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Occupational and Physical Therapy

A Guide for Families and Professionals about Types of Therapy and Service Delivery Models

Nancy J. Hitzfelder, M.D.
Medical Director

If occupational or physical therapy has been recommended for your child by your physician or therapist, and if you agree with this recommendation, you now have several decisions to make and questions to answer about getting that therapy.

Where is therapy available? How far do I have to drive? How many times a week? What time during the day? How much will it cost? Will my insurance pay? What if insurance will not pay, or I do not have insurance?

As parents begin to find answers to these questions, they discover that occupational and physical therapists work in a variety of different settings including hospitals, clinics, rehabilitation centers, private practice offices and public schools. At first, it may seem that the pediatric occupational and physical therapists in each of these settings are essentially the same. Therefore, the therapy services provided in each of these settings should be the same. Therapy is therapy, right?

Actually, no. The therapists may, indeed, be equally trained, licensed, and registered no matter where they work. But the purposes of the agency or clinic are often very different. Therefore, the type of therapy and the goals of that therapy may be very different from one setting to another. It is important to understand the different types of therapy and different goals of therapy before you choose and therapist for your child.

There are two main types of occupational and physical therapy: clinical and educational. The basic purpose behind each of these is different, although sometimes they overlap.

I. Clinical Therapy

Clinical occupational and physical therapy are based on a medical model. They are based on the underlying medical cause of the child's disability and try to treat that medical cause or the symptoms. For example, if a child has spastic cerebral palsy, the therapist tries to relax the child's muscle tone. The goals of clinical therapy are usually to improve a child's function or quality of movement. For example, goals may be to walk independently, or with better posture, or to increase range of motion of joints. Sometimes clinical therapists help a child prepare for or recover from surgery. There are three types of clinical therapy: **Active** therapy, which can be either **acute** or **long-term**, and **maintenance** therapy.

A. Acute Clinical Therapy. Acute clinical therapy is often done in a hospital or an in-patient rehabilitation center. It is usually very intense, i.e., many sessions per week, and it usually lasts only a short time, i.e., perhaps a few weeks or months. Acute therapy is often done in preparation for surgery, or right after surgery or an injury to get the most improvement in function as fast as possible. A short course of acute therapy may also be done when a child gets a new piece of equipment to teach him or her how to use it.

B. Long-Term Clinical Therapy. Long-term clinical therapy usually is done in an out-patient clinic or in your home. It may occur as often as two or three times per week, or as little as once a month. It may continue for several months or for several years. Goals include improving quantity and quality of skills; for example, learning how to walk first with a walker, then with a cane, then all alone. Therapy may be stopped when a child reaches a plateau in development and may resume later to work on new skills. Some children go on and off therapy repeatedly during childhood years and even during teenage and young adult years if needed.

C. Maintenance Clinical Therapy. Maintenance therapy is done during the time a child is not receiving active therapy. This is usually done by the family or other regular caretakers rather than by the therapist directly. The therapist teaches the family what to do and how to do it. The therapist may see the child once every month or so if needed to provide new instructions and check for problems. The goals of maintenance therapy are to maintain (or keep) the skills that the child developed while on active therapy, and to prevent the child from getting worse. It is not designed to improve function or help the child learn new skills.

A child may switch from active therapy to maintenance therapy when he or she reaches therapy goals and has no new goals to work on, or when his or her progress has stopped in active therapy and no further progress is expected in the near future.

All of the above are clinical therapy, that is, they follow a medical model and try to help the child by treating his or her underlying medical problem or symptoms. The goal is to improve function so the child can achieve the best motor function possible.

II. Educational Therapy

There is another way children may receive therapy. It is done in the public school system and is sometimes referred to as **Educational Occupational Therapy and Physical Therapy.** Occupational and Physical Therapy are considered "related services" in school. They are provided only if needed to help a child learn from his educational program. Therapy in school does not necessarily focus on the child's underlying medical problem in order to maximize the child's motor function. The purpose of occupational and physical therapy in school is to help the child function in the school setting so that he or she can benefit from the educational program. If the child has a problem that would normally be treated with clinical occupational or physical therapy to improve his or her motor function, but the problem does not interfere with his ability to learn in the classroom or school, then the student might not receive occupational or physical therapy at school. (The child might still get clinical therapy somewhere else.)

For example, if a child can walk well with a walker and can get to and from classrooms, etc., then the child may not receive educational therapy at school because he is able to learn, unrelated to his walking. That is, using the walker does not interfere with his learning. He is considered a functional walker. (He might get clinical therapy after school to help develop better balance so he or she can eventually walk alone, but that is not related to his education.)

Another example is a child whose sitting balance is so poor that he cannot sit in the classroom chairs properly. Educational, occupational or physical therapy in school might help find an appropriate seating arrangement for the child so he could sit up with classmates as well as work on activities to improve his trunk balance and make it easier for the child to use his hands for things such as writing or cutting. In this case, therapy is necessary to allow the child to benefit from his educational program. Once a good seating solution is found, the child may no longer receive occupational or physical therapy at school because the child is now able to benefit from the educational program. (The child may still be going to clinical therapy after school somewhere else to work on other things.)

