Rhyming Storybooks
Address Safety for Children With an ASD

“Playground Safety: The Slide”

The playground’s where we go and play
When we have recess every day
The big slide is my favorite part
I go there first when recess starts
When I go down the big slide here
I make sure that the bottom’s clear
I will be safe when having fun
Or else I’ll slide into someone
I will sit down each time I ride
Since that’s how I should use the slide
If my friends would like to share
I’ll let them slide too when I’m there

PLUS
Sensory Tools for Teens
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CE ARTICLE
Planning Emergency Evacuations for Students With Unique Needs: Role of Occupational Therapy
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OT Practice, November 23, 2009

FEATURES

Rhyming Storybooks To Address Safety for Children With an ASD
Lisa Jucket and Tara J. Glennon show how using rhyme and rhythm may help children with an ASD to retain safety information.

Using Sensory Tools for Teens With Behavioral and Emotional Problems
Cathy Dorman, Lindsey Nowphony Lehsten, Mary Woodin, Renee L. Cohen, Jo A. Schweitzer, & Janice Trigilio Tona describe a program in which teens are taught how to self-regulate to improve their behavior.

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All plans may vary and may not be available in all states.
Older Driver Safety Awareness Week

OTA is pleased to announce the inaugural Older Driver Safety Awareness Week, which will take place annually during the first full week in December. Between December 6 and 12 this year, Older Driver Safety Awareness Week will aim to raise awareness and increase education across the country by informing the public that the aging driver has options. Rehabilitation offers education, evaluation, modifications, and training. Empowered with information, facts, and strategies, people across America can facilitate the contribution of our aging neighbors by understanding the importance of mobility and transportation to ensure that the older adult remains an active and vital part of the community—shopping, working, or volunteering—with the confidence that transportation will not be the barrier that keeps him or her at home. Throughout the week, OTA will bring attention to a different aspect of older driver safety:

- Monday, December 7: Family Conversations
- Tuesday, December 8: Screening/Evaluations
- Wednesday, December 9: Driving Equipment/Adaptations
- Thursday, December 10: Taking Changes in Stride
- Friday, December 11: Life After Driving

For more information, please visit www.aota.org/OlderDriverWeek.

Membership Highlight

The Special Interest Section Quarterly newsletters feature articles on specialized areas of practice. The following are just a few of the topics that appear in the December issues. All Quarterly newsletters are available online to AOTA members, starting with the 1998 issues. You can find them at www.aota.org.

- Administration & Management: Recruiting and Retaining Our Newest Professionals
- Developmental Disabilities: Camp Open Arms: A Unique Approach to Constraint-Induced Movement Therapy
- Early Intervention & School: Oral Motor Interventions and Cerebral Palsy: Using Evidence To Inform Practice
- Education: Using High-Fidelity Simulations To Prepare Occupational Therapy Students for Intensive Care Unit Practice
- Gerontology: Reducing Fear of Falling Through Guided Imagery
- Home & Community Health: Community Mobility: It’s Not Just Driving Anymore
- Mental Health: From Clinician to Consultant: Use of a Sensory Processing Framework in Mental Health
- Physical Disabilities: The Shoulder Simplified: A Holistic Approach Within an Evidence-Based Practice
- Sensory Integration: Trauma- and Attachment-Informed Sensory Integration Assessment and Intervention Technology: Discovering the Power of Technology Through Service Learning
- Work & Industry: Preventing Work-Related Low Back Injuries: An Evidence-Based Approach

Scholarship Project by Occupational Therapy Students

The Scholarship Project by Occupational Therapy Students (SPOTS) is a recently launched mission from AOTA’s Assembly of Student Delegates to address Centennial Vision priorities as set by the Board of Directors. The main focus of SPOTS is to highlight, acknowledge, and reward occupational therapy student research endeavors. Currently, posters at the 2010 Annual Conference & Expo in Orlando and students who participate in presentations at AOTA will be recognized. As the program expands, AOTA will rank the student research projects through the system already in place for AOTA Annual Conference submission. The highest scores will be acknowledged and awarded. Although SPOTS is still in development, the mission focuses on continuing the research endeavors of students as they proceed into career development as clinical professionals. It promotes the Centennial Vision’s research agenda and the need for our profession to facilitate evidence-based practice.

New School Mental Health Fact Sheet

A new school mental health fact sheet has been developed to articulate the role of occupational therapy within a public health model including promotion, prevention, and...
AOTA BULLETIN BOARD

FROM AOTA PRESS

Sensory Integration: A Compendium of Leading Scholarship
Edited by Charlotte B. Royeen, PhD, OTR, FAOTA, and Aimee J. Leubben, EdD, OTR, FAOTA

C omplexity, complementary approaches, and trends for sensory integration, and includes 45 recently published articles from a wide range of sources. Six sections tackle every angle of sensory integration, including definitions, diagnosis, assessment, intervention effectiveness, research creation, and living with an autism spectrum disorder. $55 for Members, $79 for Nonmembers. Order #1248

Edited by Heather Miller-Kuhaneck, MS, OTR/L, BCP

T his must-have update addresses vital new topics, such as social skills, school-based practice, sensory integration, alternative and complementary approaches, and play. It also describes a new autism spectrum disorder diagnosis. Chapters present diagnostic criteria, assessment and intervention, sample assessment tools, and case studies. $39 for Members, $55 for Nonmembers. Order #12134

AOTA CEonCD™
Evidence-Based Review of Interventions Used in Occupational Therapy for Children With Autism Spectrum Disorder
Presented by Jane Case-Smith, EdD, OTR/L, FAOTA

O riginally, this course was presented as an AudiolnSight™ Seminar entitled Autism: Evidence for the AOTA Practice Guidelines in December 2007. It has since been expanded to include more information on what was learned from the evidence, descriptions of the effects of various interventions, and how that information can be applied to occupational therapy practice with children with ASD. $68 for Members, $97 for Nonmembers. Order #4830

AOTA CEonCD™
Sensory Processing Concepts and Applications in Practice
Presented by Winnie Dunn, PhD, OTR, FAOTA

P articipants will examine the core concepts of sensory processing based on Dunn’s Model of Sensory Processing. The course explores the similarities and differences between this approach and other sensory-based approaches, examines how to implement the occupational therapy process, and reviews evidence to determine how to create best practice assessment and intervention methods. Lesson topics include core concepts of sensory processing, explaining sensory processing concepts to others, assessing and interpreting sensory processing patterns, evidence-based intervention planning, applications to school practice, and directions for the future. $68 for Members, $97 for Nonmembers. Order #4834

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Fieldwork Educators Certificate Program Workshop

A s an occupational therapy fieldwork educator, your knowledge, supervision, and direction are critical to the success of your students and to the future of occupational therapy. AOTA is pleased to offer you the opportunity to advance your skills in this important area through the Fieldwork Educators Certificate Program (FWECP). Designed specifically for fieldwork educators and academic fieldwork coordinators, this unique 2-day training will be held in convenient workshops throughout the country. Here’s what you can expect to gain:

■ Deeper understanding of your role as a fieldwork educator
■ Effective strategies to integrate learning theories and supervision models
■ Increased skills to provide high-quality educational opportunities during fieldwork experiences
■ Interaction with trainers through dialogue and reflections about fieldwork
■ Engagement in four curricular modules: administration, education, supervision, and evaluation
■ Analysis of strategies to support best practice in fieldwork education
■ Continuing education credit (15 contact hours) toward licensure renewal

For more information on this program, including a list of currently available regional workshops, visit the AOTA Web site at http://www.aota.org/Educate/EdRes/Fieldwork/Workshop.aspx.

Intersections

Alzheimer’s Association Releases Recommendation

The Alzheimer’s Association is providing definitive information and support to professionals caring for someone with Alzheimer’s disease at home with its new Dementia Care Practice Recommendations for Professionals Working in a Home Setting. This fourth set of Recommendations emphasizes a person-centered, culturally sensitive care approach to meet the changing needs of each person with dementia and his or her family living in a home setting. These recommendations provide concrete, evidence-based practice suggestions for addressing issues unique to people with dementia living in the community, including understanding behaviors, communicating and decision making, safety and personal autonomy, and more. AOTA member Catherine Verrier Piersol, MS, OTR/L, clinical director of the Living Laboratory for Elder Care at Thomas Jefferson University, worked with the Alzheimer’s Association in reviewing the new recommendations. For more information, visit www.alz.org.

Research Highlights

Funding From NIDRR

The Rehabilitation Institute of Chicago received funding from the National Institute of Disability and Rehabilitation Research (NIDRR) to serve as a rehabilitation research and training center on improving...
measurement of medical rehabilitation outcomes. Occupational therapists involved with this program include Trudy Mallison, PhD, OTR/L, NZROT; and Joan C. Rogers, PhD, OTR/L, FAOTA.

New Autism Research Funded
Roseann Schaaf, PhD, OTR/L, FAOTA, an associate professor and vice chairman of the Department of Occupational Therapy at Thomas Jefferson University, was awarded a grant from the National Institutes of Health to study sensory dysfunction in children with autism and serve to inform occupational therapy interventions for these children.

Schaaf hopes this research will provide insight about the neural and physiological mechanisms of sensory dysfunction in autism and serve to inform occupational therapy interventions for these children.

Practitioners in the News
Cynthia S. Bell, PhD, OTR/L, received the Award for Outstanding Practice in Clinical Education 2009 from the North Carolina Occupational Therapy Association. Bell was recognized for her exceptional work as an academic fieldwork coordinator. She is an assistant professor of occupational therapy at Winston-Salem State University.

Idaho State University occupational therapy students recently conducted a CarFit event at the University. The event received coverage from the local press and took drivers through a 12-point safety check. The OT students plan to host another CarFit event in the future.

Susan L. Murphy, ScD, OTR/L, assistant professor at the Department of Physical Medicine and Rehabilitation at the University of Michigan, received a fellow award from the Gerontology Society of America, Health Sciences section. The fellow award recognizes outstanding contributions in the field of gerontology.

Darlene Perez-Brown, PhD, OTR/L, was recognized by the North Carolina Occupational Therapy Association for her efforts with intercultural fieldwork opportunities for occupational therapy students. Perez-Brown established a collaborative partnership with Santa Paula University in Costa Rica, and this summer she traveled to Costa Rica with six occupational therapy students for an intercultural experience.

OT Practice • November 23, 2009
Keeping the Habilitation in and out of Rehabilitation

Tim Nanof

As the health reform process continues to unfold, an important issue has not been getting the attention it deserves in Washington. Included in the reform proposals are Congressionally prescribed lists of services that all new insurance plans must be provided by any new plans, regardless of whether they are public or private. Amid the political wrangling, far too little attention has been paid to the critically important section listing the required benefits packages.

AOTA Federal Affairs staff reviewed each piece of House and Senate legislation to gauge what potential impact each bill might have on access to and reimbursement for occupational therapy services. Initially in the House bills and the Senate HELP Committee bills AOTA was pleased to find the benefits language included rehabilitation and habilitation services as benefit categories that all new insurance plans would be required to cover.

The Problem: The Senate Finance Committee, which is probably the single most powerful Committee with jurisdiction over health care, left out rehabilitation and habilitation services from its list of required benefits categories. In early discussions with the Committee, AOTA was assured that occupational therapy would remain a covered service under hospital and outpatient services, but that the Committee did not deem it necessary to explicitly require rehabilitation and habilitative services.

The Course: AOTA’s response was swift and sure. Immediately we reached out to APTA to combine our efforts, and sent a joint letter to Chairman Max Baucus (D-MT) and Ranking Member Charles Grassley (R-IA) of the Finance Committee, making the case for the importance of a rehabilitation and habilitation category of services. Additionally, AOTA staff used their leadership role with the Consortium for Citizens with Disabilities (CCD), a coalition of approximately 100 national disability organizations working together to promote public policy that meets the needs of people with disabilities, to rally support for including rehabilitation and habilitation as part of the required benefit category in the final health reform bill. Through that effort and direct negotiations with Finance Committee staff, CCD and AOTA were assured that if two senators expressed their support for including the rehabilitation and habilitation language to the Finance Committee they would make the necessary changes and bring their bill in line with the other Committees’ proposals.

AOTA worked collaboratively with other CCD groups to address this issue but it was direct outreach from AOTA that enlisted the support of Senator Sherrod Brown (D-OH) and Senator Patty Murray (D-WA). AOTA’s advocacy efforts and long standing relationship with both of these offices gave AOTA the ability and access to make them aware of this problem and provide them an opportunity to weigh in with the Finance Committee on this issue, about which they both felt very strongly.

The Solution: When the Finance Committee heard from the Senators, the staffs of Senators Brown and Murray were told that the Finance Committee was leaning toward accepting the new proposed language. AOTA continued its advocacy on the issue during Hill Day on October 5th when over 320 AOTA members descended on Capitol Hill to advocate for OT. On October 28th the Finance Committee released their final language explicitly including rehabilitation and habilitation as a required benefit category. The AOTA supported language is now included in all of the health reform bills and AOTA scored yet another legislative victory in the health reform process.

