This proposal has been prepared on behalf of the Newfoundland & Labrador Association of Occupational Therapists (NLAOT), an organization that represents occupational therapy interests and concerns to provincial legislators and policy developers.
PURPOSE

The purpose of this proposal is to highlight the need for the creation of school-based occupational therapy positions in Newfoundland and Labrador. In this proposal, we will define current occupational therapy services to children in this province, and will discuss why occupational therapy services should be school-based. The role of occupational therapists in
education will be described and their contributions as members of the school-based team will be presented.
SUMMARY

The number of occupational therapists working in school systems in Canada continues to increase as the profession attempts to meet the need for community-based practice, and students with exceptionalities are integrated into regular school systems (CAOT, 1990).

As provincial legislation, the Model for the Co-ordination of Services to Children and Youth requires the development and implementation of an Individual Support Services Plan (ISSP) for students encountering difficulty (Department of Education, NF. Programming for Individual Needs: Individual Support Service Plans, 1996). As a result there has been increased demand from educators and parents for assistance and involvement from occupational therapy in the ISSP process for students with special needs. The contributions and services of an occupational therapist for these students is more effective if he/she is a member of the school based team. This model of service allows the occupational therapist to:

1. become more involved in the pre-referral, referral and assessment stage.

2. consult with and assist educators, parents and student assistants regarding specific interventions to try in the class and school setting, prior to initiating an ISSP.

3. implement goals identified in the ISSP into the child’s natural environment, i.e. the school setting versus the rehabilitation setting.

To provide a more effective, less fragmented and seamless service, and one that can have a direct and positive impact on curriculum outcomes and increased independence for students, the Newfoundland and Labrador Association of Occupational Therapists recommend that occupational therapy positions be allocated in the school system by the Department of Education.
RECOMMENDATIONS

1. That occupational therapy be identified as a recognized specialty with the education system.

2. That the requirement of an education degree be removed as a prerequisite to work within the educational system.

3. That occupational therapists be hired by school boards as school-based practitioners.

4. That services for children in the health system be maintained and expanded to continue to meet the tertiary care, specialized needs of children with health problems.
**Definition of Occupational Therapy**

Occupational therapy is a health profession that promotes a person’s ability to participate in daily life activities, at home, at school, at work, and in the community.

In addition to normal and abnormal growth and development, occupational therapists are trained in the areas of anatomy, neurology, physiology, behavioral and social sciences, and medical/surgical conditions. Occupational therapists use activities, therapeutic techniques and environmental modifications to maximize the functional abilities of individuals who have been affected by physical, developmental, sensory-motor, perceptual or behavioral difficulties. Occupational therapists’ extensive academic and clinical training makes them qualified to work in various settings (Canadian Association of Occupational Therapists, 1990).

In the school setting, the goal of occupational therapy is to maximize a student’s ability to function as independently as possible and achieve educational objectives in school. Through collaboration with teachers, parents, and other educational team members, the occupational therapist assists in the development and implementation of an educational plan that addresses the total needs of the student.

In the past two decades there has been a steady increase in the number of therapists working in school systems in both Canada and the United States (CAOT, 1990). According to 1997 statistics from the Canadian Association of Occupational Therapists, 793 of the 1475 therapists who work with preschool and school age children in Canada, work in the school system rather than the health care system. Presently, there are no school-based occupational therapists working in our province.

**Current Occupational Therapy Services for Children in Newfoundland and Labrador**

In Newfoundland and Labrador, occupational therapy services for children are provided mainly by the Acute Care, Development and Learning and Children’s Rehabilitation Centre divisions of the Child Health Program of the Health Care Corporation of St. John’s.

Children with acute medical needs receive inpatient and outpatient occupational therapy services through the acute care divisions. The waitlist for the outpatient service is 1 year. Children with developmental or learning needs are followed through the Child Development & Learning Division of the Child Health Program. Due to lack of occupational therapy positions, services within this division are restricted to children aged 3 to 6, or to school aged children experiencing problems with written output. The intervention provided consists of an assessment and a consultation to daycare or school, or in limited cases, a number of treatment sessions. Children can wait up to one year for service. Children with a primary diagnosis of a physical disability receive occupational therapy services from the Children’s Rehabilitation Centre. The Children’s Rehabilitation Centre provides outpatient, and travelling clinic follow-up, and has outreach occupational therapy services in Gander, Grand Falls and Corner Brook. In areas where there is no regional pediatric occupational therapy service, occupational therapists in regional hospitals or Community Health have attempted to provide a limited consultative service.
The ability of a child to access pediatric occupational therapy services, then, is dependent on the diagnosis and age of the child, and the regional availability of an occupational therapist funded by the Department of Health. Increased public awareness of the value of occupational therapy, and the implementation of the Pathways and Individual Support Services Planning (ISSP) process has resulted in increased demands for occupational therapy service to schools for consultation, assessment, and intervention. Although occupational therapy provides a valuable service in the health system, occupational therapists employed in the health care system cannot adequately address the needs in the education system.

