Related Services Decision-Making: A Foundational Component of Effective Education for Students with Disabilities

Michael F. Giangreco

SUMMARY. This article presents a variety of issues pertaining to how decisions are made about educationally related services for students with disabilities. The first section discusses areas of general agreement in the field, as well as challenges, associated with the current state-of-the-art in related service decision-making. The second major section of the article highlights a series of guidelines that offer alternatives believed to address some of the limitations associated with current practices. Topics include: (a) teamwork; (b) defining

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Michael F. Giangreco, PhD, is Research Assistant Professor, College of Education and Social Services, The University Affiliated Program of Vermont, 499C Waterman Building, University of Vermont, Burlington, VT 05405.

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educational program components; (c) the relationship between program, placement, and services; (d) values that underlie decision-making; (e) functions of related services; (f) criteria for related service decision-making; (g) decision-making authority practices; (h) modes of service provision; (i) location and strategies for service provision; and (j) implementation and evaluation of related services. *[Article copies available from The Haworth Document Delivery Service: 1-800-342-9678.]*

It is generally acknowledged that the provision of educationally related services, such as occupational therapy and physical therapy, are important for many students with disabilities to have access to education and adequately participate in their educational program, including pursuit of identified learning outcomes. How is the need for related services determined? How are decisions made about the frequency of service provision? How is it determined whether services will be provided directly by the therapist or indirectly, on a consultative basis, through another team member? These and other critical service provision and coordination questions typically have been left to professionals to answer, based on their own personal and clinical judgment. The purpose of this article is two-fold. First, issues pertaining to the current status of related services are presented. This introductory section discusses areas of general agreement in the field as well as challenges associated with the current state-of-the-art in related service decision-making. The second major section of the article highlights a series of guidelines that offer alternatives believed to address some of the limitations associated with current practices.

SOME CURRENT ISSUES IN RELATED SERVICES

Almost without exception, the literature and litigation pertaining to the provision of related services for students with disabilities in schools (e.g., physical therapy, occupational therapy, speech/language pathology, orientation/mobility) mention that related services must, "... be required to assist a child with disability to benefit from special education ..." as originally stipulated by P.L. 94-142 *(Education for All Handicapped Children Act of 1975)* and subsequently by P.L. 101-476 *(Individuals with Disabilities Education Act of 1990).*[1-16] For students whose unique characteristics require knowledge and skills beyond those typically possessed by teachers, related services can be crucial in developing and implementing an appropriately individualized educational program. Yet the literature also presents a long-standing concern that groups formed by educational and

related service professionals often function in disjointed and fragmented ways, thus highlighting the need for more collaborative relationships.[5,17-21] The mere presence of many professionals from a variety of disciplines, regardless of each person's individual competencies, does not ensure that students will receive educationally relevant and necessary related services. Ultimately, the education of students with disabilities is compromised when input from a related service professional is not adequately synthesized with the input of the family, educational staff, and other related service providers.

Services are more likely to be *disjointed and fragmented when professionals do not share the common conceptual tenet that related services are required to be educationally relevant and necessary.* Many skillful and well-intentioned related service providers are still trained and professionally socialized to function independently within their discipline rather than interdependently as a member of a collaborative educational team. Despite all the rhetoric about teamwork, too many professionals still assess, plan, make service provision decisions, implement, and evaluate in relative isolation. Evidence collected from 585 professionals and parents across the country highlighted a series of common professional practices that respondents reported they engaged in frequently; these practices are likely to interfere with the integrated provision of related services.[22] For example, respondents indicated that it was a common practice for related service professionals to make decisions about issues such as the need for related services, frequency of service, and mode of provision (e.g., direct, indirect) prior to knowing the student's IEP (individualized education plan) goals. Educationally relevant and necessary related service recommendations cannot be made purposefully if one does not first know the contents of the educational program as reflected, in part, by the IEP. In many schools it is not uncommon for a person from each related service discipline to generate a separate set of goals which reflect outcomes valued by the respective discipline. Not only can this be confusing for families, it creates a problem whereby group members agree to each pursue discipline-specific goals rather than sharing a set of educational goals that are discipline-free; in essence group members may reach consensus to head in different directions. Examples from a recent study of 47 IEPs of students with multiple disabilities documented numerous examples where separate goals were listed by professional disciplines.[23] This raises serious questions about whether team members shared a common framework to pursue the educational relevance and necessity of service provision.

