed and selected to support the development of performance skills and performance patterns to enhance occupational engagement (AOTA, 2014b, p. S41).
- *Assessments*: “Specific tools or instruments that are used during the evaluation process” (AOTA, 2010, p. S107).
- *Client*: Person or persons (including those involved in the care of a client), group (collective of individuals, e.g., families, workers, students, or community members), or population (collective of groups or individuals living in a similar locale—e.g., city, state, or country—or sharing the same or like concerns) (AOTA, 2014b, p. S41).
- *Evaluation*: “Process of obtaining and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results” (AOTA, 2010, p. S107).
- *Intervention*: “Process and skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation related to health and participation. The intervention process includes the plan, implementation, and review” (AOTA, 2010, p. S107; see Table 6).
- *Occupation*: Daily life activities in which people engage. Occupations occur in context and are influenced by the interplay among client factors, performance skills, and performance patterns. Occupations occur over time; have purpose, meaning, and perceived utility to the client; and can be observed by others (e.g., preparing a meal) or be known only to the person involved (e.g., learning through reading a textbook). Occupations can involve the execution of multiple activities for completion and can result in various outcomes. The *Framework* identifies a broad range of occupations categorized as activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation (AOTA, 2014b, p. S43).
- *Outcome*: End result of the occupational therapy process; what clients can achieve through occupational therapy intervention (AOTA, 2014b, p. S44).
- *Reevaluation*: Reappraisal of the client’s performance and goals to determine the type and amount of change that has taken place (AOTA, 2014b, p. S45).
- *Screening*: Obtaining and reviewing data relevant to a potential client to determine the need for further evaluation and intervention.
- *Transitions*: Actions coordinated to prepare for or facilitate a change, such as from one functional level to another, from one life [change] to another, from one program to another, or from one environment to another.

Standard I. Professional Standing and Responsibility

1. An occupational therapy practitioner (occupational therapist or occupational therapy assistant) delivers occupational therapy services that reflect the philosophical base of occupational therapy and are consistent with the established principles and concepts of theory and practice.
2. An occupational therapy practitioner is knowledgeable about and delivers occupational therapy services in accordance with AOTA standards, policies, and guidelines and state, federal, and other regulatory and payer requirements relevant to practice and service delivery.
3. An occupational therapy practitioner maintains current licensure, registration, or certification as required by law or regulation.
4. An occupational therapy practitioner abides by the *Occupational Therapy Code of Ethics (2015)* (AOTA, 2015a).
5. An occupational therapy practitioner abides by the *Standards for Continuing Competence* (AOTA, 2015c) by establishing, maintaining, and updating professional performance, knowledge, and skills.
6. An occupational therapist is responsible for all aspects of occupational therapy service delivery and is accountable for the safety and effectiveness of the occupational therapy service delivery process (AOTA, 2014a).
7. An occupational therapy assistant is responsible for providing safe and effective occupational therapy services under the "direct and indirect" supervision of and in partnership with the occupational therapist and in accordance with laws or regulations and AOTA documents (AOTA, 2014a).
8. An occupational therapy practitioner maintains current knowledge of legislative, political, social, cultural, societal, and reimbursement issues that affect clients and the practice of occupational therapy.
9. An occupational therapy practitioner is knowledgeable about evidence-based practice and applies it ethically and appropriately to provide occupational therapy services consistent with best practice approaches.
10. An occupational therapy practitioner obtains the client's consent throughout the occupational therapy process.
11. An occupational therapy practitioner is an effective advocate for the client's intervention and/or accommodation needs.
12. An occupational therapy practitioner is an integral member of the interdisciplinary collaborative health care team. He or she consults with team and family members to ensure the client-centeredness of evaluation and intervention practices.
13. An occupational therapy practitioner respects the client's sociocultural background and provides client-centered and family-centered occupational therapy services.

Standard II. Screening, Evaluation, and Reevaluation

1. An occupational therapist is responsible for all aspects of the screening, evaluation, and reevaluation process.
2. An occupational therapist accepts and responds to referrals in compliance with state or federal laws, other regulatory and payer requirements, and AOTA documents.
3. An occupational therapist, in collaboration with the client, evaluates the client's ability to participate in daily life tasks, roles, and responsibilities by considering the client's history, goals, capacities, and needs; analysis of task components; the activities and occupations the client wants and needs to perform; and the environments and context in which these activities and occupations occur.