The Outcome: To some extent the importance of including a rehabilitation and habilitation category is clear; perhaps it is more surprising that it was originally left out of the Finance bill. Members of Congress and President Obama often talk about the importance of an inclusive system of care with emphasis on prevention, wellness, care management, and coordination, but those cannot stand without habilitation and rehabilitation. Often habilitation is not covered by insurance; this places many children with disabilities and others at a disadvantage. The inclusion of this required category of benefits is an enormous victory for AOTA and occupational therapy practitioners, but most importantly it is another way that AOTA continues to support the clients our members serve. This emphatic endorsement of the importance of rehabilitation and habilitation is particularly empowering to the most vulnerable populations, children and adults who often require long-term and previously controversial habilitative services to live life to its fullest. Sometimes it is very rewarding to be a lobbyist, especially working for AOTA on behalf of the profession of occupational therapy.
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Fall prevention goes hand-in-hand with what occupational therapy practitioners do, from being natural educators to taking a holistic look at the person rather than at individual components.

Fall Stop…MOVE STRONG, a community-based falls prevention program.

Carlucci had noticed that a lot of participants in her senior exercise classes were falling, asking about falling, or afraid of falling. Combined with Kardachi’s knowledge of evidence on fall risk, gleaned from teaching in the gerontology program, the two put their heads together and realized there was a need they could fulfill.

“As a society we’re very good at looking at fall prevention when we see someone in the hospital. They fell, they broke their hip, you teach them [how to avoid this in the future],” Kardachi says. “But let’s get to them before they break their hip.”

An OT practitioner teams up with a fitness instructor to develop a community-based program in fall prevention and education.

Carlucci taught exercise classes at various spots around New York City, and one of them, the Jewish Community Center (JCC) in Manhattan, had an expansive senior exercise program. The JCC staff had also noticed client interest in fall awareness and prevention, so Kardachi and Carlucci wrote a proposal for the Center for a trial class of their new program.

The outline of Fall Stop…MOVE STRONG was an 8-week program consisting of two parts: exercise and education. The exercise programs are led by Carlucci and were developed with modifications that evidence shows are best for fall prevention, like balance exercises. Kardachi leads the educational portion of the program.

“Almost always the first class is an education class where we talk about age-related changes and environmental factors that put us at risk for falls,” Kardachi says. “We talk about the benefits of exercise and we offer a lot of strategies for everyday situations, like getting your glasses checked and making sure you have the right shoes.”

Kardachi notes that one class specifically focuses on teaching ways to get up off the floor. “Usually we get almost everybody in the class down on the floor to practice getting up,” she explains. “And then we troubleshoot whatever else people have difficulties with, things like getting items off a high shelf or from a low cupboard, getting out of a car or taxi, or carrying heavy groceries.”

In addition to the classes, Fall Stop…MOVE STRONG also has a DVD of the exercise program Carlucci teaches, with three levels and an insert that discusses some of the risk-reduction strategies that Kardachi uses.

Kardachi notes that fall prevention goes hand-in-hand with what occupational therapy practitioners do, from being natural educators to taking a holistic look at the person rather than at individual components.

“Look at the profession’s brand—Living Life To Its Fullest,” she explains. “People have to live their lives, and just because they’re older doesn’t mean they don’t still need and want to live life to the fullest. Occupational therapy practitioners promote a healthy lifestyle and prevent injury and disability, and have practical solutions and strategies that help people get along in their everyday lives.”

In developing the program, Kardachi notes that one of the obstacles she and Carlucci came across was a sense of hopelessness older people had about their bodies, and the thought they often harbored that they’d reached a point of no return. The age of participants in the program ranged from the late 50s to late 90s, but the feeling wasn’t particularly age-related, Kardachi says. Promoting and encouraging a joy of movement and emphasis that knowledge is power added to the participants’ confidence, which changed many points of view.

“We know that fear and decreased confidence from falls can limit people from performing their necessary activities,” she concludes, “and that’s going to affect their occupational balance and their meaning in life. With that you get...
“Being a community-based program that gets to people before they enter the treatment system really works with wellness and prevention, and is our way of addressing this public health issue.”

AOTA Commission on Practice

The Transactional Nature of the Domain

Debbie Amini

Q: While reading the second edition of the Occupational Therapy Practice Framework: Domain and Process (Framework-II) I noticed that the term transactional is used to describe the relationship between the aspects of the domain. What exactly is a transactional relationship?

A: According to Dickie, Cutchin, and Humphrey, a transactional relationship is a process that involves two or more elements in continual association that reciprocally affect and influence each other. Within the context of the Framework-II, this concept is applied to the six aspects of the domain: areas of occupation, client factors, performance skills, performance patterns, context and environment, and activity demands. In print, these aspects appear to be separate and autonomous concepts that have no direct relationship or interaction. In reality, they are constantly modifying and being influenced by each other because they are being addressed simultaneously during the occupational therapy process. For example, areas of occupation are directly affected by the status of the various client factors that interact to create the performance patterns and skills that combine to make function possible. As performance changes, so do the factors, patterns, and skills. As the context and demands of an activity change, so do the ways in which the client engages in occupations. These changes in turn modify performance skills and patterns that ultimately affect the underlying client factors. Through the occupational therapy process, no aspect of the domain remains untouched or unaffected.

The transactional relationship is highlighted in Figure 1 in the Framework-II (p. 627), another addition to the second edition. This figure depicts the aspects of the domain as a Mobius strip, a non-orientable surface upon which an entity can traverse indefinitely, contacting each strip surface by moving in a linear fashion without need to change sides or direction. Figure 1 depicts the Mobius strip as being folded upon itself, giving it the three-dimensional perspective that further illustrates the dynamic transactive nature of the aspects of the domain.

Transactional relationships are differentiated from simple interactions by virtue of the ongoing nature of the relationship and, more importantly, the effect that each aspect has upon the others, which creates lasting change in all. In simple interactions, permanent change and a continual relationship are not inherent. Occupational therapy practitioners recognize that the six components of the domain are richly transactional and not merely interactional when observing the changes that occur in the mind, body, and spirit of the client as they work toward functionality and engage in desired and meaningful occupations.

Reference


Debbie Amini, MEd, OTR/L, CHT, is the director of the occupational therapy assistant program at Cape Fear Community College in Wilmington, NC. She is currently a doctoral candidate in adult education at North Carolina State University in Raleigh, NC.

Molly V. Strzelecki is senior editor of OT Practice.
Rhyming Storybooks

To Address Safety for Children With an ASD

LISA JUCKETT
TARA J. GLENNON

Safety awareness is an essential component of child development. Though all children are vulnerable to safety risks, children with disabilities are more susceptible to safety threats. In particular, children with an autism spectrum disorder (ASD), may have difficulty spontaneously acquiring safety skills, understanding dangerous situations, and recognizing the hazards of unsafe behavior, thus compromising physical safety. Therefore, many parents and caregivers of children with ASD find safety to be a significant concern. With this in mind, parents, educators, and professionals must educate children with an ASD about a variety of safety issues. For occupational therapy practitioners, safe and functional participation is a basic premise of supporting children.

Identifying the most appropriate and effective intervention strategies to address safety in the ASD population is a unique challenge. This article proposes one such strategy—the use of rhyming storybooks.

SAFETY AND ASD

Children with an ASD have a different means of learning about, understanding, perceiving, and reacting to safety hazards than do typically developing children. As such, some children with an ASD may not have the ability to judge safety risks in certain situations, and therefore require specific instruction to learn about safe behaviors. By effectively instructing children with an ASD about safety awareness, these children may be able to engage in more positive experiences overall. This instruction may also lead to less stress for families because of increased safety awareness, fewer fears and less anxiety, and better integration of their child into the community.

AOTA’s Occupational Therapy Practice Framework: Domain and Process, 2nd Edition identifies “safety and emergency maintenance” as an instrumental activity of daily living (IADL). Safety and emergency maintenance is the ability to prevent, recognize, and appropriately react to hazardous situations in order to preserve one’s health and safety. For children, recognizing and reducing the threat of hazards can affect several other areas, such as social, educational, and play occupations. Although typically developing children may comprehend safety precautions after brief instruction, children with an ASD may require alternative strategies to help them understand certain safety information such as the dangers of sharp objects, electrical hazards, and toxic substances, as well as basic fire safety and water safety issues. The rhyming storybook approach provides occupational therapy practitioners with a therapeutic option to target a multitude of safety concerns.

CHILDREN’S SAFETY DATA

As stated by Safe Kids Worldwide, “…accidental injury has surpassed disease to become the number one cause of death among children 14 and under.” Though this statistic supports the need for teaching safety awareness, it does not delineate between children with and without disabilities. This may be due to the lack of data pertaining to safety awareness for children with disabilities.

By using the National Health Interview Survey (NHIS), researchers investigated nonfatal injuries among children with disabilities. After interviewing children’s adult family members, the researchers found that children with vision or hearing disabilities, as well as attention deficit hyperactivity disorder, had a significantly higher rate of injury occurrence than children without disabilities. A related study concluded that children with emotional or behavioral problems had a higher injury rate than children without disabilities; however, there was no statistically significant data to support that a child’s type of disability had an impact on the characteristics of injury. Although these two studies are not directly related to children on the autism spectrum, they may shed light on issues within the safety realm of the ASD population due to the similar underlying factors of decreased processing of sensory information, attentional issues, and emotional or behavioral concerns among the subjects.

Safe Kids Worldwide recognizes the need for safety awareness programs for children and has identified specific safety risk categories with which parents and adults should become familiar: airway obstruction, bicycle safety, car safety, falls, fire and burns, pedestrian safety, poisonous substances, and water safety. In a survey designed to identify the most pressing safety risks for children with an ASD, parent respondents identified stranger awareness, traffic and pedestrian safety, emotional security, bullying, and hygiene to...
Using rhyme and rhythm may help children with an ASD to retain safety information.

"Playground Safety: The Slide"

The playground’s where we go and play
When we have recess every day
The big slide is my favorite part
I go there first when recess starts
When I go down the big slide here
I make sure that the bottom’s clear
I will be safe when having fun
Or else I’ll slide into someone
I will sit down each time I ride
Since that’s how I should use the slide
If my friends would like to share
I’ll let them slide too when I’m there

be the most important safety concerns, whereas professional respondents (occupational therapy practitioners, school psychologists, special education teachers, speech pathologists, and paraprofessionals) identified stranger awareness, fire safety, playground safety, school bus safety, and car safety as most important. These differences in safety concerns between parents and professionals demonstrate how the numerous safety needs of children with an ASD vary based on the children’s environment.

STORIES AS APPROPRIATE INTERVENTION TOOLS

Storybooks are common tools used to educate and entertain children. Storybooks have been used in a therapeutic manner to help children reduce their stress, anxiety, or grief by identifying with the characters.

Social stories, which use a story-like format to educate children with an ASD about proper social behaviors, use a prescribed format for story construction. Research has indicated, however, that the recommended social story format “is based on Gray’s preferences rather than on specific theoretical or empirical rationale” (p. 219). Some social stories aim to decrease undesired behaviors, whereas others attempt to increase desired behaviors. Several studies on social stories have shown positive results, although the research designs had limitations of small sample sizes and some difficulty controlling for confounding variables such as incidental teacher prompts.

Additionally, investigators performed a literature review of 16 social story research studies that used one or more inappropriately modified story (six stories total), meaning that the stories did not follow Gray’s construction format. However, these six modified stories elicited a higher effectiveness score among participants than those using Gray’s complete format. Recently, another such study with 45 participants concluded that other story formats were equally as effective in improving game play skills in children with an ASD. These suggest that alternatives to the uniform structure of social stories may also be effective for children with an ASD. Despite the lack of evidence to support a specific story format and the need for more empirical research, concise storybook interventions appear effective for promoting desired skills within the ASD population.

USING RHYME AND RHYTHM

Young children with and without disabilities are commonly exposed to rhymes during childhood. Nursery rhymes provide children with enjoyable ways to learn new information, while the beat, emphasis, and intonation of rhymes help embed patterns of information into their memory. While rhyming in general is believed to help children develop reading and writing skills and phonological awareness, other skills such as memory and communication are enhanced through rhyming as well. Rhymes can also facili-
Children with an ASD may require alternative strategies to help them understand certain safety information such as the dangers of sharp objects, electrical hazards, and toxic substances, as well as basic fire safety and water safety issues.

The use of therapeutic songs to enhance social skills in children with an ASD has also been explored. In three case studies, songs were composed to help improve these children’s behavior at home. Although study limitations occurred, the children’s behavior improved after song implementation. In another study, a morning greeting song was composed for two children with an ASD in order to ease their transition into child care each morning. Each child’s performance improved with song implementation, and peer interaction improvements also were noted for one of the children.

Although not specifically applied to the ASD population, research on the Interactive Metronome (IM) also draws attention to the importance of rhythm and rhyme. IM is an electronic device that guides its user toward improving his or her timing and rhythmicity. One study supported the concept that IM planning may be effective in improving the motor and cognitive abilities of children with disabilities such as ADHD, ASD, Down syndrome, cerebral palsy, and learning disabilities, among others. Because the IM trains the user’s internal timing and rhythmic abilities, it may be an effective tool for improving a child’s sequencing and motor planning skills. Rhythmicity can also help improve neural organization of the central nervous system, thus facilitating increased motor and cognitive skills such as motor planning, concentrating, thinking, and interacting—skills that are essential for an individual to attend and learn.