**Role of Occupational Therapy in the Education System**

Occupational therapists in the school system are concerned with a student’s ability to function as independently as possible in all school experiences. The goal of occupational therapy intervention is to help students to access and benefit from educational programming (Rourk, 1996; Hanft & Place, 1996; Lowman et al, 1999; Fairbairn and Davidson, 1993).

The role of occupational therapy as part of the education team is to enhance a student’s performance at school by:

1. Working directly with students, classroom teachers, non-categorical and categorical special education teachers in the development and implementation of Pathways programs. Working with other members of the ISSP team, the occupational therapist can:
   - recommend specific supports and accommodations required for a student to be successful with the prescribed curriculum (Pathway 2);
   - recommend curriculum outcomes that would need to be deleted, changed or added (Pathway 3);
   - assist with the development, implementation, and evaluation of alternate courses (Pathway 4) and assist with programming under the domains of an alternate curriculum (Pathway 5).

2. Working directly with students, teachers, and student assistants to promote independence in the skills necessary for student independence in the school environment and to prevent injury to staff and students. Through education of school personnel, recommendation for adaptive equipment or changes to the school’s physical environment, and assistance in the development of alternate courses, occupational therapists promote the principles of maximizing student independence, minimizing over-dependency on adult support, and the learning of self-advocacy and self-management skills.

3. Working with the ISSP team to develop transitional programming to assist the student with a disability to move from high school to work or the post-secondary school environment. Spencer (1992) notes that “functional, situational assessments conducted
by occupational therapy personnel are particularly helpful in the transition planning process since they will reveal the student’s abilities and needs in a variety of real-life situations (the community, home, school, job, etc.)” (p.11).

4. Educating school staff in the educational and learning implications of various disabilities. A key goal of successful school-based practice is to help members of the ISSP team to understand the reasons for student performance in school (Case-Smith, 1997) and to interpret how a student’s motor, sensory, or perceptual skills can affect learning or curriculum outcomes (Hanft & Place, 1996).

Occupational therapists are able to provide realistic assessment of the student’s potential for goal achievement in his/her school program. The occupational therapist’s knowledge of medical conditions and how functional ability is compromised allow for the establishment of realistic goals. Occupational therapists can provide education to school staff regarding the strengths, needs and functional abilities associated with various medical conditions.

5. Establishing a system-wide method of assessing and identifying the need for adaptive equipment or structural changes within the school environment. The occupational therapist can make recommendations for creating an accessible and safe school environment for all students. Through assessment and consultation regarding appropriate adaptive equipment and assistive technology, and recommendations for modifications to school facilities, the occupational therapist can assist in maximizing the appropriate use, support and distribution of equipment, and ensure appropriateness of renovations, thereby reducing the waste of professional resources and funds that presently occurs in the system.

6. Providing consistent liaison between home, school, and the Health Care system.

To meet the individual educational needs of a variety of students with disabilities, best practice in schools involves using more than one model of service delivery. Direct therapy, monitoring individual classroom programs, and collaborative consultation are the three most common service options used (Rourk, 1996; Dunn, 1988; King, 1998; Sandler, 1997; Barnes & Turner, 2001)

**Avalon West School District Pilot Project**

In May 1999 an occupational therapist was hired on a part-time basis by the Avalon West School District for a one-year pilot. For this project, the occupational therapist was required to have a degree in education and current teacher certification. The pilot was implemented in order to identify the need for occupational therapy services in the Avalon West District and to ascertain whether these services are best delivered through the health or educational systems.

The final report strongly recommended that occupational therapy services be developed within the school board, that occupational therapists be hired by the education system as part of the
educational team, and that the requirement that the occupational therapist have an education degree be removed. (Connor-Sheppard, 2000)

Specific roles of the occupational therapist within the school system were recommended. These include:

1. To Identify and assess underlying causes of fine motor dysfunction and visual motor dysfunction; provide early stage intervention; establish expected outcomes for student attainment and reevaluate as the student is faced with new challenges.