A second major problem resulting in disjointed and fragmented services is *ambiguous roles and expectations among service providers* work-

ing with the same child.[24] In a workshop activity I have conducted with thousands of educators, related service providers, and parents across the country, ambiguous roles and disorganization consistently have been selected as the two most prominent forms of group dysfunction. Additionally, a recent study[25] demonstrated that educators, parents, and related service providers differ regarding who should have authority for making related service decisions. The study showed that related service providers strongly favored retaining decision authority regarding their own discipline; both special educators and parents whose children have disabilities favored consensus decision-making instead. Such potential ambiguity and differing expectations present fertile ground for conflicts among team members and for due process hearings.

Existing models for making related service decisions, most of which lack research support, are designed to assist in sorting out issues such as the type, frequency, and mode of service provision (e.g., direct, consult), yet these models may actually contribute to the fragmentation of services. Many professionals anxious for seemingly logical and expedient ways to make complicated decisions, are drawn to existing decision-models which may have some positive features, but tend to share a common conceptual orientation that often is not recognized as problematic.[1,26-29] These models examine decision-making exclusively from the perspective of a single discipline such as occupational therapy or physical therapy.[30] Such unidisciplinary decision-making models do not account for the fact that many of the functions served by educational team members from various disciplines can, and do, overlap with those of other disciplines. A unidisciplinary orientation limits an individual team member's ability to make educationally relevant related service decisions as required by the *Individuals with Disabilities Education Act of 1990* because it fails to address the interrelationships among the disciplines involved in a student's education. When professionals make related service decisions in a unidisciplinary fashion, based on what they individually value from the perspective of their own disciplines, there is an increased probability of undesirable and unnecessary overlaps and gaps in services, contradictory recommendations from service providers, and conflicts among team members; unidisciplinary decision-making likely perpetuates role ambiguity and programmatic fragmentation.

Although these issues are sufficiently important to warrant action to improve the provision of educationally related services, another major factor compounds the challenge. Traditionally, students with multiple and/or severe disabilities, presumably those receiving the most extensive related services, have been educated in special education classes and schools. Related service providers working in these settings often were

encouraged, or asked directly by educational administrators or teachers, to generate separate goals, independently make service provision decisions, and provide direct services in isolated settings despite the fact that these practices violate the tenets of collaborative teamwork. Over the past few years new opportunities have become available for increasing numbers of students with disabilities, including those with multiple and/or severe disabilities, to be educated in general education classes while pursuing either the general education program with suitable access accommodations or a modified/individualized program with supports.[31]

Although the literature highlights many problems regarding related service provision, clearly there have been, and are, many examples where related service providers, educators, and families have worked together effectively to support students with disabilities. On the other hand, some well-intentioned professionals have attempted to transfer positive features of support from traditional, disability-only, settings to general education schools and classes. This generally does not work well because the contextual differences among classes and schools serving only students with disabilities and those serving a heterogeneous population consisting primarily of children without disabilities are so vast.[32] Just because something was valued, made sense, and seemed to work in one context does not mean it will be valued, make sense, and work in another context.