SUPPORT FOR RHYMING STORIES
The key principles of Albert Bandura’s social learning theory support storybook interventions for communicating safety awareness to children on the autism spectrum. Though Bandura stated that social behavior occurs through modeling and observation, he also recognized that coding this behavior through words, images, and labels helps the retention process more than observation alone. Observations of social behavior need to be combined with other teaching strategies in order to solidify one’s understanding of social concepts. For example, although a child may observe a person walking on a wet, slippery swimming pool deck, he or she may not understand that the person is walking (instead of running) as a safety precaution. Interacting with a safety-related storybook that explains the hazards of a slippery pool deck may help children with an ASD understand the risks associated with such an environment.

Person-Environment-Occupation Model (PEO). This client-centered model focuses on the intersection of the child with an ASD, the setting in which a safety hazard might be present, and the occupational activities in which a child might be engaging. Factors affecting the child with an ASD might be his or her understanding of safety norms; memory or attention capabilities; and communication, cognitive, physical, and psychosocial skills. Factors affecting the environment may include the time of day, physical location, level of familiarity with the location, surrounding barriers, and people involved. Finally, the child could be participating in a range of occupational activities, from school-based tasks such as using rubber cement for gluing, to home-based tasks such as locating a butter knife in the kitchen. All of these examples demonstrate how personal, environmental, and occupational factors can influence how safely a child engages in his or her occupations. By understanding how the person, environment, and occupation influence safety, one can better determine the necessary factors that should be addressed within a rhyming story.

Sensory integration (SI) and sensory motor. To an extent, the concept of rhyming stories is embedded with theoretical underpinnings of the SI frame of reference. Stories written in metered rhyme may appeal to a child’s internal rhythm, thus increas-
ing his or her attention.\textsuperscript{30} Additionally, some children with an ASD have demonstrated a unique affinity to music\textsuperscript{24,40}; therefore, a similar rhythmic format, such as metered rhyme, may also appeal to children with an ASD. Lastly, studies on IM training\textsuperscript{34,35} have indicated that rhythmicity may help improve attention, sequencing, and motor planning. Both of these factors, the affinity towards music and the benefits of rhythmicity, support the concept that stories written using rhyming and rhythmic sentences may be well received by children on the autism spectrum.

CONCLUSION

Although all children need help developing their ability to recognize safety hazards and emergency situations, children with an ASD require more individualized strategies to help hone such skills. As occupational therapy practitioners attempt to support this area of functioning, one strategy can be the use of rhyming storybook interventions. Practitioners may find these storybooks to be effective preparatory tools before practicing safety skills on the school bus, on the playground, in the classroom, and so forth. Rhyming safety books may also serve as a consistent interdisciplinary intervention tool among teachers, occupational therapy practitioners, and speech-language pathologists; for example, exposing a child to the same repetitive format may ease his or her transitions to different settings where safety awareness is required. One other possible benefit of the rhyming storybooks could be carryover into the home setting. The rhyming nature of the storybook may also help create an enjoyable bonding experience for parents and children.

The reviewed literature supports the therapeutic benefits of instructional stories, as well as rhyme and rhythm. Helping a child with an ASD identify and acknowledge safety risks, as well as communicate safety threats to an adult, could be appropriately addressed via rhyming storybooks. To address the most important safety concerns as identified by parents and professionals, several rhyming stories were developed for children with an ASD.\textsuperscript{14} Though this research has identified some of the most significant safety concerns parents and professionals have for children with an ASD, future research is needed to determine the effectiveness of these rhyming stories within the ASD population. For professionals interested in creating their own rhyming stories similar to the samples provided, it is recommended that directive (telling the child what to do or what is expected) or descriptive (explaining or describing the setting or the situation) rhyming sentences be used. Sentences should only use positive language (i.e., refrain from using words such as “don’t,” “should not,” “never,” etc.), and the child may be more receptive if the story is written in the first person from his or her point of view. For more samples of these stories and for the suggested intonation for reading these stories to children with ASD, please visit the OT Practice Magazine Forum on OT Connections (www.otconnections.org).

References


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School Bus Safety
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After school there are a lot of us
Who need to get onto the bus
There are important bus rules though
These rules are very good to know:
Keep my body in my seat
Keep my schoolbag nice and neat
I can talk—it is my choice
But I will use my “inside voice”
I’ll keep my hands inside the bus
These bus rules are for all of us
Practitioners may find these storybooks to be effective preparatory tools before practicing safety skills on the school bus, on the playground, in the classroom, and so forth.


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Adolescence is a time of rapid challenges, including emerging freedoms, responsibilities, social pressures, and development of self-identity. Increased independence requires increased responsibility for self-monitoring and effectively balancing internal drives and desires with the external pressures of socially appropriate norms, personal responsibilities, and adult expectations. Some teens, attempting to fit into a social group and manage other pressures of adolescence, have difficulty controlling their impulses, which may be related to the nervous system. Impulsivity, aggression, and risky sensory-seeking behaviors may be maladaptive. Occupational therapy using a sensory-integrative or sensory-based approach may help to identify sensory needs and to develop safe and appropriate strategies for meeting those needs.1,2

The sensory integration (SI) approach has traditionally been used via direct, individual intervention. However, when selecting any intervention approach, therapists must carefully weigh the evidence of the effectiveness of various treatments (as supported in the literature), the individual client’s needs and desires, and the available resources.3,4

In terms of evidence, occupational therapy using an SI approach for adolescents and young adults with early psychosis has been shown to be more effective than no intervention and equally as effective as other means of intervention.5 In terms of client needs, for adolescents with mental health issues an SI approach during group treatment may be more desirable than direct individual intervention, because group interaction may be pivotal for their social skills development.5,6 In terms of resources, direct individual intervention may be more costly than group interventions or indirect consultation services. Furthermore, a one-on-one SI approach, including the use of specialized equipment, may not be feasible due to limited budgets or limited availability of an occupational therapy practitioner. In some cases indirect treatment, including client and caregiver training to develop sensory strategies to address sensory needs in everyday life, is a feasible alternative.

This approach includes client and caregiver education and may involve the use of weighted vests or blankets; environmental modification to decrease stimuli; sensory diets; and mobile sensory boxes, also known as sensory suitcases, to allow individuals to select sensory items to aid in sensory modulation and use them in any location.

Lindley and McDaniel studied the use of a sensory room and a mobile sensory suitcase as adjunct, indirect therapeutic modalities for 144 teens ages 12 to 18 with dual mental health diagnoses who were residents of an adolescent treatment facility.7 Occupational therapists worked with the residents to develop the sensory room, which included fiber optic lights, weighted blankets, a weighted halo, beanbag chairs, massage rollers, and other objects. It was initially staffed by occupational therapists but was later monitored by trained staff members. Residents used the sensory room when they felt agitated or in “overdrive,” and they were encouraged to experiment with the equipment to determine which items were soothing. Similarly, the mobile sensory suitcase, also developed by the occupational therapists and residents, contained sensory items that were used in a central lounge area, within sight of staff members. Residents could use these items at any time to promote relaxation and calming.

Lindley and McDaniel found that an estimated 80% of the residents demonstrated sensory processing difficulties upon admission, based on the Adolescent/Adult Sensory Profile.8 By completing a pretest/posttest self-report questionnaire, the residents demonstrated an 84% improvement in adaptive functioning, including alertness and motor skills, after using the sensory room and items in the sensory suitcase. Functional improvements included a decrease in the frequency of requested PRN medications, a decrease in the amount of time spent in seclusion and/or restraint, and less frequent

Teaching teens to self-regulate can help improve their behavior.
chewing on household items, such as the remote control.

In 2004 Diana Henry, MS, OTR/L, FAOTA, added Sensory Integration Tools for Teens: Strategies To Promote Sensory Processing to the library of sensory tools programs, which focus on modifying the environment and providing sensory-safe activities to promote sensory processing in children, from preschoolers (Tools for Tots: Sensory Strategies for Toddlers and Preschoolers), to children in elementary school (Tools for Teachers: Sensory Integration in the Schools), to adolescents (Tools for Teens). The programs involve hands-on workshops conducted by Henry, along with written workbooks. The Tools for Teens program promotes collaboration between teens and their parents, teachers, and therapists. Henry’s presentations and the program handbook address topics such as the teenage brain, sensory diets, sleepy teens, thrill seekers, and teen spaces, in addition to providing healthy and age-appropriate alternative strategies that can be used for teens who are typically developing, as well as those experiencing challenges.

The Tools for Teens program was presented at the New York State Occupational Therapy Association Conference in 2007, which faculty and students from the University at Buffalo attended. During the following semester, three students chose to apply this information to an assigned project addressing nontraditional and community-based occupational therapy settings. The students used Tools for Teens with a group of adolescents with mental health issues, who were not currently receiving occupational therapy services.

SETTING
The Tools for Teens program was used at a residential treatment center (RTC) that serves 11- to 18-year-old girls with varied diagnoses, including learning disabilities, Asperger syndrome, pervasive developmental disorder, bipolar disorder, oppositional defiant disorder, or borderline personality disorder, and histories including abuse, involvement in gangs and drugs, trauma such as grief and loss, prostitution, and school truancy.

The site offers 24-hour supervision, an on-campus school, foster care, a detention program, and community-based services. It is based on a juvenile justice system model, rather than on a rehabilitative model. Therefore, it did not offer occupational therapy, physical therapy, or speech therapy for residents, though some residents had received these services prior to admission. The center was in the process of developing rehabilitation services, including occupational therapy, at the time the program was developed. The RTC could house up to 14 residents; when this program was implemented, there were 12 females ages 13 to 17 residing in two cottages of the RTC, with an average length of stay of 60 days.

PROGRAM DEVELOPMENT
In Phase I of the program development, the RTC staff identified the need to better understand and manage outbursts and other negative behaviors exhibited by the teens. After consulting with the occupational therapy students, staff members verbalized an interest in learning sensory-based techniques, and how understanding occupational therapy using an SI frame of reference could be used to meet the sensory needs of the residents. According to the director, upon admission each resident received a small “calming package” filled by staff with items such as squeeze balls, scents, lotion, and...
stuffed animals. Although the girls did not receive guidance on how to use them, these items were quite popular.

In Phase II of the needs assessment, a survey was distributed to six of the teens, who all resided in the same cottage, to learn about their occupational interests. The survey asked the teens to indicate the skills they thought were important by selecting from a list of seven skills, including obtaining employment and developing leisure skills. The survey also asked the teens to select activities of interest from a list of 20 choices, including relaxation/stress management, healthy cooking, and Internet security. A small focus group was held following the survey, and the adolescents repeatedly indicated that they did not know how to handle anger or how to calm themselves in an acceptable manner, resulting in fighting and destroying property when feeling conflicted, and biting their nails when anxious.

**PROGRAM GOALS AND OBJECTIVES**

As a result of the Phase I needs assessment, which indicated that staff were interested in increasing their understanding of sensory issues, programming goals for staff focused on identifying the teens’ sensory needs and providing appropriate activities to meet those needs. As a result of the Phase II needs assessment, which indicated difficulty with self-calming and managing anxiety, programming goals for residents focused on occupational engagement, appropriately incorporating sensory-based strategies, and demonstrating effective interpersonal communication skills to help the teens safely interact within their environment. Sensory strategies included actively participating in and exploring a variety of sensory stimuli and techniques (e.g., ball, tactile, deep pressure, relaxation, calming, and proprioceptive activities). Occupational engagement included creating a sensory-safe space by having the residents help construct equipment for sensory activities (weighted blankets, animals, and shoulder/lap snakes). The items were kept in a sensory box in the lounge area of the cottage, and the residents were permitted to use the items in this “sensory safe” area.

**Occupational engagement** included creating a sensory-safe space by having the residents help construct equipment for sensory activities. The items were kept in a sensory box in the lounge area of the cottage, and the residents were permitted to use the items in this “sensory safe” area.

Interpersonal skills included developing the ability to self-identify times to use the sensory-safe space to meet internal sensory needs, and communicating these needs with staff in an appropriate manner.

**INTERVENTION SESSION 1: MAKING SENSE OF THE SENSES**

The purpose of first session was to educate the residents about their bodies with regard to sensation and nutrition, and to administer the Adolescent/Adult Sensory Profile8 for baseline data. The session began with an introduction of the occupational therapy student leaders and group members, an overview of the purpose of the session, and an explanation of how the information would play an important role in developing a sensory-safe space for the teens. The occupational therapy students used a visual cue board to present icons for each of the five senses as they facilitated a group discussion. Then the two unconscious senses (proprioception and vestibular) were taught in a very basic manner.
group discussion regarding the sensory equipment and how it affected each group member individually.

**INTERVENTION SESSION 2: MAKING GEAR FOR THE SENSES**

The purpose of this session was for the residents to construct two weighted blankets, five weighted stuffed animals, and two weighted shoulder/lap snakes. They also participated in a group discussion on the purpose and use of the crafted sensory equipment.