2. Establishment of realistic goals for student attainment and appropriate programs within Challenging needs classrooms, including providing inservice education to challenging needs teachers and advising on appropriate allocation of student assistants.

3. To ensure the program plan within the regular classroom is appropriate for students with functional disabilities.

4. To enable kindergarten assessments to be completed in a timely manner in order to support opportunities for early intervention.

5. To ensure information provided from the health system is integrated into the program plan for the student.

6. To assess and identify the need for adaptive equipment or structural changes within the school environment, and support opportunities for standardized equipment throughout the district.

The report identified opportunities for cost savings through appropriate allocation of student assistants and the purchase of standardized equipment throughout the district.

The therapist participated in a demonstration project on Transitional Strategic Planning for Secondary Students with Disabilities through the Avalon West School District. She carried out functional assessments on the 12 students who participated in the project. The Final Project Report (2000) noted that “In certain instances, the Occupational Therapy Assessments were very valuable to assuring appropriate job development. Parents were provided with copies of the OT reports, and, as a result, identified strengths that they would not have recognized without the completed Assessments. In particular cases, these Assessments were vital in securing successful job matches. Without the Assessments, it would have been difficult to determine appropriate matches” (p.32).

The benefits of a school-based occupational therapy service is clearly demonstrated by the case studies drawn from the Avalon West Pilot Project (Connor-Sheppard, 2000) (Appendix A).

Why Should Occupational Therapy Services to Schools be School-Based?
There has been considerable debate about whether occupational therapy services to schools should be provided through the health or education system. Based on current literature and the results of the Avalon West Pilot Project, it is the position of the Newfoundland and Labrador Association of Occupational Therapists (NLAOT) that these services need to be school-based, not health-based.

Occupational therapists employed by the Department of Health and Community Services provide services from within a health model. Attempts to address the occupational therapy needs of children in school by occupational therapists working in this system are not adequate as problems with trying to address the educational issues of special needs students’ from within a health context are numerous. (Connor-Sheppard, 2000)

Referrals to occupational therapy are most often for complicated issues in the presence of physical, developmental, learning and attentional problems (Miller et al, 2001). Literature has shown that these problems usually present in early school years but if not addressed will persist into adolescence, and lead to secondary educational and mental health issues including poor social competence, academic problems, behavioral problems and low self esteem (Cantell, Smyth & Ahonen, 1994; Gillberg & Groth, 1989; Losse, et al 1991). Current research to date demonstrates the need for comprehensive, long-term service for these children (Miller, et al, 2001). A consultative service from occupational therapists employed by the Department of Health as currently exists cannot meet this need.

Many children in the school system are having difficulties that are impacting on their educational achievement but do not have a medical diagnosis, and hence are unable to access occupational therapy through existing health-related services. Occupational therapists working within School Health Support Services in Ontario are receiving increasing numbers of referrals for children who demonstrate extreme physical awkwardness and are experiencing difficulty with academic and self-care tasks in the classroom but do not have a diagnosis of a health problem (Miller, et al, 2001). In a pilot project completed by the Avalon West School District, 97 of the 142 occupational therapy referrals received had no known physical disability or developmental delay (Connor-Sheppard, 2000).

Much of the current literature about school-based occupational therapy emphasizes the importance of providing educationally-relevant services which necessitates collaborative consultation with students, teachers and parents, and an understanding of the priorities of the educational plan for each student (Hanft & Place, 1996). Effective collaborative consultation develops over time and is essential for effective intervention for students with special needs to take place in today’s educational environment (Hanft & Place, 1996; Barnes & Turner, 2001). The needs of students with disabilities are so complex that involved personnel must rely on each other to share expertise in order to provide appropriate and comprehensive educational programs (Giangreco, 1996). These personnel are better able to communicate and coordinate services when they are in closer proximity to each other, formally or informally (Barnes & Turner, 2001). When occupational therapists work outside of education, they may not be perceived as members of a child’s educational team (Bloom, 1983). Consistency and continuity of liaison between school-based occupational therapy and educational personnel would assist the ISSP process and reduce the inefficiencies presently occurring in the system (Connor-Sheppard, 2000).
The provision of occupational therapy services to schools from a medical system results in a fragmented and ineffective method of service delivery (Niehues, Bundy, Mattingly & Lawlor, 1991). In order to provide comprehensive and effective programming within the most appropriate context, occupational therapy services to schools must be school-based. This, however, does not eliminate the need for occupational therapists in the health system. Children in the health system have many other occupational therapy needs beyond the needs required for educational performance. The services in the health system are also essential to support the therapists in the school system. As was demonstrated in the Avalon West Pilot Project, the occupational therapists in the health system must be available for detailed assessments and specialized treatment that can’t be performed in the school setting as well as consultation to the school therapists (Connor-Sheppard, 2000).

