College of Occupational Therapists

COT/ BAOT Frequently Asked Questions

Defining and presenting occupational therapy involvement for children and young people who have education, health and care needs

Last Update: August 2014
Lead Group: Practice
Country Relevance: England, Scotland, Wales, Northern Ireland

Scotland: The Education (Additional Support for Learning) (Scotland) Act 2004 came into force in November 2004 and was amended in 2009. This states that children and young people with special educational needs may be supported through **Personal Learning Planning** (PLP), **Individualised Educational Programmes** (IEP) **and Co-ordinated Support Plans (CSP)**. Statutory Guidance relating to the Education (Additional Support for Learning) (Scotland) Act 2004 as amended can be found at http://www.scotland.gov.uk/Publications/2011/04/04090720/0.

England: From 1st September 2014 the Special Educational Needs and Disability Code of Practice will come into effect as part of the Children and Families Act 2014. Special educational needs and disability support will be graduated for children and young people in nurseries, schools and colleges. This will replace School Action and School Action Plus. Statements of special educational needs will be replaced with **education, health and care (EHC) plans** for children and young people with complex needs. For further information please see http://www.cot.co.uk/children/children-young-people-and-families (a. For transitional arrangements for children and young people who have statements, please see https://www.gov.uk/government/publications/implementing-the-0-to-25-special-needs-system.

Wales: Special Educational Needs Code of Practice 2004 states that children with additional learning needs may be supported through **School Action, School Action Plus and Statements**. For detailed guidance please see http://learning.wales.gov.uk/resources/special-education-needs-code-of-practice/?lang=en. This is currently under revision and pilot sites have been using **Individual Development Plans (IDP)**. For further information please see http://wales.gov.uk/statistics-and-research/programme-action-research-additional-learning-needs-pilot/?lang=en

Northern Ireland: Statutory responsibility for services relating to children and young people with special educational needs the rests with both schools and the five Education and Library Boards (ELBs). For further information please see http://www.deni.gov.uk/index/support-and-development-2/special_educational_needs_pg.htm. The Special Educational Needs and Disability (Northern Ireland) Order 2005 came into operation on the 1st September 2005. This states that children and young people with special educational needs may be supported through **statements**.

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Q1. I have been asked to provide a contribution for a child's Education, Health and Care Plans (EHCP) / Coordinated Support Plan (CSP) / Statement. What should be the purpose of my report?

A. In essence your report should:

- Detail the needs of the child or young person in relation to their **occupational performance and participation** in their roles (e.g. student, friend, sibling, player etc.). As the agendas within all four countries emphasise integration and personalisation, this could include the child or young person's needs within the home, educational setting, short breaks, leisure and community settings.
- The focus must be on the outcomes for the child or young person in relation to their school, home and community participation, rather than skill development. When framing outcomes, it is important to state what the child or young person will be able to do following input i.e. the **tasks** they will be able to do (please see table below for examples).
- It may be necessary to identify the occupational therapy resource requirements which need to be specified and justified. While this is clearly important, the focus must remain on the outcomes for the child or young person.