As we move further into this new era of opportunities for students with and without disabilities to be educated together, the time is right to establish the importance of effective coordination and provision of educationally relevant and necessary related services. Programmatic advances and research pertaining to related service decision-making, provision, and effectiveness will continue to be a critical need because:

a. such services affect a high proportion of students with disabilities in public schools across every age group and racial/cultural heritage;
b. the involvement of professionals from various disciplines is considered both necessary and desirable in supporting the education of many students with disabilities,[4,33] yet existing, invalidated approaches suffer from a unidisciplinary orientation resulting in gaps, overlaps, contradictions, and role ambiguity among service providers;
c. the literature indicates that cross-disciplinary service relationships pose currently unresolved problems related to coordination and decision-making among professionals and between professionals and families whose children have disabilities, resulting in disjointed and fragmented educational programs;[5,18-20,34]

d. insufficient research data exist regarding related services to draw empirically sound conclusions regarding their effectiveness in supporting the education of students with disabilities;[35]
e. the national movement to include more students in general education schools and classrooms is raising new issues regarding appropriate service provision as the context for service provision shifts to educational settings frequented predominantly by students without disabilities;[32,36]
f. the shift toward general education placements has resulted in a shift in staffing patterns from related service providers as employees of special schools or health agencies, to related service providers as private contractors and/or school district employees; this has altered the role of related service providers and their relationship to local education agencies and school personnel in ways that have yet to be studied or fully understood;
g. with the passage of P.L. 99-457 and its emphasis on service provision in the least restrictive environments, increasing numbers of young children with disabilities are making the transition from early intervention programs into integrated daycare settings, preschools, and kindergartens, thus adding to our need to understand related service issues more thoroughly and develop approaches to serve students and families more effectively; and
h. families and people with disabilities are increasingly expressing concern about the transition from school to community living and the critical need for related service type supports after graduation in terms of living arrangements, work, transportation, recreation, and communication access.[37-40]

ALTERNATIVE PRINCIPLES TO GUIDE RELATED SERVICE DECISION-MAKING

The following subsections describe ten interrelated guidelines that provide alternative ways to think about related service provision in educational settings (see Table 1). These interrelated guidelines have been applied to the practice of related service decision-making through a process known as VISTA (Vermont Interdependent Services Team Approach).[18,41] Specific instructions for the use of VISTA are beyond the scope of this article. Although VISTA represents one way of organizing these guidelines, their applicability is not limited to use within the VISTA framework–they can be valuable guidelines and principles when used less systematically and can likely be organized in a variety of ways to support reasoned, collaborative decision-making.

TABLE 1. Interrelated Guidelines to Facilitate Related Service Decision-Making

1. Establish and Maintain a Collaborative Team
2. Define Components of the Educational Program
3. Understand the Interaction Among Program, Placement and Services
4. Use a Value System to Guide Decision-Making: "Only-As-Special-As-Necessary"
5. Determine Functions of Service Providers and Their Interrelatedness
6. Apply Essential Criteria When Making Service Recommendations: Educational Relevance and Necessity
7. Determine Who Has Authority for Decision-Making: Consensus
8. Match the Mode and Frequency of Service Provision to the Function Served
9. Determine the Least Restrictive Location and Strategies for Service Provision
10. Implement and Evaluate Related Services

When used in combination, these guidelines are designed to: (a) increase team members' confidence that their related service provision decisions are educationally relevant and necessary; (b) increase reliability among a team regarding which aspects of a student's program require support from various members and what functions those members need to serve (who is doing what to whom and why); (c) reduce unnecessary and undesirable overlaps, gaps, and contradictions in related service provision recommendations; (d) reduce conflicts among team members by focusing intra-team communication on student- and context-specific information; (e) assist in matching the mode and frequency of service provision to the functions of related service involvement required to support an individual student's educational program; (f) guide implementation of related services in supportive but minimally intrusive ways; (g) evaluate services based on learning outcomes and valued life outcomes; and (h) increase team members' satisfaction with their related service decision-making practices. Initial research on VISTA with six student planning teams serving students with multiple disabilities has yielded promising results;[18] a series of additional studies are underway. The following sections summarize some of the main points pertaining to the ten interrelated guidelines we find to be useful when making educationally relevant and necessary related service decisions.