**Funding And Service Delivery Models**

Funding and administrative structures for occupational therapy service delivery in the schools are different in each province. Funding mechanisms, available occupational therapy manpower, and provincial legislation have created the need for variability. (CAOT Practice Paper, Occupational Therapy in the Schools, 1990).

In Ontario, the Ministry of Health funds Community Care Access Centres (CCAC) to distribute services for children. The complex children are served by the children’s treatment centres and the CCAC contracts with private practitioners to serve the rest of the population. Services can be provided in the home or school, but most occupational therapy services are in the school, with a minimum number of visits mandated each year. (personal communication, Maria Saint, Occupational Therapist)

In Alberta, the provincial government allocates a budget to each health region for school therapy services. The health regions hire the school therapists. In Edmonton and Calgary, the public school boards hire in-house therapists and contract their services to other school districts (i.e. to the north, for Edmonton). (personal communication, Diane Sekuloff, Shila Nicholson, Occupational Therapists)

In British Columbia, the Departments of Health and Education jointly fund school age services. In some regions, therapists are hired directly by the school board; in others, therapists are contracted from Child Development Centres which are health funded.

There are advantages and disadvantages to each model. Therapists hired by the school board will be immersed in the educational system and can work with any child with occupational performance issues, whether they have a health-related diagnosis or not. Therapists will be more accessible to teachers and will be more effective consultants because they understand the system better. Therapists hired by the health system to work in schools will still be immersed in the health system, and less accessible to teachers, but will have a better liaison and access to health services.
The most effective model for funding an occupational therapy service delivery in Newfoundland and Labrador may depend on the geography of the region. In larger areas with a more concentrated population, therapists may be employed full time in the school boards. In less populated rural areas, it may be more appropriate for the school board to reach an arrangement with the local health board to allocate a percentage of the occupational therapist’s time to schools in the region.

Newfoundland and Labrador is the only province that requires occupational therapists to have an education degree to work in the school system (Connor-Sheppard, 2000). This requirement is a barrier to hiring occupational therapists and must be addressed before an effective school-based system can be implemented.
CONCLUSION

Current literature in Occupational Therapy and the outcome of the pilot project in the Avalon West School Board clearly demonstrate the benefits of school-based occupational therapy in enhancing the educational experience for children with special needs. It is unrealistic to expect that the over-loaded health care system will be able to meet the ever-increasing demands from parents, teachers, guidance counselors, educational psychologists, speech-language pathologists, and others in the education system. School-based occupational therapy services are the most effective and efficient system for service delivery.
APPENDIX A

Case Study # 1

Jean is a student with multiple challenges. She is 14 years old and has been followed by the Children’s Rehabilitation Team for 13 years. She is now in a challenging needs class in high school. The Occupational Therapist and Physiotherapist from the Children’s Rehabilitation Centre visited the school in October at the beginning of the school year. Upon their arrival the teacher had identified areas of concern requiring their attention. These were:

- The wheelchair appeared too small.
- The student assistants found Jean difficult to transfer from her wheelchair to the toilet.

The Occupational Therapist demonstrated the appropriate method of transfer for Jean from the mat on the floor to the wheelchair and toilet/change table. The therapist also identified that the wheelchair was indeed too small and that her name would be added to the seating clinic wait list. The therapist did adjust the seating to allow for additional space on a temporary basis. All issues were assessed and all were addressed in the 30 minutes allocated for Jean in this school visit.

In this case, as in others, the Occupational Therapist responded to the needs identified by the teacher and did not look further into Jean’s needs in relation to the overall school system.

The school Occupational Therapist on the other hand focused on Jean in relation to her school programming. In reviewing the school record, it was recognized by this therapist that the educational goals for Jean had not changed in 10 years. What goals were present in 1992, as she entered kindergarten, were still present as she entered grade nine. Jean was being toileted 4 times a day in the school program requiring the services of two adult attendants each time. The goal of the toileting program was toilet training. She was being transferred to the floor mat twice a day again with two attendants. The goal of the program was visual sensory stimulation.

The School Occupational Therapist identified:

1. The teacher in the challenging needs class had never worked with students with physical challenges and the student assistants were the ones directing the classroom curriculum.