4. An occupational therapist initiates and directs the screening, evaluation, and reevaluation process and analyzes and interprets the data in accordance with federal and state laws, other regulatory and payer requirements, and AOTA documents.
5. An occupational therapy assistant contributes to the screening, evaluation, and reevaluation process by administering delegated assessments and by providing verbal and written reports of observations and client capacities to the occupational therapist in accordance with federal and state laws, other regulatory and payer requirements, and AOTA documents.
6. An occupational therapy practitioner uses current assessments and assessment procedures and follows defined protocols of standardized assessments and needs assessment methods during the screening, evaluation, and reevaluation process.
7. An occupational therapist completes and documents the results of the occupational therapy evaluation. An occupational therapy assistant may contribute to the documentation of evaluation results. An occupational therapy practitioner abides by the time frames, formats, and standards established by practice settings, federal and state laws, other regulatory and payer requirements, external accreditation programs, and AOTA documents.
8. An occupational therapy practitioner communicates screening, evaluation, and reevaluation results within the boundaries of client confidentiality and privacy regulations to the appropriate person, group, or population.
9. An occupational therapist recommends additional consultations or refers clients to appropriate resources when the needs of the client can best be served by the expertise of other professionals or services.
10. An occupational therapy practitioner educates current and potential referral sources about the scope of occupational therapy services and the process of initiating occupational therapy services.

Standard III: Intervention Process

1. An occupational therapist has overall responsibility for the development, documentation, and implementation of the occupational therapy intervention plan based on the evaluation, client goals, best available evidence, and professional and clinical reasoning. When delegating aspects of the occupational therapy intervention to the occupational therapy assistant, the occupational therapist is responsible for providing appropriate supervision.
2. An occupational therapist ensures that the intervention plan is documented within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, state and federal laws, and other regulatory and payer requirements.
3. An occupational therapy practitioner collaborates with the client to develop and implement the intervention plan, on the basis of the client's needs and priorities, safety issues, and relative benefits and risks of the interventions and service delivery.
4. An occupational therapy practitioner coordinates the development and implementation of the occupational therapy intervention with the intervention provided by other professionals, when appropriate.
5. An occupational therapy practitioner uses professional and clinical reasoning, available evidence-based practice, and therapeutic use of self to select and implement the most appropriate types of interventions. Preparatory methods and tasks, education and training, advocacy, and group interventions are used, with meaningful occupations as the primary treatment modality, both as an ends and a means.
6. An occupational therapy assistant selects, implements, and makes modifications to therapeutic interventions that are consistent with the occupational therapy assistant's demonstrated competency and delegated responsibilities, the intervention plan, and requirements of the practice setting.

7. An occupational therapist modifies the intervention plan throughout the intervention process and documents changes in the client's needs, goals, and performance.
8. An occupational therapy assistant contributes to the modification of the intervention plan by exchanging information with and providing documentation to the occupational therapist about the client's responses to and communications throughout the intervention.
9. An occupational therapy practitioner documents the occupational therapy services provided within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, federal and state laws, other regulatory and payer requirements, and AOTA documents.

Standard IV. Transition, Discharge, and Outcome Measurement

1. An occupational therapist is responsible for selecting, measuring, documenting, and interpreting expected and achieved outcomes that are related to the client's ability to engage in occupations.
2. An occupational therapist is responsible for documenting changes in the client's performance and capacities and for transitioning the client to other types or intensity of service or discontinuing services when the client has achieved identified goals, reached maximum benefit, or does not desire to continue services.
3. An occupational therapist prepares and implements a transition or discontinuation plan based on the client's needs, goals, performance, and appropriate follow-up resources.
4. An occupational therapy assistant contributes to the transition or discontinuation plan by providing information and documentation to the supervising occupational therapist related to the client's needs, goals, performance, and appropriate follow-up resources.
5. An occupational therapy practitioner facilitates the transition or discharge process in collaboration with the client, family members, significant others, other professionals (e.g., medical, educational, social services), and community resources, when appropriate.
6. An occupational therapist is responsible for evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.
7. An occupational therapy assistant contributes to evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.
8. The occupational therapy practitioner responsibly reports outcomes to payers and referring entities as well as to relevant local, regional, and national databases and registries, when appropriate.

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Adopted by the Representative Assembly, 2015NovCO14

Note. These standards are intended as recommended guidelines to assist occupational therapy practitioners in the provision of occupational therapy services. These standards serve as a minimum standard for occupational therapy practice and are applicable to all individual populations and the programs in which these individuals are served.