Establish and Maintain a Collaborative Team

Although having two or more members is essential to establishing and maintaining a collaborative team, it is not sufficient, even if the members possess various skills and knowledge, share information, and regularly meet together. First, we must ensure that the members of the team include those people who will be affected by decisions made by the team.[42] In addition to special educators and related service providers who are typically part of the team, it is critical to include the student when appropriate, the parents, general education teachers, paraprofessionals, and potentially others (e.g., peers, bus drivers, administrators). In some cases, on the other hand, the number of team members can become overwhelming and make decision-making unnecessarily complicated. A recent study of students with multiple disabilities indicated team sizes ranging from 5 to 21 with the average team including 11 members.[23] Teams can reduce the number of people involved in regular meetings by designating a *core* team comprised of those people who have the most ongoing involvement with the student and an *extended* team that includes the core team plus those members who have less frequent involvement with the student, and by establishing *situational* teams comprised of individually determined combinations of team members to address specific issues or concerns. In this way, team members' time can be used efficiently.

Once team membership has been established, the most foundational and defining characteristic that distinguishes a *collection of people* from a *team* is the development of a shared framework and the purposeful pursuit of a shared or common set of goals. Important supportive characteristics of teamwork, such as sharing resources, effective communication, and consensus decision-making, ultimately will only have the desired impact when applied within a shared framework and to meet common goals.

Define Components of the Educational Program

One of the most explicit ways to operationalize a shared framework and common goals is for the team to reach agreement and document the components of a student's educational program. The framework discussed here for determining the components of the educational program is based on COACH (Choosing Options and Accommodations for CHildren).[43] The components of the educational program can be broadly categorized as a student's: (a) priority learning outcomes, (b) additional learning outcomes, and (c) general supports; these components describe only *what* the educational program will consist of and do not address issues of where or how education will be provided.

A student's *priority learning outcomes* refer to a small set of the most important learning outcomes. These priority learning outcomes are family selected, individualized, and discipline-free. They are not based on what is valued from the perspective of various disciplines, but rather are referenced to individually determined valued life outcomes, such as personal health, having personally meaningful social relationships, having age-appropriate choice and control, having access to personally and societally valued places and activities, developing skills for life-long learning, and contributing to one's community. Priority learning outcomes typically are documented as annual goals and short-term objectives on the IEP.

Additional learning outcomes refer to individually determined student program content that extends beyond the small set and potentially narrow boundaries of the top priorities. These additional learning outcomes, determined jointly by team members, are designed to ensure that the student has access to a broad range of learning outcomes from curriculum areas included in the general education program as well as other sources that extend beyond it in any direction. For example, if a particular student's priority learning outcomes focus primarily on communication, social, and self-care areas, additional learning outcomes may include other items from those same areas as well as learning outcomes from different curriculum areas, such as language arts, math, science, physical education, arts, or computer literacy. The configuration and number of additional learning outcomes will vary for each student based on his or her individual needs and characteristics.

The third category, which completes the components of the educational program, are *general supports* that *need to be provided to or for the student* to allow access to education or to facilitate participation in the educational program. Unlike the learning outcomes discussed in the previous paragraphs which seek observable changes in student behavior, general supports seek changes in the behavior of team members other than the student. General supports generally are broad and cross-situational as opposed to highly specific to a particular lesson. Five categories of general supports have been listed in COACH; they include: (a) *personal needs* (e.g., feeding, dressing, giving medication); (b) *physical needs* (e.g., therapeutic positioning, managing specialized equipment, environmental modifications); (c) *sensory needs* (e.g., Braille translation, access to large print materials, sign language interpretation); (d) *teaching others about the student* (e.g., teaching classmates the student's augmentative communication system; teaching staff crisis intervention or health emergency protocols); and (e) *providing access and opportunities* (e.g., arranging community-based vocational experiences, providing literacy materials in the student's native language, providing access to regular class activities).