Calming music was played as the girls were divided into two groups of three to work on separate aspects of the weighted tie blankets. One group was given two pieces of fleece, each about the size of a twin bed sheet, with Velcro-closing pockets ironed onto one piece. These residents began by pinning the two pieces of material together and cutting fringe along the entire perimeter of both pieces. They then tied knots in the fringe to connect the two pieces. The second group remained seated at the table and measured ½ cups of dry beans into zipper plastic bags to be used inside the pockets as weights for

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**Figure 1. Sensory Box Rules and Equipment**

**Rules for the Sensory Box**

- Please take care of the items inside the box...you helped to make these items...be PROUD of them.
- The sensory box is only to be used with permission from a staff member.
- After using the items, put them back in the box neatly.... They do not go into your room.
- If an item is broken, please give it to a staff member.
- Share the items with other girls.
- Enjoy!

**Equipment for the Sensory Box**

**Weighted Deep Pressure/Calming Equipment**

1. **Weighted Blanket:** The blanket provides deep pressure to the overall surface of the body. This extra pressure helps to calm and organize you when you are feeling anxious or upset. The blankets are washable, but be sure to remove the bean bags before washing.

2. **Weighted animals, lap/shoulder snakes:** The items provide you with extra weight and deep pressure to help calm and organize yourself when you are stressed out or upset.

3. **Spandex Hugs:** This is wrapped around your shoulders, then you pull the ends tightly around yourself. It provides deep pressure to the shoulders which helps to calm and organize you. The spandex hugs are washable.

4. **Large Ball:** The ball can be used to sit on, bounce on, or roll over the body. The ball provides pressure to the body which helps to calm and organize you when you feel anxious or stressed out.

5. **Music Maker:** The music maker has a variety of soothing sounds. It can be plugged in or battery operated. The music helps provide a soothing feeling to help and focus you during times of a lot of stress or when you need to pay attention.

6. **Moon Sand:** Moon sand can be a calming and relaxing activity that also helps to relieve anxiety. The ball can be used to sit on, bounce on, or roll over the body.

7. **Rice and Bean/Cornmeal Container:** Running a mixture of rice, beans, and cornmeal over your hands is a way to de-stress by pulling, squeezing, or stretching it. It provides input to your joints, which can be calming or stimulating. You can also use this to make objects or to write your name.

8. **Silly Putty:** Silly Putty is another fun way to de-stress by pulling, squeezing, or stretching it. It provides input to your joints, which can be calming or stimulating. You can also use this to make objects or to write your name.

9. **Oral-Motor Equipment**

1. **Hard Candy/Licorice/Gum/Pretzels:** Sucking on hard candy, eating licorice sticks, chewing gum, or eating pretzels are good ways to satisfy your oral-motor needs. These activities also provide input to your muscles and can wake you up if you’re feeling tired.

2. **Bubbles:** Blowing bubbles and/or using the scented bubbles if you like to smell objects can provide sensation to your mouth, instead of chewing on pens or your nails.

10. **Scented Equipment**

1. **Lavender Air Freshener:** Many people find lavender to be relaxing. If you are feeling agitated, try opening the solid lavender air freshener and putting it near the area where you are sitting.

2. **Lavender lotion:** Spreading lavender lotion on your body can help calm you through your senses of smell and touch. Squeeze a little lotion between your hands and warm it up before you spread it on your arms and legs. You might find it more relaxing if you use firm, slow movements when you rub it in.

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the blankets. After the first weighted blanket was completed, the groups exchanged responsibilities and made a second one. They then had the option of removing stuffing from small precut stuffed animals, or using socks to make shoulder/lap snakes. The empty stuffed animals or socks were then filled with beans, poly beads, or both, and the residents sewed the animals and shoulder/lap snakes with assistance as needed from the occupational therapy students. Licorice sticks, hard candy, pretzels, and a cup of soda were provided with a brief explanation about how these items could help meet the teens’ oral-motor needs.

After cleanup, the teens were provided with an overview of the next session so they could anticipate the interaction. The occupational therapy students accounted for all scissors and needles before exiting the facility.

INTERVENTION SESSION 3: MAKING THE MOST OF THE SENSES

The purpose of this final session was to ensure that the teens and staff understood the contents of the sensory box, provide them with information on ways to expand the sensory-safe place, and evaluate the teens’ and staff members’ perceptions of and satisfaction with the program.

Each group member received a folder that contained information and pictures of the equipment in the sensory box and possible uses and benefits of each (see Figure 1), along with an individual plan with suggestions of ways to use the equipment to meet their sensory needs, based on the results of the Adolescent/Adult Sensory Profile completed in intervention session one. The staff members also received folders containing specific information regarding the use and benefits of each piece of equipment in the sensory box, along with an inventory list for the box and a therapy catalog to purchase specific equipment if desired.

Following a brief overview of the session, the residents were provided with lollipops (if desired) to address their oral-motor needs. The occupational therapy students reviewed each piece of sensory equipment (see Figure 1) with a brief explanation of possible uses and received input from group members on how they felt the equipment would be beneficial to them. Each piece of equipment was passed around the room for each group member to explore.

Interestingly, the director and executive director of the center happened to observe the latter part of this session, which provided an opportunity for the residents to demonstrate their handmade sensory projects and their knowledge of sensory processing. The teens were quite animated as they showed the administrators what they had made and how each piece of equipment would help. They were able to explain, for example, the use of a weighted blanket and the spandex hug when they were feeling anxious and needed to calm down; they also explained the use of the other items. They were able to explain the rules of the sensory box and the need for the inventory list. This was quite exciting because many of the items had been discussed in previous sessions but not yet reviewed, yet the residents had still retained the information and were able to apply it. The administrators verbalized how impressed they were in the girls’ ability to identify and address their needs, and their overall excitement and engagement in the session. The teens were simply smiling from ear to ear and were ecstatic with having the sensory box to use when they felt the need. One resident even showed the list of equipment to her grand-mother, who then purchased it for her to use individually and to keep after leaving the RTC. Following this last session, completed surveys were collected from the staff and residents. The surveys revealed that they all thought the equipment was useful, with all participants indicating “agree” or “strongly agree” on all statements.

PUTTING IT ALL TOGETHER

Overall, the goals for this program were met, in that the teens learned about their own sensory needs, identified ways to meet those needs, participated in constructing sensory equipment to do so, and learned how to advocate for themselves using appropriate interpersonal skills. The staff were educated on the SI frame of reference and demonstrated an appreciation for the use of sensory-based strategies to decrease behavioral outbursts. Unfortunately, this was a short-term program, and no objective follow-up data were collected. However, this program could be replicated in other RTCs as part of an experimental or quasi experimental research study to determine the effectiveness of Tools for Teens. For example, measuring the frequency of outbursts for a period of time before and after introducing the sensory box, and repeating the Adolescent/Adult Sensory Profile after implementing the sensory box would help determine the efficacy of this intervention. By educating teens about the sensory aspects of their bodies, the Tools for Teens program promotes independence and adaptation during a time of rapid change.
By educating teens about the sensory aspects of their bodies, the Tools for Teens program promotes independence and adaptation during a time of rapid change.

References

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_Renee L. Cohen, MS, OTR_, is an occupational therapist at Staten Island University Hospital. At the time of this project she was a student in the BS/MS OT program at the University at Buffalo.

_Jo A. Schweitzer, MS, OTR_, is a clinical assistant professor and OT academic fieldwork coordinator in the Department of Rehabilitation Science at the University at Buffalo. She was the faculty advisor for this student project.

_Janice Trigilio Tona_, PhD, OTR, is a clinical assistant professor in the Department of Rehabilitation Science at the University at Buffalo.

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As sensory integration becomes an area of rapidly increasing interest in the health care community, your scholarship on the subject is more important than ever. This exciting new book tackles every angle of sensory integration and provides you with a compendium of the latest sensory integration research, debates, and trends. It is ideal for occupational therapy practitioners, students, researchers, and health care professionals who seek to better understand this complex and fascinating field.

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Look for the AOTA Approved Provider Program (APP) logos on continuing education promotional materials. The APP logo indicates the organization has met the requirements of the full AOTA APP and can award AOTA CEUs to OT relevant courses. The APP-C logo indicates that an individual course has met the APP requirements and has been awarded AOTA CEUs.

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**December**

Ogdens, UT  Dec. 3–5  The Listening Program® Provider Certification Course. Becoming an AST Certified Provider of The Listening Program® (TLP) will not only change how you practice, but you will achieve faster results and better outcomes. TLP is a music listening therapy that provides engaging brain stimulation through listening to well-researched classical music. TLP is easy to use in the home, school or clinic setting. Get trained to offer TLP on CD or iPod with portable bone conduction technology. Now is your chance to learn a revolutionary method that improves learning, communication, behavior and self-regulation. Earn 1.4-2.5 AOTA CEUs. Also in Scottsdale, AZ, Jan. 23 and Online. Contact: Advanced Brain Technologies, 888-228-1796; or visit www.advancedbrain.com

Miami, FL  Dec. 5–15  Lymphedema Management. Certification courses in Complete Decongestive Therapy (135 hours), Lymphedema Management Seminars (31 hours). Coursework includes anatomy, physiology, and pathology of the lymphatic system, basic and advanced techniques of MLD, and bandaging for primary/secondary UE and LE lymphedema (incl. pediatric and post-amputee). Insurances cover billable issues, certification for compression-garment fitting included. Certification course meets LANA requirements. Also in Ft. Lauderdale, FL, January 16-20, AOTA Approved Provider. For more information and additional class dates/locations or to order a free brochure, please call 800-863-5935 or log on to www.acols.com

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**January**

Torrance, CA  February 19–20, 2010  R2K: Research 2010. Stress, Resilience and Sensory Integration. Pediatric Therapy Network’s eleventh annual research symposium is devoted to research on stress and resilience and their relationship to development including sensory integration and protective factors that contribute to children’s and families’ strengths, competence, and well-being. 12 contact hours or 1.2 CEUs through AOTA. PRE-CONFERENCE INSTITUTE, Feb 17-18: Measuring the Fidelity of Ayres Sensory Integration® Intervention; Presenters: Susanne Smith Rayle, MS, OT/RL, FAP-AOTA, AOTA, Paul Hymes, MA, OTR/L, FAOTA; Jeanne Fournier, MA, OTR/L, AOTA; Stefanie Polk, MA. Contact hours—9 (1 CEU). Contact Allison Young at Pediatric Therapy Network, 310-328-0276, ext. 202; allisone@ptnmail.org or visit www.pediatrictherapynetwork.org for further information.

San Diego, CA  February 20–21, 2010  Low Vision Rehabilitation: Treatment of the Older Person and Vision Loss. Faculty: Mary Warren MS, OTR/L, SCLV, FAOTA. Practical workshop teaches functional evaluation and treatment approach for adults with vision loss from macular degeneration, diabetic retinopathy, and glaucoma. Documentation for insurance reimbursement included. Appropriate for all OTs/OTAs working with older adults. Contact: www.visabilities.com, 888-752-4364; or fax 205-823-6657.

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**February**

Philadelphia, PA  Mar. 6–9, 2010  The Philadelphia Meeting—Surgery and Rehabilitation of the Hand With Emphasis on Trauma. Sponsored by the Philadelphia Hand Rehabilitation Foundation and endorsed by the Jefferson Health System. Hands-on workshops, panel discussions, surgical demonstrations and anatomy labs will comprise this five-day time efficiently packed with twelve 3-day tutorial and 1-day seminar available. Honored Senior Professors Lynn M. Feehan, PT, PhD, CHT; Wilma L. Waish, B.Occ.Thy., OTR, CHT; Mark E. Baratz, MD; Amy L. Ladd, MD; David S. Ruch, MD; Thomas E. Trumble, MD. For more information, please contact Terri Skirven, OTR/L, CHT, at 610.768.5958 or hr@handfoundation.org, or visit our Web site at www.handfoundation.org.

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**March**

Minneapolis, MN  Apr. 10–11, 2010  Eval and TX of Visual Perceptual Dysfunction in Adult Brain Injury, Part 1 UPDATED. Faculty: Mary Warren MS, OTR/L, SCLV, FAOTA. Updated course has the latest evidence based research. Evaluation, treatment, and documentation of visual perceptual deficits following CVA and TBI are addressed using a practical, functional, and reimbursable approach. Topics include hemianopia, visual neglect, oculomotor impairment, and complex visual processing. Also in Salt Lake City, UT, May 22–23 and Grand Rapids, MI, Oct. 16–17. Contact: www.visabilities.com or 888-752-4364; fax 205-823-6657.

**April**


**Ongoing**

AOTA CeOnCD™  Ongoing  Model of Human Occupation Screening Tool (MOHOST): Theory, Content, and Purpose. Gary Keilholtz, DrPH, OTR/L, FAOTA; Lisa Castle, MBA, OTR/L; Supriya Sen, OTR/L, and Sarah Skinner, MED, OTR/L. Occupation-focused practice and top-down assessment make occupational therapy unique when assessing and documenting client services. Unfortunately, therapists often turn to quicker impairment-oriented or performance-based assessments. The MOHOST occupation-focused assessment tool is comprehensive and easy-to-administer with a wide range of clients at different functional levels. This new course teaches you how to integrate a variety of information into an interview, chart review, and proxy reports to complete the MOHOST tool. Earn .4 AOTA CEU (4 NBCOT PDUs/4 contact hours). Order #4838, $125 AOTA Members, $180 Nonmembers.