2. The physical layout of the newly renovated classroom did not allow for physical accessibility to the sink, refrigerator or counter. Programs involving water for stimulation had to be performed by filling a plastic washbasin and transporting it to Jean’s location. Jean was unable to use the sink as it was too high, although this would have been the natural functional task associated with normalcy within the home or school environment.

3. The need for toileting 4 times in the school day was excessive, particularly when the potential for Jean to become toilet trained in these circumstances was nonexistent. This was
a request of the mother, who was also directing her school program, and had directed the staff at school to perform this function as it was required.

4. The requirement for the services of two student assistants to provide transfers was excessive; one student assistant could perform the same task with a mechanical manual lift.

5. The lift sling that came with Jean each morning from home was not the same type of sling needed for the ceiling lift installed in the school; thus, the sling had to be removed every morning and replaced with the sling at school for toileting. This necessitated an additional two lifts throughout the school day.

6. The student assistants, while in the bathroom, bodily lifted Jean to their waist height for changing, and to the toilet for toileting. A student assistant had to stay with Jean while she was on the toilet as she did not have the trunk stability to remain there unsupported. Toileting therefore required the students assistants for at least 30 minutes for each of four toileting sessions throughout the school day.

7. The change tables available required two student assistants to perform the lift to waist height of this student, who was over 100 lbs in weight, at considerable risk of injury to themselves or Jean.

**Intervention by the School Occupational Therapist:**

1. At the ISSP meeting:

   a) the requirements for toileting were changed as the mother admitted she hoped that the toileting program would provide her daughter added stimulation so that she was not ignored in the classroom. Jean was to be toileted once in the morning and once in the afternoon. This resulted in a savings of two hours of student assistant time.

   b) the educational goals were changed to reflect the needs of the student. The mother identified that she had gone along with the goals previously identified for all these years “because the teachers meant well”. A program of Sensory Stimulation was initiated.

   A manual mechanical lift was recommended and purchased by the School District to be used when required by any child in the system, should Jean move out of the district or no longer require the lift. The lift was used in transfers to the mat as well as toileting transfers.

1. The teacher was provided with information on sensory stimulation activities to implement into the ISSP plan.
Case Study #2

Ron is a 5-year-old student who has Spina Bifida. He is confined to a wheelchair for mobility and is in a regular kindergarten classroom.

The Occupational Therapist from the Children’s Rehabilitation Centre visited the school in October but Ron was not in school that day as he was sick. However, it was identified by the student assistant that Ron had difficulty accessing the computer in the classroom, and that a modified keyboard system was required. In addition the teacher requested fine motor activities to assist with hand development as Ron clearly had difficulty with handwriting. The CRC Occupational Therapist recommended that Ron be referred to the technology team for assessment, should the adapted equipment ordered by the student assistant prove ineffective. In addition the therapist agreed to suggest fine motor activities, following the next clinic visit in 3 months time. The Occupational Therapist provided suggestions for fine motor activities to the classroom teacher as promised following the clinic visit. No further follow-up was planned as “the school identified no other concerns”.

The School Occupational Therapist identified:

1. Ron was not wheeling his own wheelchair either in the classroom or outside the classroom. However, he was capable of doing so without the assistance of the student assistant. Independent mobility was thus included in the ISSP, although the student assistant had to be reminded repeatedly not to push the wheelchair and Ron had to be reminded that he could do it himself.

2. Ron was capable of accessing the regular keyboard and could consistently and accurately press the required letters through his own memory or when these were dictated. Ron, therefore, did not need any adaptations to the keyboard or special equipment that had been ordered, nor did he need the referral to the technology team.

3. Ron sat apart from the class in his accessible desk so that the student assistant could position herself beside him to assist in writing and maintaining his attention on the task. The desk was moved to be within the range of the other kindergarten students and the student assistant was asked not to attend to such a degree, as Ron needed to learn that he was expected to perform as an equal to his peers and that educational expectations were no different for him as for the other students.