This revision replaces the 2010 document *Standards of Practice for Occupational Therapy* (previously published and copyrighted in 2010 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy*, 64(Suppl.), S106-S111. <http://dx.doi.org/10.5014/ajot.2010.64S106>

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Citation. American Occupational Therapy Association. (2015). Standards of practice for occupational therapy. *American Journal of Occupational Therapy*, 69(Suppl. 3), 6913410057. <http://dx.doi.org/10.5014/ajot.2015.696S06>

Value of Occupational Therapy Assistant Education to the Profession

The American Occupational Therapy Association (AOTA) recognizes the value, necessity, and viability of occupational therapy assistant education. Occupational therapy assistant educational programs meet standards of performance established by the Accreditation Council for Occupational Therapy Education (ACOTE®) to produce competent entry-level occupational therapy assistants who are eligible for national certification and state licensure. Occupational therapy assistants work collaboratively with occupational therapists in contributing to the profession's pursuit of providing high-quality, cost-effective services to promote health and wellness by meeting society's occupational needs. Occupational therapy assistant education provides a sound foundation for practice with the development of competent skill sets to fulfill various professional roles within contemporary practice. These roles include direct care provider, educator, and advocate for the profession and the consumer (ACOTE, 2012).

The collaboration of occupational therapy assistants with occupational therapists in service delivery ensures greater affordability and accessibility of occupational therapy services for all populations so that more of society's occupational needs can be effectively met. The rising costs of higher education can impose limits on one's pursuit of a career in occupational therapy. Affordability, accessibility, and reduced time commitment are key components of an occupational therapy assistant education that enable timely entry of skilled occupational therapy practitioners into the workforce to meet the growing demand for services within the expanding health care environment. Occupational therapy assistants are equipped to promote the value and role of occupational therapy services with persons across the lifespan in rehabilitation, habilitation, prevention, wellness, chronic disease management, and other critical areas while providing skilled occupational therapy services to improve client outcomes at lower costs (AOTA, 2014a). In this way, occupational therapy assistant education produces highly skilled practitioners who, in partnership with occupational therapists, help to achieve the triple aim of health care reform to improve the individual experience of care, improve the health of populations, and reduce the cost of care (AOTA, 2014b).

Ensuring a diverse workforce is a priority within health care. Occupational therapy assistant educational programs are housed in academic institutions that are designed to meet the needs of a diverse student body that is representative of the surrounding communities in which graduates ultimately become employed and serve. Many students within occupational therapy assistant educational programs bring a variety of life experiences and commitment to their local communities that enrich the teaching-learning process and community engagement. These factors, in combination with an education based on rigorous accreditation standards that develop knowledge in the domain and process of occupational therapy; competencies in the application of culturally relevant, client-centered, evidence-based, and occupation-based interventions; and skills in the areas of written and verbal communication, leadership and management, scholarship, advocacy, and professional values, ethics, and responsibilities, result in the occupational therapy assistant becoming a vital partner with the occupational therapist and a valued member of the interprofessional team.

The Commission on Education (COE) recognizes that occupational therapy assistant education adds an important and valued dimension to the provision of occupational therapy services. The COE is committed to the support of occupational therapy assistant education by seeking role clarification, promoting collab-

oration among educational programs for occupational therapy assistants and occupational therapists, and advocating for the qualifications of occupational therapy assistants within all contexts of service delivery.

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- American Occupational Therapy Association. (2014b). The role of occupational therapy in primary care. *American Journal of Occupational Therapy*, 68(Suppl. 3), S25–S33. <http://dx.doi.org/10.5014/ajot.2014.68S06>

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Note. This revision replaces the 2008 document *The Importance of Occupational Therapy Assistant Education to the Profession*, previously published and copyrighted in 2008 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy*, 62, 705–706. <http://dx.doi.org/10.5014/ajot.62.6.705>

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted: 12/4/2015	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Occupational Therapists Affiliated Credentialing Board			
4) Meeting Date: 3/8/2016	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Informational Item – White House Report on Occupational Licensing	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Item is informational only. If the Board would like to discuss it, it could be added as a separately listed item on a future agenda. https://www.whitehouse.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Nifty Lynn Dio, Bureau Assistant On behalf of Tom Ryan, Executive Director		2) Date When Request Submitted: 12/14/2015 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Occupational Therapists Affiliated Credentialing Board			
4) Meeting Date: 03/08/2016	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Informational Items <ul style="list-style-type: none"> • National Conference of State Legislatures (NCSL) Partnership Project on Telehealth: Telehealth Policy Trends and Considerations 	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: http://www.ncsl.org/documents/health/telehealth2015.pdf			
11) Authorization			
Nifty Lynn Dio		03/02/16	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: <ol style="list-style-type: none"> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. 			