AOTA CeOnCD™  Ongoing  Driving Assessment and Training Techniques: Addressing the Needs of Students With Cognitive and Social Limitations Behind the Wheel. Miriam Monahan, MS, OTR, CDRS, CDI. Occupational therapy practitioners in the driver rehabilitation area are challenged by students with non-perceptual, non-verbal learning disabilities, autism, traumatic brain injury, attention deficit disorders, and lower IQ scores. This new course is highly visual and creative in addressing critical issues related to driving assessment and training. Course highlights include skills deficits related to these diagnoses, methods and tools that address driving skills (including video review), assessment techniques to determine the readiness to drive, and intervention techniques for developing specific social and executive function skills necessary for driving tasks. Earn 1 AOTA CEU (10 NBCOT PDUs/10 contact hours). Order #4837, $249 AOTA Members, $395 Nonmembers.

AOTA CeOnCD™  Ongoing  Pain, Fear, and Avoidance: Therapeutic Use of Self With Difficult Occupational Therapy Populations. Renee R. Taylor, PhD. Discover strategies for managing three of the most common and difficult emotions in occupational therapy practice—pain, fear, and avoidance. With a school as a major context for interacting that are based on the conceptual practice model recently developed by Dr. Taylor, you will learn how to best manage these emotions and behaviors so that treatment goals can be accomplished. The model is particularly useful when therapists are having difficulty engaging clients or sustaining active participation in therapy. It is designed for practitioners and supervisors at all experience levels to identify and build upon existing interpersonal strengths and develop new skills to enhance their work. Earn 2 AOTA CEUs (2 NBCOT PDUs/2 contact hours). Order #4836, $68 AOTA Members, $97 Nonmembers.

AOTA CeOnCD™  Ongoing  Sensory Processing Concepts and Applications in School Settings. With Bonnie Dunn, PhD, OTR/L, FAOTA. Participants in this new program from AOTA will examine the core concepts of sensory processing based on Dunn’s Model of Sensory Processing. The course explores the similarities and differences between this approach and other sensory based frameworks, examines how to implement the occupational therapy process, and reviews evidence to determine how to create best practice assessment and intervention techniques. With school as a major context for children, applications within school-based practice will be also discussed and several case studies will be examined to practice implementation within everyday lives of children. In addition, the course looks at the knowledge and practice issues on the horizon as occupational therapy approaches that employ sensory processing concepts are refined. Earn .2

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**CALENDAR**

**Continuing Education**

Starting January 21, 2010

USC/WPS Comprehensive Program in Sensory Integration

Course 1: January 21–25

Course 2: March 11–15

Course 3: June 24–28

Course 4: August 6–10

For additional sites and dates, or to register, visit www.wpspublish.com or call 800-648-8857.
AOTA CEonCD™ Ongoing
Staying Updated in School-Based Practice.
Yvonne Swithin, PhD, OTR/L, FAOTA, and Mary Muhlenhaupt, OTR/L, FAOTA. Provides participants with information and practical strategies they can use to keep current with issues, trends and new knowledge related to providing services for children and youth in the public schools. Topics include current legislation such as the Individuals with Disabilities Education Improvement Act (IDEA 2004), the No Child Left Behind Act (NCLB), and Section 504 of the Rehabilitation Act. Ideas and approaches will be presented that can be implemented by an individual occupational therapy practitioner or in collaboration with other colleagues or members of a school district team. Participants will also explore web-based resources, resource manuals, education sources, collaborative methods and more. Earn .15 AOTA CEU (1.5 NBCOT PDUs/1.5 contact hours). Order #4835, $51 AOTA Members, $73 Nonmembers.

AOTA CEonCD™ Ongoing
Creating Successful Transitions to Community Mobility Independence for Adolescents: Addressing the Critical Issue of Community Mobility Skill Development for Youth with Diagnoses that Limited Daily Occupations. Addressed the critical issue of community mobility skill development for youth with diagnoses that challenge cognitive and social skills, such as autism spectrum and attention deficit disorders. Community mobility is vast in that it includes mass transportation, pedestrian travel, and driving, and is essential for engaging in vocational, social, and educational opportunities. The course is appropriate for occupational therapy practitioners practicing in educational settings and in driver rehabilitation. Earn .7 AOTA CEU (7 NBCOT PDUs/7 contact hours). Order #4833, $175 AOTA Members, $250 Nonmembers.

AOTA CEonCD™ Ongoing
Hand Rehabilitation: A Client-Centered and Occupation-Based Approach. Presented by Debbie Amini, Med, OTR/L, CHT. Describes how to use the occupation-based approach to enhance hand rehabilitation protocols without sacrificing productivity or detracting from the concurrent client factor focus. CD-ROM includes MP3 audio file of the entire course. Earn .2 AOTA CEU (2 NBCOT PDUs/2 contact hours). Order #4830, $68 AOTA Members, $97 Nonmembers.

AOTA CEonCD™ Ongoing
Evidence-Based Review of Interventions Used in Occupational Therapy for Children With Autism Spectrum Disorder. Presented by Jane Case-Smith, EdD, OTR/L, FAOTA, BCP. Identifies the primary issues in children with ASD that limit daily occupations and participation in school, home, and community settings. Based on an extensive review of the research literature, evidence-based interventions for children with ASD will be identified and described. Earn .2 AOTA CEU (2 NBCOT PDUs/2 contact hours). Order #4830, $68 AOTA Members, $97 Nonmembers.

AOTA/Genesis CEonCD™ Ongoing
Seating and Positioning for Pediatric Aging: An Occupation-Based Approach. Presented by Felicia Chew, MS, OTR, and Vickie Pierman, MSHA, OTR/L. Reviews seating and positioning from evaluation to outcome, with a concentration on interventions. Information reviewed will be applicable to a variety of settings, including skilled nursing facilities, home health, rehab centers, assisted living communities, and others. Primarily addresses manual wheelchair mobility. Earn .4 AOTA CEU (4 NBCOT PDUs/4 contact hours). Order #4831, $97 AOTA Members, $138 Nonmembers.

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ASHT Test Preparation. This intermediate-level course provides a comprehensive overview of all topics related to upper extremity rehabilitation. There are twenty-five PowerPoint chapters with over 2,000 slides and sample multiple-choice test questions accompanied each chapter. Earn 30 AOTA approved contact hours (3 AOTA CEUs/30 NBCOT PDUs). Order #4850, $300 AOTA Members, $450 Nonmembers.

AOTA CEnCD™

Experiencing the Domain and Process of Occupational Therapy Using the Occupational Therapy Practice Framework, 2nd Edition, Presented by Suzanne Smith Roley, MS, OTR/L, FAOTA; Janet V. DeLany, DEd, OTR/L, FAOTA. Explore ways in which the document supports occupational therapy practitioners by providing a holistic view of the profession. Earn 3 AOTA CEU (3 NBCOT PDUs/3 contact hours). Order #4829, $73 AOTA Members, $103.50 Nonmembers. CEnCD and text: Order #1139K, $85.60 AOTA Members, $121.40 Nonmembers.

Available From AOTA

Physical Agent Modalities: Occupational-Based Implementation of Electrical Agents (DVD), available from AOTA Continuing Education by special arrangement with Treatment2Go in St. Petersburg, FL. Presented by Paul Bonzani, MHS, OTR/L, CHT. This DVD-formatted instructional course helps occupational therapists integrate thermal agent modalities as a preparatory intervention in practice to improve client-centered and occupation-based outcomes. Evidence that identifies the effectiveness of each electrical modality intervention is presented as well as the step-by-step practical application of each device. Earn 2.5 AOTA CEUs (25 NBCOT PDUs/25 contact hours). Order #4881, $299 AOTA Members and Nonmembers.

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Available From AOTA

Under the Skin: Relating Tendon Anatomy of the Hand to Clinical Questions, Available from AOTA Continuing Education by special arrangement with Handlab, Raleigh, NC. Presented by Judy C. Colditz, OTR/L, CHT, FAOTA, and Richard S. Moore, Jr., MD. This DVD/CD set learning module scrutinizes the relationship between digital tendons and tendon gliding. Through a live course atmosphere, examine tendon pathology, demonstrate common tendon surgical procedures, and discuss the clinical significance of the exercises. Earn 3 AOTA CEUs (6 NBCOT PDUs/6 contact hours). Order #4855, $277 AOTA Members and Nonmembers.

AOTA Conference Session Webcast

Ongoing Medicare 101, Presented by Jennifer Bogenrief, Esq., and Tim Nanof, MSW. Whether you are a new therapist beginning your career or a practitioner learning a new payment system in a new setting, this Webcast offers insight and strategies that can lead to successful Medicare reimbursement. Earn .5 AOTA CEU (1.5 NBCOT PDUs/1.5 contact hours). Order #CSC115, $45 AOTA Members, $64 Nonmembers.

AOTA Conference Session Webcast

Ongoing Evidence-Based Practice Resource Directory and AOTA Occupational Therapy Code of Ethics (2005) to provide guidance on ethical issues that may also have legal and employment consequences. Earn .5 AOTA CEU (1.5 NBCOT PDUs/1.5 contact hours). Order #CSC200, $45 AOTA Members, $64 Nonmembers.
AOTA Conference Session Webcast Ongoing

Raising the Bar: Elevating Knowledge in School Mental Health. Presented by Susan Bazyl, PhD, OTR/L, FAOTA; Sharon Brandenburger Shabsy, EdD, OTR/L, FAOTA; Donna Downing, MS, OTR/L; Jennifer Richman, OTR/L, and Sandra Schelkind, MS, OTR/L. This Webcast provides an overview of school mental health (SMH) movement and how occupational therapy helps address mental health and psychosocial needs of children in schools, including service within the 3-tiered model of school-wide SMH using occupation-based practice, positive behavioral supports (PBS), and social-emotional learning (SEL). Earn 1.5 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours). Order #CSC303, $45 AOTA Members, $64 Nonmembers.

AOTA Conference Session Webcast Ongoing

Hemianopsia: Strategies Based on Research and Clinical Experience That Support Performance in Daily Occupations. Presented by Timothy Holmes, OTR/L, COMS. Homonymous hemianopsia is the most common visual impairment resulting from stroke or TBI. This short course will provide an update on what appear to be the most effective interventions for occupational performance for people with visual field loss, including research and clinical experience with scarves, identification of visual space, and optokinetic therapy. Earn 1.5 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours). Order #CSC223, $45 AOTA Members, $64 Nonmembers.

AOTA Conference Session Webcast Ongoing

Senior Mobility Choices: National Speakers Identify Opportunities for Funding, Program Development, and Education (Featuring a tool for identifying dementia-friendly transportation options). Presented by Elin Schold Davis OTR/L, CDRS; Essie Wagner, MA; Lisa Tucker, MA; Nina M. Silverstein, PhD, and Helen K. Kerschner, PhD. Occupational therapy programs have an opportunity to play a proactive role in developing services that meet community mobility needs for clients. This session enables learners to identify accessible options in their communities including those for seniors with dementia, and explores opportunities for advocacy, funding, and enhanced mobility service networks. Earn 3 AOTA CEU (3 NBCOT PDUs/3 contact hours). Order #CWS201, $79 AOTA Members, $112 Nonmembers.

AOTA Conference Session Webcast Ongoing

Paradigm Shift and Innovations in Stroke Rehabilitation. Presented by Leah S. Dunn, MS, OTR/L; Valerie Hill Kerman, MS, OTR/L, and Lisa Finnen, MS, OTR/L. A growing body of evidence indicates that intense, task-oriented therapy programs incorporating various technologies are efficacious in promoting upper-extremity function post-stroke. This workshop will highlight the potential of wearable robotics and virtual reality. Earn 3 AOTA CEUs (3 NBCOT PDUs/3 contact hours). Order #CSC300, $25 AOTA Members, $36 Nonmembers.

AOTA Conference Session Webcast Ongoing

Service Delivery in School-Based Practice: Understanding the Assistive Technology Process and Sustaining Changes in Practice. Presented by Elin Schold Davis OTR/L, CDRS; Essie Wagner, MA; Lisa Tucker, MA; Nina M. Silverstein, PhD, and Helen K. Kerschner, PhD. Occupational therapy practitioners with knowledge of the AT process as it is delivered in schools, and how it can facilitate planning and sustaining changes in practice and influencing families/education personnel to engage in collaborating with occupational therapists. This course will improve knowledge and expertise with our dynamic continuing education courses. The IWA specializes in fitness related topics which give you practical information for both yourself and your patients.

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AOTA Online Course Ongoing

Understanding the Assistive Technology Process to Promote School-Based Occupation. Presented by Beth Goodrich, MS, MEd, OTR, ATP; Lynn Gillow, PhD, OTR/L, ATP; and Judith Schooner, MEd, OTR/L, ATP. The purpose of this course is to provide occupational therapy practitioners with knowledge of the AT process to promote school-based occupations, and how to assist practitioners in considering the use of technology to increase student participation in meaningful school-based occupations. Earn 1 AOTA CEU (10 NBCOT PDUs/10 contact hours). Order #OL21, $225 AOTA Members, $320 Nonmembers.