III. Differences

A. How Therapy is Provided. Educational therapy and clinical therapy are provided differently. Clinical therapy is usually done directly by the therapist with the child. It is usually done one-on-one or in small groups, and parents may be taught some activities to do at home. Educational therapy begins with an assessment which is done directly by the school occupational or physical therapist. If the school therapist recommends educational therapy, it any be done directly by the OT or PT, or

the therapist may consult with the child's teacher or classroom aide. Since the goal of educational therapy is to help the child benefit from his or her educational program, a big part of the school therapist's job is to show teachers and aides ways to reach these goals in the classroom. Then the teacher or aide uses the therapist's instructions in the classroom to reach the goals set. Educational therapy is often transdiciplinary, involving role release. This means that one therapist, either an occupational or physical therapist, might address both gross motor and fine motor skills with your child, and that a teacher or aide might carry out the therapist's recommendations.

B. Qualifying for Therapy. Another difference between clinical and educational therapy is how a child qualifies to receive occupational and physical therapy. For clinical therapy, if a physician writes a prescription, the therapist can begin treatment. For educational therapy, you may still need a doctor's prescription, but you also need to "qualify" as a special education student because OT & PT are special education related services in school. The therapy must also be needed to help the child function and learn in the classroom and to achieve the goals set for him in his ARD meeting (see below). It is important to realize that just because the doctor prescribes therapy, this does not auto-matically mean that the child can get it at school. He must first "qualify" and the therapy must be necessary for him to benefit from his educational program.

There are many disabilities which will qualify a student for special education services. The school can give you information and test your child to see if he or she has a disability that makes your child eligible for special education services. The disability must be accompanied by an educational need. This means that the disability must interfere with the child's ability to learn.

Once your child qualifies for special education services, you will have an ARD meeting with the school. (ARD means "Admissions, Review, and Dismissal" and it is a meeting between you and the school staff.) You will develop an Individual Education Program (IEP) with the school. It will list what the goals will be for your child in school, and what related services will be needed to help achieve those goals. If the goals on your child's IEP might require occupational and/or physical therapy to help achieve them, then your child will have an occupational and/or physical therapy assessment at school. The school therapist will make recommendations which might include direct therapy, consultation, monitoring, or perhaps no therapy at this time. If therapy goals are set, they may be carried out by a therapist (either occupational or physical), an aide, or the teacher, as discussed above.

C. Paying for Therapy. Finally, there is a difference in how therapy fees are paid. Clinical therapy is a medical service and may be paid for by health insurance, Medicaid or by you directly. Therapy in school is an educational-related service and is paid for by your school tax dollars and sometimes by Medicaid in a special program for school health related services. It does not cost you extra money out of your pocket. Some families who do not have health insurance (or the therapy recommended is not covered by insurance) hope to get all of their child's therapy at school, both clinical and educational occupational and physical therapy. But the school can provide only educa-tional therapy, not medical or clinical therapy. This can cause misunderstandings and hard feelings when the child would benefit from clinical therapy but does not qualify for educational OT or PT, and the school cannot provide you the therapy that you and your doctor think the child needs. It is important to understand that educational therapy and clinical therapy have different purposes, and are provided in different ways.

D. Fuzzy Boundaries. From these definitions and descriptions, it sounds like the differences between clinical and educational therapy are clear and that deciding which therapy a child "needs" is simple and clear-cut. Sometimes; usually it is not.

What a child needs to "function" at school is sometimes unclear and sometimes a matter of perspective or opinion. For example, a child may walk with a walker and get around the classroom adequately, but if he walked independently and could move around the school more easily, could he benefit from the school program even more? If so, should he get therapy at school? Questions like these have no single right or wrong answer and each child's case must be examined individually. It is the job of the ARD Committee to work with you to make these tough decisions.

IV. Summary

There are many factors to consider when therapy is prescribed for your child. There are different kinds of occupational and physical therapy with different purposes and goals. Families will have may questions, and they deserve clear and honest answers. Open communication among family, doctor, therapist and school will help you understand your child's needs and match them to the resources available. It can also help avoid misunderstandings and begin to solve any problems.

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Text prepared by: Nancy J. Hitzfelder, M.D., Medical Director – Easter Seals of Greater Dallas, a medical outpatient rehabilitation facility, 4443 N. Josey Lane, Carrollton, Texas 75010.

In consultation with – Region X Special Education Ad Hoc Committee:
Richard Craig, Director of Special Education, Duncanville ISD
Lois Hogan, Director of Special Education, Mesquite/Sunnyvale Co-op
Maryann Moorman, Director of Special Education, Greenville ISD
Sharon Ricks, OTR, Senior OT, Garland ISD
Sandra Shugart, Director of Special Education, Irving ISD

The author wishes to thank the many parents and professionals who provided critical review and comments of this article.