Explicitly documenting the components of a student's educational program in this way has at least three primary benefits. First, the agreed upon set of learning outcomes and general supports become the basis for determining the educational relevance of related services; decision-making would be compromised if team members agree to this shared list yet retain a separate agenda of learning outcomes and general supports. Second, clearly differentiating between learning outcomes and general supports provides clear expectations regarding what we expect the student to learn and do versus what we expect other team members to learn and do. Unnecessary conflicts arise when team members have different expectations about educational program components. For example, one member may be under the impression that the student is learning dressing skills and wheelchair transfers, while another thought these were supports for the student. Third, research has indicated that professionals sometimes confuse learning outcomes and general supports so that IEP annual goals are actually general supports rather than learning outcomes–this can result in IEPs that are unnecessarily passive and therefore do not tap the learning potential of students.[23,44] "Rosa will be repositioned every half hour" is an example of a general support that may need to be provided for Rosa but positioning is not an annual goal that requires Rosa to learn.

Understand the Interaction Among Program, Placement, and Services

Existing data[22] suggest that the sequence with which professionals consider a student's program, placement, and services may interfere with developing an appropriately individualized program in the least restrictive environment. For example, evidence suggests that related services providers frequently make service decisions in isolation prior to knowing the educational program components, thus making the educational relevance and necessity of such services unknown. In some cases, professionals reported recommending placement of a student in special education school so he or she could get access to related services, also prior to knowing the educational program components. Although both of these scenarios are common practice, they reflect questionable logic because such service recommendations are likely based on presumed disability characteristics rather than individually identified needs.

The sequence of program, then placement, then services is offered here as an approach that is conceptually, philosophically, and pragmatically congruent with the intent to have related services be educationally relevant and necessary. By determining the educational program components first, we know what we want the student to learn and experience in school. Once we know what we want for the student, based on his or her individual needs, we

can then consider the least restrictive placement option where the student can pursue the identified educational program components. The *Individuals with Disabilities Education Act of 1990* along with the 1994 decision in the California case of Sacramento City Unified School District v. Rachel H.[45] have reaffirmed that the general education classroom is the primary placement option for students with disabilities, including those with the most severe disabilities. It is crucial to remember that the law states that a student should only be removed from regular class if his or her individual needs cannot be met when given supplemental supports and aids; it does not say that students should be denied access to the regular class based on categorical disability labels, their need for individualized curriculum and/or instruction within the general class setting, or their need for specialized supports. Determination of related service needs logically comes after determining educational program components and placement because the latter factors will influence the need for related services.

Use a Value System to Guide Decision-Making: "Only-As-Special-As-Necessary"

Decision-making models are all based on underlying assumptions and values which are sometimes clearly articulated for the consumer and other times require a bit of detective work to figure out. Exemplary practices in education and related services are rooted in a broad set of values, such as access, equity, individualization, interdependence, diversity, collaboration, and community.[46] Given the enormous variation that exists among students, families, schools, and communities, having an underlying value system can assist team members when faced with unique challenges by facilitating consideration of whether the decisions and actions being proposed are congruent or incongruent with the team's underlying values.

When specifically considering related service decision-making, some team members practice a "more-is-better" approach. Like the young child who would rather have ten pennies than one quarter, this approach is misguided because it confuses quantity with value. Another, hopefully less prevalent, approach is "return-on-investment" which places a high value on serving students who have a favorable history and prognosis for being remediated and those likely to contribute the most, economically, to society. Return-on-investment approaches fail to recognize the important contributions made by people with the most severe disabilities that may be difficult to measure in dollars and cents. Parents have concerns that professionals may use the "return-on-investment" approach as a rationale for reducing or discontinuing services to a student rather than risk exposing that they are challenged by a situation and may not know exactly what to

do.[34] This parental observation raises important and difficult questions that we must ask ourselves as professionals. It is heartening to note that the same set of parents preferred that professionals honestly acknowledge when they do not know something and be willing to support needs identified by families. Theoretically, the pressures to guard one's professionalism by avoiding challenging situations can be reduced when we support each other within a collaborative team.