AOTA Online Course Ongoing

Occupational Therapy in School-Based Practice: Contemporary Issues and Trends. Edited by Yvonne Swinth, PhD, OTR/L. Gain an understanding of and suggestions for service delivery and intervention strategies in school-based settings based on IDEA, the No Child Left Behind initiative, the philosophy of education, and the Occupational Therapy Practice Framework. The content of the Core Session has been updated to reflect the changes in the 2014 IDEA amendments. Core session: Service Delivery in School-Based Practice: Occupational Therapy Domain and Process. Earn 1 AOTA CEU (10 NBCOT PDUs/10 contact hours). Order #OL53BC, $225 AOTA Members, $320 Nonmembers. Elective sessions: After completing the Core session, choose supplemental sessions to further enhance your knowledge for specific school-based populations, types of settings, and service delivery issues. Each provides 1 AOTA CEU (1 NBCOT PDU/1 contact hour), $22.50 AOTA Members, $33 Nonmembers.

AOTA Self-Paced Clinical Course Ongoing

Collaborating for Student Success: A Guide for School-Based Occupational Therapy. Edited by Barbara Harlt, MA, OTR, FAOTA, and Jayne Shepherd, MS, OTR, FAOTA. Engages school-based occupational therapists in collaborative practice with education teams. Identifies key steps in initiating and sustaining changes in practice and influencing families/education personnel to engage in collaborating with occupational therapists. Perfect for learning to use professional knowledge and interpersonal skills to blend hands-on services for students with team and system supports for families, educators, and the school system at large. Earn 2 AOTA CEUs (20 NBCOT PDUs/20 contact hours). Order #3023, $370 AOTA Members, $470 Nonmembers.

AOTA Self-Paced Clinical Course Ongoing

Advancing Gerontology Excellence: Promoting Best Practice in Occupational Therapy. Edited by Susan Coppola, MS, OTR/L, BCG, FAOTA; Sharon J. Elliott, MS, OTR/L, BCG, FAOTA; and Pamela E. Toto, MS, OTR/L, BCG, FAOTA. Foreword by: Wendy Wood, PhD, OTR/L, FAOTA. Excellent resource for gerontology practitioners today to help sharpen skills and prepare for the spiraling demand among older adults for occupational therapy services. Special features include core best practice methodology with older adults, approaches to and prevention of occupational problems, health conditions that affect participation, and practice in cross-cutting and emerging areas. Earn 3 AOTA CEUs (30 NBCOT PDUs/30 contact hours). Order #49024, $490 AOTA Members, $590 Nonmembers.

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Department of Occupational Therapy

Opening for a full-time lecturer, 2-year renewable contract, to teach and advise occupational therapy graduate students starting September 2010. The position requires expertise in the interdisciplinary area of health and community systems, and this is the primary area in which the person will be expected to teach. Secondary areas of teaching may include clinical reasoning and health promotion. The position requires the person to develop teaching and scholarship collaborations with disciplines relevant to occupational therapy or occupational science, particularly in the areas of mind-body-environment interactions, cultural competence, and full participation in community living for individuals with disability or at risk of disability.

This is an exciting opportunity to lead the Occupational Therapy Department’s focus on community health. This candidate must demonstrate a commitment to health promotion and programming for people with disabilities. The Department of Occupational Therapy is located in the progressive Graduate School of Arts & Sciences, firmly rooted in the traditional hallmarks of academic distinction and bearing the resources of Tufts University—a great research institution with a rigorous intellectual culture. The school offers students and faculty alike intimate educational experiences and opportunities to explore multidisciplinary approaches.

Applicant must hold a doctoral degree by September 2010 (PhD, ScD, OTD, EdD, MD), have demonstrated ability to develop high quality interdisciplinary teaching and scholarship, and a strong promise and commitment with respect to mentoring both graduate and undergraduate students’ development in the areas of research and scholarship. Development of innovative service learning opportunities and service in the areas of student recruitment and admissions is required.

Screening of applicants will begin December 15 and continue until the position is filled. Send letter of interest, curriculum vitae and three professional references to: Michelle.Molle@tufts.edu. In addition, have three letters of reference sent directly to the same address. Tufts is an Affirmative Action/Equal Opportunity employer. We are committed to increasing the diversity of our faculty. Members of under-represented groups are encouraged to apply.

Applicant must hold a doctoral degree and experience in rehabilitation science programs are important aspects of this position. Candidates should have an active research program or the potential to develop grant-funded research projects. Our Department’s highly experienced multi-disciplinary faculty are poised to mentor junior applicants or collaborate with more senior researchers.

The ideal candidates will have teaching and research experience, with a minimum of 3 years of clinical experience preferred. Mentoring and advising students in our entry-level MOT and PhD in Rehabilitation Science programs are important aspects of this position. Candidates should have an active research program or the potential to develop grant-funded research projects. Our Department’s highly experienced multi-disciplinary faculty are poised to mentor junior applicants or collaborate with more senior researchers.

The position is available beginning July 1, 2010. Interested candidates should submit a letter of interest, curriculum vitae, and the names and addresses of four references whom we can contact directly. Application materials are due by January 15, 2010, with interviews to begin in early 2010.

Please send to: Janet Powell, PhD, OTR/L, Chair, Occupational Therapy Faculty Search Committee Department of Occupational Therapy, Tufts University, Medford, MA 02155 along with an electronic copy to Michelle.Molle@tufts.edu. In addition, have three letters of reference sent directly to the same address. Tufts is an Affirmative Action/Equal Opportunity employer. We are committed to increasing the diversity of our faculty. Members of under-represented groups are encouraged to apply.
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F-4394

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Faculty members in the Department of Occupational Therapy enjoy a collegial environment, engage in research, teach students in areas of expertise, and participate in university, community, and international service. The administration strongly supports the program with substantial resources allocated for teaching, scholarship, and service. Internal research grants and reasonable teaching loads and class sizes foster innovation and sustainability. Academic rank and salary are commensurate with credentials and experience. Interested applicants should send a cover letter, curriculum vitae, and three professional references to: Alexander Lopez, JD, OT/L, Chairperson of the Search Committee, Occupational Therapy Program, School of Health Technology and Management, Level 2, Room 467 Stony Brook University, SUNY, Stony Brook, NY 11794-8206. Applications will be reviewed until the position is filled. The University of Scranton is located in northeastern Pennsylvania. A reasonable cost of living and a diversity of urban, suburban, and rural living choices and leisure opportunities contribute to quality of life. The University of Scranton is, by tradition and choice, a Catholic and Jesuit university. It is committed to providing liberal arts education and strong professional and pre-professional programs in the context of Ignatian educational principles, especially the care and development of the whole person and a commitment to social justice. The University’s mission statement may be found at www.scranton.edu/mission. The University is committed to developing a diverse faculty, staff, and student body and to modeling an inclusive campus community that values the expression of differences in ways that promote excellence in teaching, learning, personal development, and institutional success. In keeping with this commitment, the University welcomes applications from candidates with diverse backgrounds.

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F-4380

Faculty

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Required: Doctoral degree (i.e., P.D., OTD, DHS, DPS, Ed.D., Sc.D.) or significant progress towards completing a doctorate; A.B.D.’s will be considered. Preferred: Earned doctoral degrees. All candidates must be New York State licensed occupational therapists or eligible for a New York State occupational therapy license. Successful applicants must have at least one year of higher education teaching experience in an occupational therapy program, and a minimum of five years of clinical experience in at least two different practice settings. Academic occupational therapy teaching experience is also preferred.

Anticipated effective date: As soon as possible. Review of applications will begin immediately and continue until the position is filled. Salary and academic rank are commensurate with qualifications and experience.

For a full position description or application procedures, visit www.stonybrook.edu/jobs
|JOBS Reference #: F-4380-09-09| or send a signed letter of interest (including your salary history in your cover letter), curriculum vitae, and three professional references to: Alexander Lopez, JD, OT/L, Chairperson of the Search Committee, Occupational Therapy Program, School of Health Technology and Management, Level 2, Room 467 Stony Brook University, SUNY, Stony Brook, NY 11794-8206.

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F-4440
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Faculty

Quinnipiac University—Clinical Faculty Positions

The Department of Occupational Therapy at Quinnipiac University invites applications for two 9.5-month clinical faculty positions beginning in fall 2010.

Position A: The successful applicant will be responsible for teaching in the combined BSHS-MOT curriculum as well as the online post professional master’s degree program, student advising, departmental committees, mentoring post-professional graduate students, continuing scholarly or creative endeavors, or professional service. Master’s degree required, earned doctoral degree preferred. Qualified applicants will also have at least five years of clinical practice, experience in teaching, eligibility for State of Connecticut licensure, and an established area of clinical expertise that is supported by scholarship. The clinical expertise priority for this position may be one or more of the following areas: community-based practice, cognitive rehabilitation, pediatrics including transition planning, or developmental disabilities.

Position B: We are seeking an educator with experience in traditional classroom teaching including lecture, labs, problem-based learning, fieldwork Level I supervision, and service-learning. The successful applicant will be responsible for teaching in the combined BSHS-MOT curriculum, supervising students in fieldwork Level I, supervising students in service learning, student advising, and University and professional service. Qualified applicants will have a master’s degree or near completion of a master’s degree, at least seven years of clinical practice, experience in teaching, eligibility for State of Connecticut licensure, and an established area of clinical expertise within one or more of the following priority areas: human anatomy, functional kinesiology, psychosocial practice, and developing and implementing documentation systems.

Apply online at https://careers.quinnipiac.edu. Application materials should include a letter of interest specifying the position to which the candidate is applying, curriculum vitae, and contact information for three professional references. Other inquiries may be directed to Kimberly Hartmann, PhD, OTR/L, FAOTA, Associate Professor and Chair, Department of Occupational Therapy (kim.hartmann@quinnipiac.edu).

To be assured of full consideration, applications should be received by January 10, 2010; however, applications will be accepted until the positions are filled.

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W-4412

W-4125
More than 250 occupational therapy students, and more than 40 occupational therapy practitioners, attended Capitol Hill Day on October 5, 2009, in Washington, D.C., to advocate on behalf of “Occupational Therapy: Part of the Health Care Solution” during this critical time of health care reform. The day started with a briefing by the American Occupational Therapy Association’s (AOTA’s) Federal Affairs staff to highlight the issues affecting occupational therapy in the health care reform debate, including extending the exceptions process for the Medicare outpatient therapy caps, ensuring access to rehabilitation and habilitation services, improving home health services for Medicare beneficiaries, and addressing health care workforce needs. The day was a success as the attendees visited over 95 offices of their senators and representatives from their respective states!

As a Federal Affairs intern at AOTA, I have learned the importance of student advocacy for our profession; gained a direct understanding of how policy affects practice; learned the value of networking with other students, practitioners, state and federal leaders, and members of other special interest groups to make our voices heard; and realized the importance of research in defending our profession politically. It is imperative that as students we start developing the advocacy skills that will be necessary throughout our professional careers. On Capitol Hill Day I joined three students from Shenandoah University in Virginia, and met with the staff of four of the representatives and both senators from their state. I felt we really made an impact on them to advance the interests of our profession and our clients.

Prior to Capitol Hill Day, I was able to meet with Senator John Thune (R) from my home state of South Dakota to discuss occupational therapy initiatives and how they would affect the constituents in our state. I also received the opportunity to represent AOTA at several fundraising events for various senators and representatives. At one event we discussed occupational therapy with Representative Betty McCollum (D) from Minnesota. She was wearing a wrist splint, which provided an ideal way to initiate a conversation about her experience with occupational therapy following her injury. Because she has had first-hand experience with occupational therapy services, she is a primary candidate to advocate to other lawmakers on behalf of our clients in the health care reform debate.

Developing relationships with members of Congress can open many doors for the future of our profession. After collaborative relationships have been established, we can invite our senators and representatives into our clinics and hospitals to further educate them on what we do and how we help our clients to live their lives to the fullest. From my experience, members of Congress are interested in representing the constituents from their districts, and that includes you. If practitioners and students from every state form these relationships, think of the greater impact we would have on increasing Congress’s understanding of the services we provide.

I have also discovered the importance of using research to support our initiatives. One key issue of health care reform is the idea of comparative effectiveness research. How can the profession of occupational therapy use research to provide the most effective interventions for our clients?

Because the research on occupational therapy outcomes is limited, we need to be proactive by adding to this body of knowledge. As students, we must initiate this process by submitting quality research to peer-reviewed journals. We also need to consult the research already available to help guide our decisions when determining the most effective interventions for our clients. Presenting quality research studies to lawmakers is an effective way to demonstrate the value of our services and defend our profession. Every health care group can discuss the importance of their services through anecdotal evidence; however, a stronger argument is presented when advocates have tangible research to support their claims.

AOTA consistently uses research to support various federal issues. Attending Capitol Hill Day and completing my internship with AOTA has shown me the dynamic relationship between policy and practice. I hope my experiences can motivate other students to get out there and make a difference for our profession. I am very passionate that OT is part of the health care solution, and we need to get others to believe in our role as well!

Melissa Meier is an OTD student at Creighton University in Omaha, Nebraska, and an intern in AOTA’s Federal Affairs department.
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Planning Emergency Evacuations for Students With Unique Needs

Role of Occupational Therapy

ASHA ASHER, MA (OTR/L), MED (SPED)
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This article was developed in collaboration with AOTA’s Developmental Disabilities Special Interest Section.