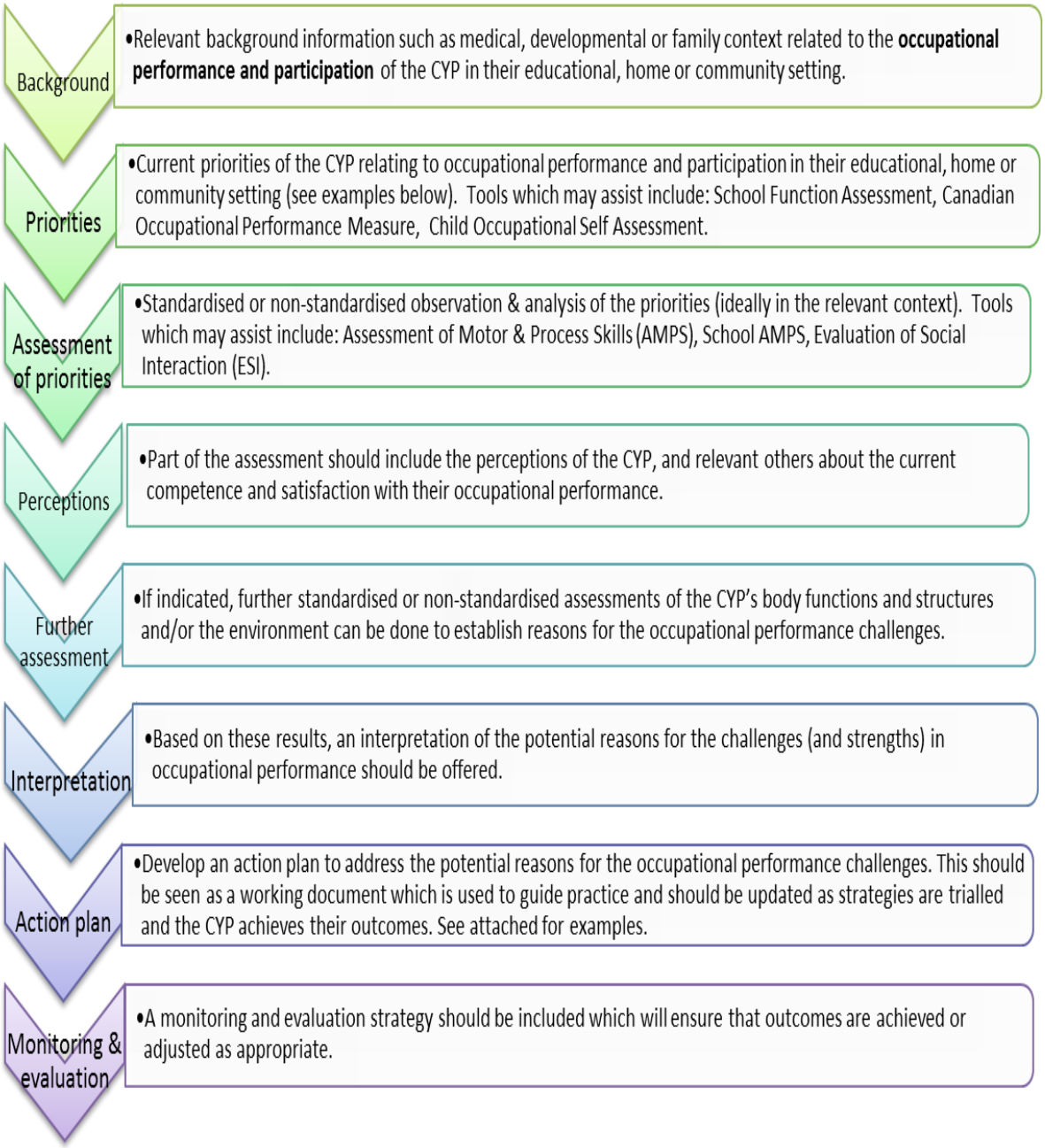
Occupations refer to everything people do in the course of their everyday life. When determining **occupational priorities**, consideration should be given (but not limited to) the following areas:

Education setting	*For example:*
In the classroom	• *Completing written work for various subjects (including using the computer)* • *Completing craft or maths projects including the use of tools and equipment* • *Playing sport and participating in physical education* • *Following directions for an activity* • *Working in a group to do a school project* • *Packing up and tidying a desk*
In the playground	• *Playing/socialising in the playground at break time*
Arriving & leaving school	• *Arriving at school and carrying out the morning school routine* • *Leaving school and getting home*
Self-care including toileting activities	• Going to the toilet • Getting changed for sport
Moving around the educational setting	• *Finding the way around the school* • *Lining up to go back into the classroom*
Mealtime or snack time	• *Participating in breakfast club* • *Eating lunch / school dinner*
Other school/college participation:	• *Participating in assembly / school concerts/ clubs* • *Going on school trips*
At home	*For example:*
Personal activities of daily living	• *Waking up and getting out of bed/ going to bed and sleeping* • *Accessing and moving around the house and garden* • *Brushing teeth* • *Using the toilet (including managing menstruation)* • *Having a bath or shower* • *Getting dressed* • *Sexual awareness and sexual activity as appropriate* • *Eating breakfast / lunch / dinner / snack* • *Organising yourself to go out*
Doing homework	• *Planning what to do and completing homework tasks*

Household chores	• *Washing the dishes* • *Tidying a bedroom* • *Setting the table* • *Watering the plants* • *Feeding / grooming / walking pets*
Play & leisure	• *Playing a game or socialising with a sibling / friend* • *Playing outside* • *Reading a book* • *Listening to music* • *Riding a bike*
In the community	*For example:*
Moving around the community	• *Using the bus or train* • *Walking or cycling in the community*
Play & leisure	• *Going to the cinema/shopping with friends* • *Playing sport, going swimming or going to the gym* • *Going on holiday* • *Going on a date* • *Attending Scouts / Guides / Brownies or other structured groups*
Work, appointments & errands	• *Going to appointments or meetings* • *Going to the supermarket / bank / post office* • *Doing a part time job / volunteering*

Q2. What should the report contain?