An alternative value system that allows for various combinations of direct and indirect services is to provide supports that are "only-as-special-as-necessary."[47,48] This approach allows for the provision of needed services and acknowledges the contributions made by various disciplines, but takes precautions to avoid the inherent drawbacks of well-intentioned over service. Providing more services than are necessary may: (a) decrease time for participation in activities with non-disabled peers; (b) cause disruption in acquiring, practicing, or generalizing other important educational skills; (c) cause inequities in the distribution of scarce resources when some students in need remain unserved or underserved; (d) overwhelm families with the involvement of an unnecessarily high number of professionals; (e) create unnecessary or unhealthy dependencies; or (f) unnecessarily complicate communication and coordination among team members. The "only-as-special-as-necessary" approach is based on the notion that rather than trying to obtain the *most* services possible, we should seek to determine the appropriate amount and type of services for each individual student, not too little, not too much; this will necessarily be a collective "best guess."

Determine Functions of Service Providers and Their Interrelatedness

It is critical for team members to have a shared understanding of what functions each person is serving and how they interrelate to support the student's educational program. In a recent study, 318 special educators, related service providers, and parents of students with severe disabilities rated a set of related service functions commonly cited in the professional literature.[25] These people indicated that the four most important functions for serving students with severe disabilities were: (a) developing adaptations and/or equipment to allow for active participation and/or prevent negative outcomes (e.g., regression, deformity, discomfort, pain); (b) transferring information and skills to others (e.g., related service providers, educators, parents); (c) serving as a resource and/or support to the family; and (d) applying discipline-specific methods or techniques to promote active participation and/or prevent negative outcomes. These essential functions may be augmented by discretionary functions that are individually and situationally appropriate.[25] Clarifying the functions served by each team

member and the interrelatedness of these functions helps to further develop the team's shared framework and allows members to purposely explore service functions for potential gaps, overlaps, and contradictions.

Apply Essential Criteria When Making Service Recommendations: Educational Relevance and Necessity

The professional literature is replete with suggested criteria for making related service decisions for students with disabilities.[1,26-29] Some of the criteria are situationally useful and others highly suspect; only two appear to be essential across all situations. First, we must always consider whether a proposed related service is *educationally relevant*. We can do this by referencing it to identified components of the student's individual educational program as previously identified by the team. If the proposed related service is relevant to the educational program, then we must employ the second essential criterion to determine whether the related service is *necessary*.

There are at least four basic ways to test for educational necessity. First, we can ask ourselves if there are any existing data or logic to suggest that the absence of the proposed service will interfere with the student's access to or participation in his or her educational program, including pursuit of identified learning outcomes. If the absence of the service poses a threat to access or meaningful participation, then the service is necessary; if it does not pose such a threat, it is not necessary. Making such decisions requires team members to rely on the "only-as-special-as-necessary" value system. If the service passes this test for necessity, we can then consider potential gaps, overlaps, and contradictions among team members. For example, a necessary service to provide appropriate therapeutic positioning could be suggested by both the occupational therapist and the physical therapist. Team members need to clarify what they are referring to regarding therapeutic positioning; if members' skills are overlapping, the team needs to decide whether the overlap is necessary and desirable or not. A third way to explore the potential necessity of related services is to check with both the sender and receiver of the service. For example, an occupational therapist may say that she needs to serve the function of transferring specialized information and skills regarding eating and drinking to the paraprofessional who works with the student at lunch time. In this example, although serving this function may meet the previously suggested tests for necessity, the team members may agree that the paraprofessional is sufficiently experienced and skilled with this particular student that such support is not necessary. In an opposite scenario, the potential receiver of a service can make it known that he or she needs a certain type of support. For example, if the general supports for a student indicate that one of the