ABSTRACT
Emergency preparedness involves having a system in place to prevent, prepare for, respond to, and recover from emergencies. Individuals with disabilities are entitled to the same level of safety as everyone else should an emergency situation develop. Through daily practice in a public school district, occupational therapy practitioners realized that students with disabilities needed alternative emergency evacuation plans. This article describes a framework to develop individualized emergency evacuation plans (IEEPs) for students in inclusive school settings. Aspects of occupational therapy practitioners’ knowledge base and expertise that make them ideal to contribute to the planning process are discussed.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Recognize the need for practical emergency evacuation plans for students with disabilities in an inclusive school setting and the contribution of occupational therapy to that plan.
2. Identify different types of emergency evacuation situations and procedures, and relate these to the individual students with disabilities and their unique needs.

INTRODUCTION
Tony, a student with spastic quadriplegia and extensor spasms, was transported using a manual wheelchair in his school, a two-story building with a slow elevator. During fire drills, he was always removed out of the building before the alarm was set off, with the explanation, “In case of a real emergency we will just pick him up and run!” There was no consideration of how to carry a child weighing about 80 pounds, who may have extensor spasms, down the stairs while the rest of the school was using the same stairs. Nor was there a consideration of who would assist the teacher if help were needed.

John had spastic diplegia and transferred to a desk chair with maximum assist in some of his classes. During a fire drill, adult assistance was needed to transfer him back to his wheelchair and then to transport him out of the building. Typically, the only adult in the room was a regular education classroom teacher, and supervision had to be provided to the rest of the class as they evacuated the building. Therefore, a designated person was needed who knew where the student’s class was in the building at any given time, because students change locations with each period at the secondary school. This attending adult had to know the location of the accessible exits in relation to the location of each of John’s classes. At times, the nearest exit used by the student’s class was not wheelchair accessible.

Nick, a student with only one functional limb, was fully included in the junior high school, which was housed in a two-story building. He was independently mobile in a power chair, but he needed assistance to realign his trunk to midline. During a fire drill his accessible routes, availability of support personnel, and need for descending stairs changed depending on which classroom he was in at any given point.

Suzie had autism and exhibited challenging behavioral responses because of severe sensory processing difficulties. With the noise of a fire alarm and change of routine that occurred with an emergency drill, Suzie often responded by falling to the floor. This could impede the other students exiting the classroom.

Recent natural and manmade disasters emphasize the need for emergency preparedness, which involves having a system in place to prevent, prepare for, respond to, and recover from emergencies. The Americans with Disabilities Act of 1990 (ADA) guarantees that in an emergency, people with disabilities, including students with special needs in the regular education system, are entitled to the same level of safety as everyone else. Occupational therapy practitioners have a unique knowledge of a client’s capability and needs as well as an appreciation of the accessibility issues of an environment, which puts them in an ideal position to help
formulate authentic emergency evacuation plans for students with disabilities.

This article provides examples of the individualized emergency evacuation plan (IEEP), a framework and tool that can be used to plan emergency drills for students with disabilities, developed by the Occupational Therapy/Physical Therapy Department in one Midwest school district. This framework ensures that a reliable plan is developed to transport students with special needs to safety. It considers each student in every possible building location and designates specific adults for assistance. The plan addresses pertinent emergency scenarios such as fire, lockdown (when students are contained in classrooms for safety), or natural disasters (e.g., tornados, earthquakes). The framework includes guidelines for reviewing the IEEP in conjunction with the student’s annual individualized education program (IEP) and the school building's established emergency plan. The unique skills and knowledge base of occupational therapy practitioners relating to a student’s functional performance within his or her natural environment make them ideal to facilitate this planning.

BACKGROUND INFORMATION
Legal Mandates and Resources for Emergency Evacuation Procedures
Public and private schools in most states are required by their state laws (e.g., California Senate Bill 187, 1997; Commonwealth of Pennsylvania, 1978; Illinois School Safety Drill Act, 2005; Ohio Fire Code, 2007) to develop a comprehensive safety plan, which includes instructing and training the children to leave the building in the shortest possible time without confusion, by means of drills or rapid dismissals. Details are specified as to the number of drills that must be conducted during the year, the frequency of these drills, the times of the day the drills should be conducted, and the assembly points when the buildings are evacuated. Safety considerations of students with special needs are mentioned by some states (e.g., Illinois, Pennsylvania, California); however, these are not mentioned explicitly in the regulations for Ohio, where we reside.

A wide range of emergency preparedness resources is available to help schools create safe and secure environments for their students including several planning and training resources to prepare comprehensive all-hazard emergency preparedness plans (National Clearinghouse for Educational Facilities [NCEF], 2008). The ADA now has specific guidelines for accessible egress (U.S. Department of Justice, n.d.). It also directs that the unique abilities of those with disabilities be considered when planning emergency egress, and that they should be involved in the planning process. The ADA Web site gives information on drawing up detailed plans for new buildings specifying width and elevation changes for accessible routes, areas of rescue assistance, and so forth (U.S. Department of Justice, 2007). The United States Access Board (2006) specifies the need to have a system in place for emergency preparedness, which includes plans to prevent, prepare for, respond to, and recover from emergencies. The importance of putting the plans into writing with periodic review, and holding surprise drills to confirm the practicality of the plans is emphasized. The U.S. Department of Education’s Office of Safe and Drug-Free Schools briefly addresses the evacuation of students with special needs and disabilities when discussing crisis planning for schools (U.S. Department of Education, 2007). They recommend considering mental, physical, motor, developmental, and sensory limitations of children when planning evacuation and relocation procedures. Suggestions include providing accessible accommodations for individuals with limited mobility or visual impairments, alternate communication for those with hearing impairments, and awareness that individuals with developmental disabilities may get upset with changes in routine.

The NCEF reviewed best practices in school building design for accommodating the evacuation and sheltering needs of individuals with special needs or disabilities (2008). They concluded that the current ADA requirements appear to be adequate; however, they recommended that to increase the safety of students with special needs, school emergency management plans should include procedures and training for evacuating all school occupants in a variety of emergency and building conditions and by a variety of routes.

THE ROLE OF OCCUPATIONAL THERAPY IN DEVELOPING SCHOOL-WIDE AND INDIVIDUAL EMERGENCY PLANS
The expertise of occupational therapy practitioners is useful when working with those affected by disasters (e.g., Foote, 2003, 2008; Schoessow, 2009; Smith & Notaro 2009; Strzelecki, 2006). Practitioners target aspects such as evacuation and care of those with special needs as well as helping clients regain control and rebuilding their lives which includes normalizing routines (Strzelecki, 2006). Practitioners also promote the use of occupation to alleviate the effects of stressful situations and promote health by reinforcing identity, contributing to a sense of mastery, providing a diversion, and restoring habits and normalcy (McColl, 2002). The American Occupational Therapy Association (2006) has documented the role of occupational therapy in disaster preparedness by participating in the planning process, which enables a community to respond effectively should disaster strike; however, the specific contribution of occupational therapy practitioners in a school environment has not been delineated.

Emergency evacuation drills require the execution of many skills on the part of a student at school. Without prior warning, the student needs to orient to the auditory alarm, tolerate the sound, and comprehend the meaning of the alarm and the teacher’s verbal directions. In a quick, quiet, and safe manner, the student then needs to physically
respond by changing positions and moving his or her body through space to a new location, together with his or her peers. Environmental factors such as furniture placement, congested hallways, noise, lighting and temperature changes, and uneven ground surfaces, as well as social factors such as close proximity to others, can all affect the student’s reaction to an emergency evacuation drill. Occupational therapy practitioners’ expertise in positioning and mobility, motor planning, sensory impairment, sensory processing, attention, and functional communication provide essential information for the planning process.

As members of the educational team, occupational therapy practitioners can guide the design of the IEEP by applying knowledge of the student’s performance skills, physical and social environments, and strategies for assisting the student to safely manage the demands of the activity. Occupational therapy practitioners have the skills to train staff to understand the exceptional needs of a student and to use specialized methods to assist the student to participate effectively and with optimal independence in the drills. Through a collaborative model, occupational therapy practitioners and school staff can identify when and why a student is unable to follow the standard emergency evacuation procedures, design potential solutions through the specific plan, aid the student in carrying out the plan, and assess the effectiveness of the plan. The entire educational team takes ownership of the IEEP and its implementation.

**DESCRIPTION OF FORM:**

**PRESCHOOL/ELEMENTARY AND SECONDARY**

The IEEP provides a concise synopsis of the student’s abilities and needs when dealing with emergency and evacuation procedures in the school setting. Outlined in an easy-to-follow format, the plan is written so that school staff, family members, and community emergency service personnel can understand the individual plan for the student. Two IEEP formats are used to meet the needs of the student: one for students in preschool and elementary school (see Figure 1 on p. CE-4), and the other for students in secondary school (See Figure 2 on p. CE-4). Guidelines for using the IEEP form are specified (see Figure 3 on page CE-5).

**Procedure:** Every student has documentation on his or her IEP about whether he or she is able to follow the typical emergency evacuation procedure used by the class, or whether an IEEP is necessary. If used, the alternative plan is attached to the IEP, and updated with each annual IEP meeting. Additionally, the IEEP is updated at the beginning of the school year as the child changes grades and/or buildings, and then throughout the academic year in accordance with the student’s schedule changes.

**Form Content:** In addition to the student’s identifying information, the form records the following:

- **Functional performance:** A short description of the student’s posture and mobility status as required for sitting, standing, and moving between locations. Information such as floor and chair sitting balance, transfer status, and, if appropriate, weight bearing status, is beneficial to note. The student’s ambulatory status and whether an assistive device such as a wheelchair or a walker is used is described. Adult assistance for transfer and mobility needs, as well as for safety, is also delineated.

- **Communication:** A brief statement describing the student’s basic receptive and expressive communication status. It is important to state whether the child is verbal and can express his or her needs to others or is nonverbal. Information for children with limited communication abilities may consist of: “has a head shake for yes/no,” “uses an augmentative communication device,” or “cannot follow basic directions.” It is helpful to note whether an alternative method is used for the child to comprehend directives such as sign language, picture cues, or a Social Story (Gray, 2004).

- **Precautions/Health Risks:** Brief documentation of the significant factors that can affect health and safety during emergency evacuation. These issues may include muscle tone influences such as rigidity, flaccidity, or joint instability; decreased body awareness, balance, endurance, stamina, or attention; the effects of temperature; the existence of life-threatening allergies; the presence of a gastrointestinal tube, tracheotomy, or seizure disorder; or the need for regular catheterization. The need for immediate access to medication or snacks as needed for students with diabetes or asthma also is noted here.

The form further outlines the elements of the emergency evacuation scenarios, in geographically relevant situations (e.g., earthquakes in California, tornados in the Midwest) including how the student is transported, moved, and positioned, any personal equipment that may need to accompany the student, where to exit the building, or when to stay in the building. Adult assistance is documented by listing a specific staff member’s name. A back-up staff member is identified by referring to the general staff schedule. This individual is given pertinent information to assist the student should the primary support staff member be absent. If appropriate, walkie-talkies are used and listed on the form as a support.

The IEEP is customized to the student’s schedule per day and time of day because in this district students in kindergarten through sixth grade have art, music, gym, and library only on certain days of the week. The form is printed on yellow or gold paper to distinguish it from other papers, and copies are distributed to each teacher, the front office staff, the nurse, and the family. Also, a copy is placed with the child (such as in a wheelchair or walker bag), stored in each of the student’s classrooms’ red emergency bags, and...
attached to the student’s IEP. In this district, each classroom in the school building has a red emergency bag. The bag contains a first aid kit; class list; class medical forms; building administrators’ cell phone numbers; note pad and pen; district emergency action plans for possible scenarios such as fire, bomb threats, etc.; and building evacuation maps. Additionally, the bag contains red and green paddles that the teacher uses during an evacuation to inform the fire marshal from a distance whether all the students from the classroom are with him or her.

**CASE EXAMPLES**

**Preschool**

Ben is a 3-year-old who has just completed his initial evaluation through the public school district as part of his transition from early intervention to preschool services. He currently does not have a diagnosis; however, further evaluation for a mitochondrial disease is being explored. Ben wears bilateral dynamic ankle foot orthoses and either uses his Reverse Kaye Walker or crawls to get around the house. He does not use his walker in the community. His parents report that Ben will use furniture for support to move around at home.

Locomotion is Ben’s weakest ability. He exhibits a stable sitting posture in a chair or on the floor for a functional length of time, but he displays a posterior pelvic tilt with a rounded spine. He is slow to transition from sit to stand. In open spaces such as a hallway, Ben ambulates using his walker in a fast paced, unrefined, and unstable gait pattern, requiring close adult supervision for safety.