A. Any reports must adhere to the Health and Care Professions Council's standards of proficiency for occupational therapy (please see http://www.hcpc-uk.org.uk/). While there are principles which should be adopted when writing reports for this process, there is no set way of writing advice. It would be sensible to check locally produced documentation developed with education authorities, for practitioners who are contributing to co-ordinated support plans. These may differ between education authorities and between countries. As a general outline the following headings could be used:



Q3. What might an action plan look like?

A. There may be local variation on the format of action plans so please consult with your local authority. Below is an example of an action plan which emphasises the outcomes for the child. Further detail outlining the steps to achieving these outcomes would be required and these could be included in the occupational therapy notes.

Occupations	Desired outcome: what this means for the child	Actions: What will be done and who will do it	Resources (including frequency)	Example of type of provision
Arriving at school	Joshua will find his peg and hang his coat and bag up, by October 2014.	• The class teacher will move Joshua's coat peg to the end of the row, and work with all the children to develop ways of identifying individual coat pegs. • The occupational therapist will work with Joshua and the learning support assistant to develop skills for taking off and putting on his coat.	During the Autumn term 2014, the occupational therapist will visit the school three times and work in collaboration with the teacher to establish, monitor and review strategies. Also daily support from school staff.	Therapy and school provision
Participating in breakfast club at school	Joshua will get his choice of breakfast and find a place to sit at breakfast club, by November 2014.	• The occupational therapist will work with the breakfast club staff to arrange a consistent place for Joshua to sit each day. • The occupational therapist will work with Joshua and his family to plan what breakfast Joshua will choose each day.	During the Autumn term 2014, the occupational therapist will visit the school three times and work in collaboration with the breakfast staff to establish, monitor and review strategies. Also daily support from school staff and family.	Therapy, school provision and family support
Riding a bike at home	Joshua will be able to get on his bike, pedal and stop, by April 2015.	• Joshua will attend the occupational therapy bike riding group to develop his riding skills. • Joshua and his parents will practice riding with the support of the occupational therapist.	During the Autumn half term week Joshua will attend the bike riding group. Weekly support from the family and up to 2 visits from the occupational therapist.	Therapy provision and family support
Attending Scouts	Joshua will be able to attend and participate in Scouts, by October 2014.	• The occupational therapist will liaise with the Scout leader and negotiate strategies to assist Joshua participate in the Scout activities.	The occupational therapist will visit the Scout group and provide three additional telephone consultations to support the Scout leader to grade and adapt the activities.	Therapy provision, community and family support

Q4. To whom is my primary obligation, when writing reports?

A. The occupational therapist's primary obligation is to the child or young person. You have a professional obligation to be clear and make specific recommendations relating to the child's needs within his/her educational, home and community environment. This is a legal document and practitioners do not have an obligation to adapt their recommendations to suit their employer, the local authority, the family, or the available resources.

Q5. What should I consider when making recommendations?

A. Any recommendations should clearly state whether the occupational therapist will:

- be involved in determining environmental adjustments within the school;
- provide specific recommendations for equipment;
- involve direct therapy intervention with the child;
- take an advisory role with school staff

The occupational therapy intervention that is recommended **must be based on what the child needs**, and **what is appropriate** for the child. It should **NOT** be based on, or influenced by, what is available, what is the least that is required, or what would be deemed a "luxury" service. **This is of paramount importance should you be called to a tribunal.**

Rationale supporting the type of intervention currently (or to be) provided should be included. This may require information from assessments, observations and your subsequent reasoning. It is good practice to ensure that all recommendations are evidence-based, wherever possible. Recommended provision needs to be explained in relation to the identified objectives. Should the process go to appeal, you may have to justify your report at a tribunal.

If you are already providing input, state if the child has made progress (quantitative or qualitative) from your approach and state in which areas progress has been made. Provide any evidence to support this, e.g. outcome measures or feedback from school staff.

Quantify the recommended input in terms of frequency and time frames. This needs to be specific enough to make it enforceable, but needs to be flexible to meet the changing needs of the child.

Q6. How should I decide upon the frequency of input?

A. This will of course be based on your reasoning. A guide to the frequency of the provision should follow the effectiveness of your actual practice. For example, if your current practice is monthly input with daily follow up from classroom assistants and this is successful, then your recommendations should be consistent with this. When determining the level of therapy in the recommendation, the balance should be more than just the minimum but does not have to be the maximum possible, i.e. it should be more than adequate. Children are entitled to receive the therapy that they require.