student's personal needs is assistance with eating, the teacher may raise the fact that the newly hired paraprofessional has no experience assisting a child with oral-motor difficulties with eating and therefore may require transfer of information and skills from the occupational therapist. When possible, it is always desirable to check directly with the student; this can provide essential information and promote self-advocacy. A fourth test for necessity is to consider whether a service provided in one context can be adequately generalized to other settings without the direct involvement of the specialist. For example, if the physical therapist has assisted core team members by sharing specialized information and skills pertaining to transfers in and out of a student's wheelchair in the general education classroom, the team needs to determine whether it is necessary for the therapist to be directly involved in the same transfer of information and skills across all environments where wheelchair transfers will occur (e.g., gymnasium, cafeteria, playground, library) or whether such information and skills can be adequately transferred to other places and people, possibly with the specialist monitoring periodically to ensure quality and accountability. Use of these simple tests of necessity can assist in avoiding the inherent problems of over service discussed earlier.

Determine Who Has Authority for Decision-Making: Consensus

Three basic options exist for making decisions; autocratic, democratic, and consensus.[25] Each possesses positive and negative features. In autocratic decision-making, the specialist retains individual authority. Democratic decision-making provides one vote for each team member, and like an election, majority rules. Both autocratic and democratic decision-making are quick, easy, and familiar, but they have drawbacks. Autocratic decision-making increases the probability of individual errors in judgment and is likely to perpetuate disjointed and fragmented services by failing to account for interrelationships with other team members. This issue can become especially problematic for school-based staff when well-intentioned physicians write prescriptions for services like occupational therapy and physical therapy without the benefit of being part of the team or having any notion of the educational relevance and/or necessity of the services they are prescribing. Democratic decision-making tends to polarize factions within teams, fails to recognize the potential value of dissenting opinions, and invariably leaves parents outnumbered.

Although consensus decision-making is likely to require more time and effort than autocratic or democratic approaches, the benefits of this option outweigh the drawbacks. By reaching mutually valued agreements, team members strengthen and extend the development of their shared framework, have opportunities to learn from and support each other, and establish clearly communicated expectations designed to facilitate effective service provision and quality education.

Match the Mode of Service Provision to the Functions Served

For years the professional literature has included debates about the virtues and pitfalls of direct versus indirect/consultative service provision. The issue is not which mode of service provision is better, but rather which mode or combination of modes matches the function being served. Once a function (e.g., making an adapted switch for use of a communication device) has been determined to be educationally relevant (by being referenced to an identified component of a student's educational program) and educationally necessary, the appropriate mode(s) of service provision can be selected by considering whether the function lends itself to direct or indirect service. For example, let's assume that an occupational therapist builds or modifies the adapted switch so that it is individually appropriate for the student and then trains other team members on its use. Both of these functions (making the adaptation and transferring information/skills) are indirect services. These indirect functions require the specialist to have knowledge of the student and interact with him, but the purpose of that interaction is to gather information and/or work through others rather than to provide direct therapeutic intervention. It is conceivable that a student could receive educationally relevant and necessary related services indirectly or through a direct/indirect combination. Because the skills and knowledge of related service providers need to be extended to other team members, it is almost inconceivable that a student could receive appropriate related services in a direct service mode exclusively, yet this remains a common practice. Team members can determine which mode(s) of service provision match the functions determined to be educationally relevant and necessary and then can make an initial "best guess" at how much time will be required to fulfill the identified functions. Be wary of formulas that offer prescribed modes of service provision and/or suggested frequencies and duration of service; there are simply too many unique variables about students, families, team members, schools, and communities for such formulas to offer appropriate individualization. Reasoned decision-making will be aided by a group of competent and caring team members working together to understand each others' perspectives and building a shared framework.