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<table>
<thead>
<tr>
<th>Evacuation: (Fire)</th>
<th>Special area class/room no./time</th>
<th>Plan</th>
<th>Adult Assistance</th>
<th>Backup</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Day</td>
<td>Art</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Day</td>
<td>Music</td>
<td></td>
<td></td>
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<tr>
<td>C Day</td>
<td>Gym</td>
<td></td>
<td></td>
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<tr>
<td>D Day</td>
<td>Library</td>
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<td></td>
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<tr>
<td>E Day</td>
<td>Computer lab</td>
<td></td>
<td></td>
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<tr>
<td>Cafeteria</td>
<td></td>
<td></td>
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<tr>
<td>Hallway</td>
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<td></td>
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<tr>
<td>Bathroom</td>
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<td></td>
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<tr>
<td>Nurse’s Office</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assemblies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bus plan in place?</td>
<td>Y</td>
<td></td>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>

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**Figure 1: Abbreviated Elementary IEEP Form Template**

**Individual Emergency Evacuation Plan**

- Date: ____________
- Name: ______________________________________________
- Homeroom teacher: ________________________  Rm No.: ____
- Teacher of Record: ________________________
- Functional performance: ________________________
- Communication: ________________________
- Precautions/Health Risks: ________________________

<table>
<thead>
<tr>
<th>Homeroom</th>
<th>Special area class/room no./time</th>
<th>Plan</th>
<th>Adult Assistance</th>
<th>Backup</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Day</td>
<td>Art</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Day</td>
<td>Music</td>
<td></td>
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</tr>
<tr>
<td>C Day</td>
<td>Gym</td>
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<tr>
<td>D Day</td>
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<tr>
<td>E Day</td>
<td>Computer lab</td>
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<td>Hallway</td>
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<tr>
<td>Nurse’s Office</td>
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<tr>
<td>Assemblies</td>
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<tr>
<td>Bus plan in place?</td>
<td>Y</td>
<td></td>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>

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**Figure 2: Abbreviated Secondary IEEP Form Template**

**Individual Emergency Evacuation Plan**

- Date: ____________
- Name: ________________________________  Rm No.: ______
- Homeroom teacher: _____________ Teacher of Record: _______
- Functional performance: ________________________
- Communication: ________________________
- Precautions/Health Risks: ________________________

In the event of a lockdown, the student will follow this alternate plan.

<table>
<thead>
<tr>
<th>Bell</th>
<th>Rm. No.</th>
<th>Plan</th>
<th>Adult Assistance</th>
<th>Backup</th>
</tr>
</thead>
<tbody>
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<td>7</td>
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</tr>
<tr>
<td>Media Center</td>
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<tr>
<td>Cafeteria</td>
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<td>Hallway</td>
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<tr>
<td>Bathroom</td>
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<tr>
<td>Nurse’s Office</td>
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<tr>
<td>Assemblies</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Bus plan in place?</td>
<td>Q Y</td>
<td></td>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>
Ben follows one-step directives but needs gestural or verbal cuing to retain two-step directives. He requires verbal models to request assistance; otherwise he displays fretful behaviors when he needs help. Ben does not yet use language to comment or to ask questions. He needs extra wait time in order to verbally respond and he becomes distressed, sometimes crying, when others use language that expresses negation, protest, or excitement. Through observations and parent report, Ben is noted to be fearful and startles with loud noises. He fatigues easily and hot and cold weather conditions affect his normal body temperature.

Preschoolers such as Ben who are ambulatory but display physical, emotional, or communication limitations that affect their speed and coordination during an emergency drill, prompted the purchase of sturdy wagons for the preschool classrooms as alternative mobility devices. During Ben’s initial IEP meeting, the school staff and Ben’s parents discussed the options to transport Ben safely during drills yet maintain his optimal independence. The team decided that in all three emergency situations, Ben would access a wagon.

During a fire drill or evacuation from the building, Ben would be assisted to climb into the wagon and wheeled out of the building by the classroom educational assistant, allowing the preschool teacher to be available to escort other children from that classroom. This would ensure the quickest and safest exit from the building due to Ben’s unstable gait pattern, his fearful and startle responses to loud noises, and his difficulty executing two-step directives. For similar reasons, Ben would be seated in the wagon during a tornado drill, and wheeled with his class into their designated building location. Ben would remain in the wagon next to his classmates who were seated on the floor, to provide him with a more stable sitting surface should he become anxious or fatigued. In the case of a lockdown, the wagon would be brought into the classroom to ensure that it was in close proximity if needed, while the students gathered together with their teacher and educational assistant in a designated corner of the room. In all scenarios, Ben’s classroom educational assistant would remain next to him throughout the duration of the drill to provide physical as well as emotional support.

**Elementary School**

Bill is a 6-year-old in the first grade who has multiple congenital anomalies. He presents with an undiagnosed genetic syndrome manifested by congenital heart disease, damage to his cranial nerves resulting in the placement of a tracheotomy tube (removed at the start of this school year) and a gastronomy tube, difficulty with smiling and speech, vision and hearing issues, and low tone and strength on the entire right side of his body. Bill excels in the regular first grade curriculum and can navigate the school environment independently. However, due to his health issues, he continues to need supervision during unstructured situations. He has poor balance, resulting in falls when he is not attentive to environmental hazards. If he were injured, Bill would require immediate medical attention from a registered nurse. An educational assistant is assigned to supervize Bill during recess, and the nurse attends to his G-tube feedings during lunch.

The entire team had to understand the ramifications of Bill’s multiple needs and find creative solutions to develop his IEP. To protect Bill from the amplification of the sound of a fire drill through his earphones, a familiar adult (either the regular homeroom teacher or the hearing itinerant aid) would reduce the volume of his hearing aids just enough to allow him to still follow directions. Bill was independently mobile but needed to be close to an adult in the event that his balance deficit resulted in a fall. He also needed specialized glasses to protect his eyes from the sunlight. It was not practical to have the six or seven pairs of specialized glasses available in every room that Bill used during the day in the event that he had to leave the building for a fire drill. The glasses could be stored in his homeroom; however, when his class was with another teacher, his homeroom teacher might be away from the classroom and not able to return to retrieve the glasses. This problem was resolved by having a baseball cap in each teacher’s emergency bag—the visor of the cap would provide temporary protection against the sunlight. One pair of the specialized glasses was kept with the nurse’s equipment, and she handed them to Bill if the class was outside for an extended time. The physician clarified that Bill could assume the “tornado-safe” position together with his classmates. (For this position the student gets on his or her knees, sitting on the calves and feet. Then the student bends forward to lie face down over the thighs, covering the back of the head with the hands.) However, because of his limited hearing, Bill was not able to understand how the situation

---

**Figure 3: Guidelines for Using the IEEP Form**

**Guidelines**

1. Forms updated quarterly
2. Distributed to:
   - A. Each teacher/bell (place in subfolders for teacher and educational assistant)
   - B. One with child (i.e., on wheelchair/walker bag)
   - C. Stored in emergency bag of each teacher
   - D. Front office
3. Identifiable folder—yellow paper in red folder
4. Copy of plan to nurse
5. Wheelchair-accessible exits to be marked on general exit routes
was progressing because the visor blocked visual cues when he lowered his head. He therefore was placed closest to his teacher for redirection and reassurance as needed.

The personnel identified to assist him were CPR certified. They were trained in his specific needs and how to ensure that he was medically safe in any emergency, while maintaining his independence. By using the framework of the IEEP, appropriate plans were drawn up for Bill that allowed him to participate in the regular education programming.

Secondary School
Alton is a 16-year-old with autism. During a medical procedure he suffered an iatrogenic insult, resulting in a T4 spinal cord injury with paralysis from the chest down. Alton is transported in a manual wheelchair and is totally dependent for all mobility and self-care. A Hoyer lift is used to move him to the mat table for pressure relief and to attend to hygiene needs. He is not allowed any oral intake because of aspiration, and receives all nutrition through a G-tube. Alton’s day is mainly within the resource room of the high school due to his medical and educational needs. His classmates are eight students with developmental disabilities, of whom six are independently mobile. The teacher has the support of at least two educational assistants. At any given time during the school day Alton has assistance from one adult which could be the teacher, a therapist, or an educational assistant. Alton has a shortened day to accommodate the increased time needed to complete medical routines at home. On arrival, he gets his medication in the nurse’s office and proceeds to his classroom. The next period he attends adaptive physical education which may involve activities in the gymnasium or on the athletic field. The rest of the day Alton participates in activities in his resource classroom, which is set up apartment style to include a kitchen, washer-dryer, and living area.

Alton’s IEEP involved a coordinated effort of all the team members, including the classroom teacher, the educational assistant primarily assigned to support him, and the occupational therapy practitioner. Additional members included the administrators to help locate safe areas within the school, the nurse to clarify medical needs, and the speech-language pathologist to address Alton’s communication needs. The team decided that during emergency drills Alton would be accompanied by a certified staff member (his teacher or the nurse) and one educational assistant. The other educational assistant would attend to the student with mobility issues, and the remaining students would exit with students from the home economics class next door. Alton’s medical fragility and heightened anxiety with unexpected changes in routine resulting from his initial diagnosis of autism, compounded by the traumatic events surrounding his T4 injury, necessitated this level of support.

As part of the IEEP process, all the wheelchair accessible exits across the school were located and marked on the school map, including some exits that were not typically used by students. The team checked Alton’s location during each period and found the appropriate accessible exit. An alternate exit route was also planned in case the primary exit was obstructed.

In case of a tornado drill, Alton would accompany his classmates to the designated safe area. The nurse and the occupational therapist advised that to protect him from further injury, Alton should not be placed in the “tornado-safe” position on the floor assumed by the others. The administrator advised that the faculty restrooms located in the area where Alton’s class takes shelter have reinforced walls, and Alton could safely stay in his wheelchair in this area.

In case of a lockdown, Alton would remain with his class. The nurse kept an additional feeding kit and supplies in his teacher’s emergency bag in case of an extended lockdown situation. The nurse assumed responsibility for replenishing these supplies to ensure their freshness.

To address Alton’s anxiety, the speech-language pathologist created a Social Story (Gray, 2004) outlining the procedures of the emergency drill and placed a laminated copy with a distinctive visual on one side, in the emergency bag. To accommodate Alton’s low reading level, the Social Story was pictorial. This story was read to Alton each time the teacher discussed emergency procedures with all the students. During a drill (or in the event of an actual emergency), the distinctive visual on the Social Story was shown to Alton to alert him to the change in routine. The Social Story was read to him when he reached his safe area, which helped to reduce his anxiety.

CONCLUSION
Occupational therapy practitioners consider the interaction among client factors, environmental factors, and activity demands to design solutions optimizing the occupational performance of their clients. Their expertise is ideally suited to assume leadership within school teams in the development of IEEPs for individual students. This article provided a framework to develop reliable emergency evacuation plans ensuring safety of students with special needs in the eventuality of a disaster.

Acknowledgements: The authors thank the management and staff of Sycamore Community Schools for supporting this project and implementing the IEEP. Sincere thanks to Dr. Tracy Jirikowic, PhD, OTR/L; Terry K. Crowe, PhD, OTR/L, FAOTA; and Adel Herge, OTD, OTR/L, for valuable editing assistance.
REFERENCES


2. Occupational therapy practitioners contribute to emergency planning because they possess unique knowledge in positioning and mobility, sensory impairment and processing, communication, and environmental factors.
   A. True
   B. False

3. Which of the following is recommended when designing and implementing an IEEP?
   A. Include a classic definition of the student's diagnosis.
   B. Review it with the student's annual individualized education program (IEP).
   C. Post it on classroom bulletin boards for easy access and visibility for everyone.
   D. All of the above

4. In the school setting, which of the following is not considered when developing a student's IEEP?
   A. Educational goals documented on the student's IEP
   B. Collaboration with the educational team
   C. Parental input
   D. The student's abilities and needs

5. Maggie walks independently, but not always at the same pace as her classmates. She has difficulty with activity and location transitions, schedule changes, and noisy environments. She is verbal but her language abilities are delayed. Which of the following strategies are best to consider in designing her IEEP?
   A. Have a typical peer in Maggie's class take her hand and walk her out of the building.
   B. Assist Maggie to transfer to a wheelchair to easily transport her to the desired location.
   C. Use Social Stories and visuals, and practice the drills.
   D. Have the nearest available extra staff member come to Maggie's room and help her follow the drill with her classmates.

6. ADA guidelines for accessible egress specify:
   A. Width and elevation changes for accessible routes when constructing new buildings.
   B. How many individuals with special needs can be accommodated in the building.
   C. Evacuation methods for each kind of disability.
   D. All of the above

7. After reviewing best practices in school building design, the NCEF recommends that:
   A. Each school structure must be approved as earthquake proof.
   B. Each school should include procedures for training and evacuating students with special needs in a variety of emergencies and building conditions, and by a variety of routes.
   C. Each school must provide an area that can withstand a weather-related emergency.
   D. None of the above

8. When planning an IEEP, which of the following are beneficial?
   A. Schedules of staff in the building
   B. A map of the building with wheelchair accessible exits clearly marked
   C. The student's class schedule
   D. All of the above

9. Which of the following is not part of the team planning an IEEP?
   A. Speech-language pathologist
   B. Special education teacher
   C. Building administrator
   D. PTA president

10. A student with sensory processing challenges needs special consideration when planning an IEEP because he or she may:
    A. Get overwhelmed with the change of routine and not follow the teacher's instructions.
    B. Display atypical behavioral responses, such as screaming or falling to the floor.
    C. Not be able to use his or her typical mode of communication because of sensory overload.
    D. All of the above

11. Medical status of the student provides important information in planning the IEEP because:
    A. Certain situations, such as extended standing, may be contraindicated.
    B. The student may need medications at predetermined times.
    C. The student may need specific procedures at predetermined times.
    D. All of the above

12. The complexity of natural and manmade disasters do not support the requirement of planning for, reacting to, and recovering from emergencies for students with disabilities.
    A. True
    B. False