You will also need to give the rationale for how the therapy input is to be provided e.g. spread evenly over the year, or provided in a block/s. You will also need to state when the child will be reviewed and any implications of this, e.g. if goals are met how this will change the input.

Q7. What factors will be important if I am recommending indirect therapy or a whole class approach?

A. You may determine that a universal or targeted approach would benefit the child rather than only one-to-one intervention. If the type of intervention is to train teaching assistants to deliver the therapy, then there must be reference to what this will entail, e.g. provision of hand-outs, expected outcomes and how this will be monitored. You can argue that occupational therapists can work at three major levels (Arbesman et al 2013):

Level 1: Whole – population or universal programmes designed for all children and young people. For example:

- Working with teachers in the classroom has improved the legibility, speed and fluency of children's handwriting (Case-Smith et al 2012)

Level 2: Targeted, or selective services designed to support children and young people who are at risk of poorer health or wellbeing outcomes. For example:

- Social behaviours of adolescents on the autism spectrum were improved through an occupational therapy programme based on role play (Gutman et al 2012).

Level 3: Intensive, or specialist occupational therapy services provided for children and young people with identified mental, physical, emotional, learning or behavioural needs which impact on their participation in life roles. For example:

- Working with children with acquired brain injury using an individualised intervention approach - Cognitive Orientation to Daily Occupational Performance (CO-OP) that teaches cognitive strategies necessary to support successful performance (Missiuna et al 2010).

Further information on these approaches can be found in the College of Occupational Therapists evidence factsheet: Occupational Therapy for children and young people (free to download from the www.cot.co.uk).

Q8. How specific do I have to be in the provision of my recommendations?

A. The law states that in most cases provision should be specified. The tendency is for hours to be specified. In a considerable number of cases, this may actually underestimate the amount of time the therapist is providing the child. Therefore, it may be more prudent and practical for the word "sessions" to be used as there will be many sessions which will often exceed the allotted time specified and therefore the recommendations risk underestimating therapeutic input.

Q9. Do recommendations just cover how the child is now?

A. Recommendations can include expected future needs. You can also accommodate the changing needs of the child by saying that you will do **X** and depending on the outcome will provide either **Y** or **Z**.

Q10. Can I name a specific school for a child?

A. An occupational therapist cannot recommend or name a specific school, but the advice given about the child's needs can help guide the local authority's and parent's decision, e.g. the assessments that have been done may indicate the need for an alternative type of placement for the child.

Q11. Can I use a general report that I have previously written as my contribution to the process?

A. It is not good practice to use reports that have not been written for the purpose of contributing to the Education, Health and Care Plans (EHCP) / Coordinated Support Plan (CSP) / Statement process as these may not adequately reflect the purpose of this report. However, recent reports can be amended and used if they are deemed suitable.

In Scotland, often the contribution to a CSP is through the Local Authorities' paperwork, by filling in a form. In many cases this was developed with local allied health professionals. The evidence presented at a Tribunal may well include previous reports / paperwork (e.g. seating profiles etc.)

Q12. Do I need to review a child before writing a report?

A. If you have not seen a child, whose case is still open in your department within a reasonable time (for that child) e.g. 6 months, it would be good practice to review them before writing the contribution for the Education, Health and Care Plans (EHCP) / Coordinated Support Plan (CSP) / Statement.

Q13. What should I do if I receive a request for a contribution for a child that has been discharged from the occupational therapy service?

A. If the child has been discharged from a caseload, and the practitioner subsequently receives a request for a contribution to the Education, Health and Care Plans (EHCP) / Coordinated Support Plan (CSP) / Statement process, they should inform the local authority of the child's discharge.

Q14. Is there anything else that I should consider?

A. Occupational therapists need to consider the following points:

- Practitioners should only be assessing and providing recommendations and advice within the limits of their expertise and knowledge. (COT 2010, Section 5.1).

- The involvement and agreement of the parents, and young person (as appropriate), is a key principle of the process. It is good practice for parents to know the content of the occupational therapy advice/report before it is sent to the local authority. If the parents subsequently ask the practitioner to change the report, they are not obliged to do so, as this is the professional opinion of the occupational therapy practitioner.

- Contribution to Education, Health and Care Plans (EHCP) / Coordinated Support Plan (CSP) / Statements for children who are active on a practitioner's caseload should be made within deadlines specified within the legalisation as these are legally binding timeframes.

- It is important that the local authority is informed when the input changes from that written in the final Education, Health and Care Plans (EHCP) / Coordinated Support Plan (CSP) / Statement. This would usually, (but not necessarily), be communicated at annual reviews of progress.