Determine the Least Restrictive Location and Strategies for Service Provision

Traditionally, many related services have been provided in isolated settings such as therapy rooms using specialized strategies that may be

considered unusual or intrusive if used in general classroom settings. As integrated provision of related services became increasingly recognized as more effective than isolated service provision, confusion surfaced regarding where and how these new integrated services were to occur.[49,50] Some well-intentioned team members arranged for traditional, isolated therapy to take place within the classroom; this does *not* necessarily constitute integrated provision of related services. In fact, provision of certain types of service in the classroom or other school locations could potentially be quite inappropriate. For example, one day in a school cafeteria, a concerned second-grader asked me, "Why does that lady have Lauren in a headlock and why is she making her gag–I don't think Lauren is having a very good time." An itinerant occupational therapist was attempting to elicit a gag reflex and subsequently was using full jaw control with Lauren. Although the techniques used by the therapist are rather standard and would not stand out negatively in a special school or special class, in the general education cafeteria they appeared more like a combination of Championship Wrestling and some sort of punishment than techniques designed to be helpful.

Team members should strive to provide services in the most natural environments and use approaches that are socially acceptable within those integrated settings. As mentioned earlier, when contexts change, we must realize that other people's reality may be different from our own. What we do for, or with, students with disabilities must enhance their status. In other words we need to make sure that we do not make students with disabilities look bad in front of their peers in the name of "service." It is important to consider the student's privacy, dignity, and the perceptions of peers when selecting both where services will be provided and what strategies will be used. If the team agrees for some individualized reason that a student temporarily needs to receive services in a private setting (as might be true for a student without disabilities), plans should be put in place to monitor the situation and create mechanisms to re-integrate the student into the typical school and classroom settings as soon as possible. When considering location and strategies, always start with and strive for those that are the least restrictive and least intrusive while attending to identified student needs.

Implement and Evaluate Related Services

Once the team has thought through a reasoned plan, related services can be implemented either through a combination of direct and indirect services or through primarily indirect services. One question often left unanswered is whether the provision of the related service has been effective. The first step in being able to evaluate the impact of a related service is to know what

components of the educational program the service was intended to support. As discussed earlier in this article, the related service could be designed to address the student's learning outcomes or general supports. By knowing which educational program components are being supported and which functions are being served, the team can ask individually appropriate questions such as: (a) Has the service provided access to, or allowed for participation in, the educational program? or (b) Has the service facilitated improvement in identified learning that would probably not occur in the absence of the service? Although educational access, participation, and improvement in learning outcomes are meaningful indicators of related service effectiveness, ultimately the team must consider if, and how, the student has experienced positive changes in his or her valued life outcomes as a result of the service. In other words, is the student's life better and, if so, how, as a result of receiving this service? Thinking about these kinds of quality of life issues is complex and highly individualized.[51] Parents of children with disabilities have identified some valued life outcomes as: (a) being safe and healthy; (b) having networks of personally meaningful relationships; (c) having choice and control that matches one's age; (d) having a variety of interesting places to go and meaningful activities to do; (e) having a home to live in, now and in the future; (f) engaging in personal growth and lifelong learning; and (g) contributing to one's community.[34,52] Are not these the same outcomes that many families value for their children who do not have disability labels? As we gather both quantitative and qualitative data to evaluate the impact of related services, we are challenged to continually cycle through the process of considering the educational relevance and necessity of services and the emergent interrelationships among team members as changes occur in team membership, the context for learning, the family, and the student.

CONCLUSION

This article has presented a series of ideas designed to assist you in considering the related service needs of students with disabilities as they increasingly access typical school and other community environments along with people who do not have disabilities. Given the history of related services decision-making and provision in public schools, the need for further research and programmatic advances is evident. Therefore, the ideas presented here are meant as a springboard to continue cross-disciplinary discussions designed to serve students with disabilities and their families more effectively.

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