4. The suggestions for fine motor activities provided by the Occupational Therapist at the CRC were not being used, and the IRT was not aware that they had been provided to the school. Only the classroom teacher had a copy. As she read them, she identified she was unable to implement the suggestions in the classroom so they were filed for future reference. The fine motor activities were reviewed by the School Occupational Therapist and it was agreed that the suggestions were not appropriate for classroom implementation. They were appropriate for a home program and should be implemented at home. At school Ron should be encouraged to color, and print when required, but if cognitive thought was the intention, as in journal writing, then the computer should be used. The probability of Ron being a functional
writer was limited without intensive therapy; additionally, the requirement for written assignment places him at a disadvantage with his peers, resulting in frustration and the student assistant doing his work for him.
Case Study #3

Karrie is a grade 5 student who was identified in kindergarten with having difficulty learning. At that time she was referred to a pediatrician whom she saw while she was in grade one. She then was referred by the Pediatrician to the Occupational Therapist at the Learning and Behavior clinic at the Janeway. She was also referred to the Behavioral Management Specialist in the community. She was seen by the Occupational Therapist in grade three. The therapist identified a developmental dyspraxia which required a different learning approach. The therapist met in March of the grade three year with the classroom teacher, the IRT and the parents to identify the method of learning which would be the most effective for Karrie. The Janeway Occupational Therapist was left with the impression that everyone understood Karrie’s difficulties, and that remediation and the regular school curriculum would continue as outlined.

In 1998 Karrie was in grade four with the same difficulties she had experienced in her first 4 years of school. She was referred to the School Occupational Therapist in June of 1999 by the Speech-Language Pathologist who admittedly “kept Karrie on my caseload as she needed someone to see her.” Karrie was seen in school in September 1999.

The School Occupational Therapist identified:

1. In the transition from grade three to grade four, the new teachers did not understand what developmental dyspraxia was let alone how to help Karrie in school.

2. Psychological testing in kindergarten had shown average intelligence. In grade four she was now in the borderline range.

3. Modifications to the school curriculum in the areas of math and reading had not been implemented, other than by providing resource time along with a developmentally delayed student. Both students had entirely different needs.

4. Karrie, according to her mother, had gained considerable weight over the past three years and was no longer physically active.

5. Karrie was unable to write clearly in grade five nor was she at age level for reading or math.

6. Karrie was a behavior problem at home but not in school.

Intervention by the School Occupational Therapist:

A school meeting was called with the classroom teacher, the Instructional Resource Teacher, the Physical Education teacher, the mother and the Behavioral Management Specialist. The Occupational Therapist identified the diagnosis of developmental dyspraxia and the implications for reading, writing and math. Suggestions were provided regarding writing development, approach to math skills, position in the classroom for optimal learning, expectations for learning, and appropriate physical education activities to promote motor planning and postural development. In addition, the Behavior Management Specialist identified areas at home which
were being interpreted as Karrie’s inattentiveness, but were in fact the result of motor planning dysfunction. Suggestions for a home program of exercise were provided by the therapist, and a referral to her family doctor for a diabetic check.

A follow-up meeting one month later identified that the implemented program was working effectively, and that Karrie now had an interest in school work as a result of her success. Her handwriting had improved and the classroom teacher noted no difficulties with attention in the classroom. She was doing the prescribed home program and had changed her eating habits.
Case Study #4

Gordon is an 8-year-old boy who presented with odd behaviors at home and at school. Gordon was obsessive regarding hand washing. A behavior modification plan had been initiated with some improvement. Gordon did not socialize well with other children. His handwriting skills were below age level and his reading was poor although comprehension was good. The school guidance counselor had referred to the Educational Psychologist who identified average intelligence and possible obsessive-compulsive disorder. He was subsequently referred to the Janeway Psychiatric team. His scheduled appointment with the psychiatric intake worker was pending when the referral was generated to the school occupational therapist.

Intervention by the School Occupational Therapist:

Gordon’s assessment was prioritized due to the pending intake at the Janeway. He was seen at school in the classroom, walking in the hallway and in an assessment room with his mother present. He would walk by himself down the hallway although not in line with the other classmates. When eating lunch, he would place his lunch in a systematic order around his eating area almost like he was protecting his space. His mother when questioned reported tactile defensive tendencies and gravitational insecurity. Assessment findings pointed to a possible vestibular imbalance. A copy of the report was sent to the psychiatric intake worker. Upon receipt of the report Gordon was referred back to the school occupational therapist.

A home program was initiated to be conducted by Gordon’s mother. Follow-up 2 months later showed some improvement in behavior, less hand washing and less fear when he was walking downstairs. A referral to the Occupational Therapist with the Learning and Behavior Team confirmed the vestibular dysfunction and Gordon is now undergoing intensive therapy in St. John’s.

The above case example demonstrates how Gordon could well have been diagnosed with a psychiatric illness and placed on medication when he had an underlying sensory integrative dysfunction.
REFERENCES


