DO NO HARM

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Attic Therapy

Building Research Connections – Thinking Outside the Box

School of Rehabilitiation Science, University of Saskatchewan

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ETHICS WHEN OT IS ASKED TO WORK IN EDUCATION SETTINGS

OR

Why the status quo is not working and needs to CHANGE

AND

How that might look

Statements I think deserve more critical inquiry than I can describe adequately in this presentation will be made in red.

BACKGROUND TO MY THINKING

- OT since 1993
- Have worked in long term care, home care, outpatient, functional capacity assessment, secondary assessment teams, specialized seating team, and been legal expert witness
- With children, have worked in home care, Alvin Buckwold Child Development Clinic, clinic setting, outpatient in hospital setting, satellite clinic in school (partnership between school and health), transdisciplinary diagnostic team (preschool), multidisciplinary diagnostic team (school age), and private practice out of my home or in clients' homes
- In schools, have fulfilled contracts with First Nations Bands, Tribal Councils, conseil des écoles fransaskoises, and Parkland School District, prior to this contract

THE PROBLEMS CONFRONTING CHILDREN IN SASKATCHEWAN SCHOOLS

Poverty Homelessness Addictions Abuse Cycles Mental Health Disorders Physical Disorders Genetic Syndromes War Immigration Language Barriers Communication Barriers Cultural Barriers Historic Trauma Ongoing Trauma Political Polarization Economic Downturns Silos Corruption Suicide Epidemics Isolation Climate Change Women's Issues Sexual Orientation Issues Colonialism War Social Media Echo Chambers Cynicism Distrust of Science Loss of Privacy

"CULTURE"

culture noun

cul·ture | \ ˈkəl-chər \

Definition of *culture* (Entry 1 of 2)

1 **a** : the customary beliefs, social forms, and material traits of a racial, religious, or social group

also : the characteristic features of everyday existence (such as diversions or a way of life) shared by people in a place or time

// popular *culture*

// Southern *culture*

b : the set of shared attitudes, values, goals, and practices that characterizes an institution or organization

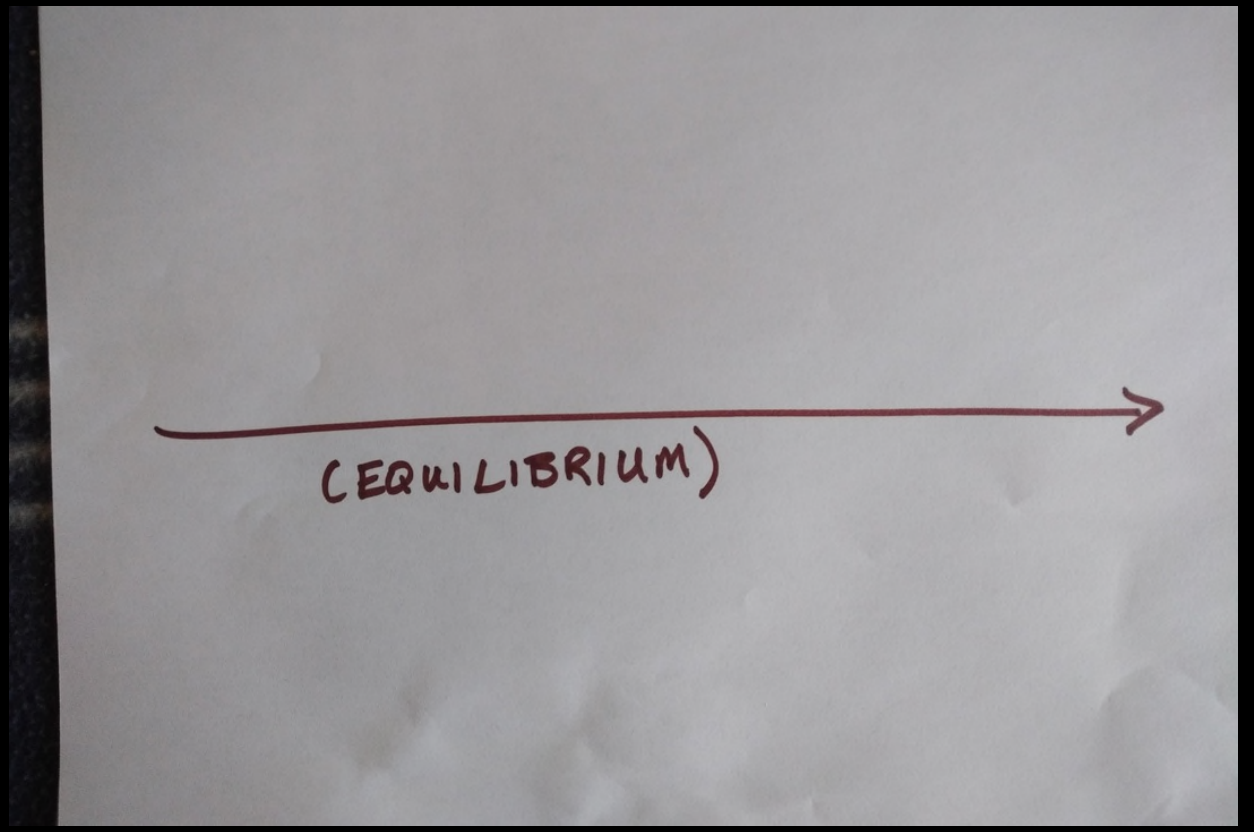
// a corporate *culture* focused on the bottom line

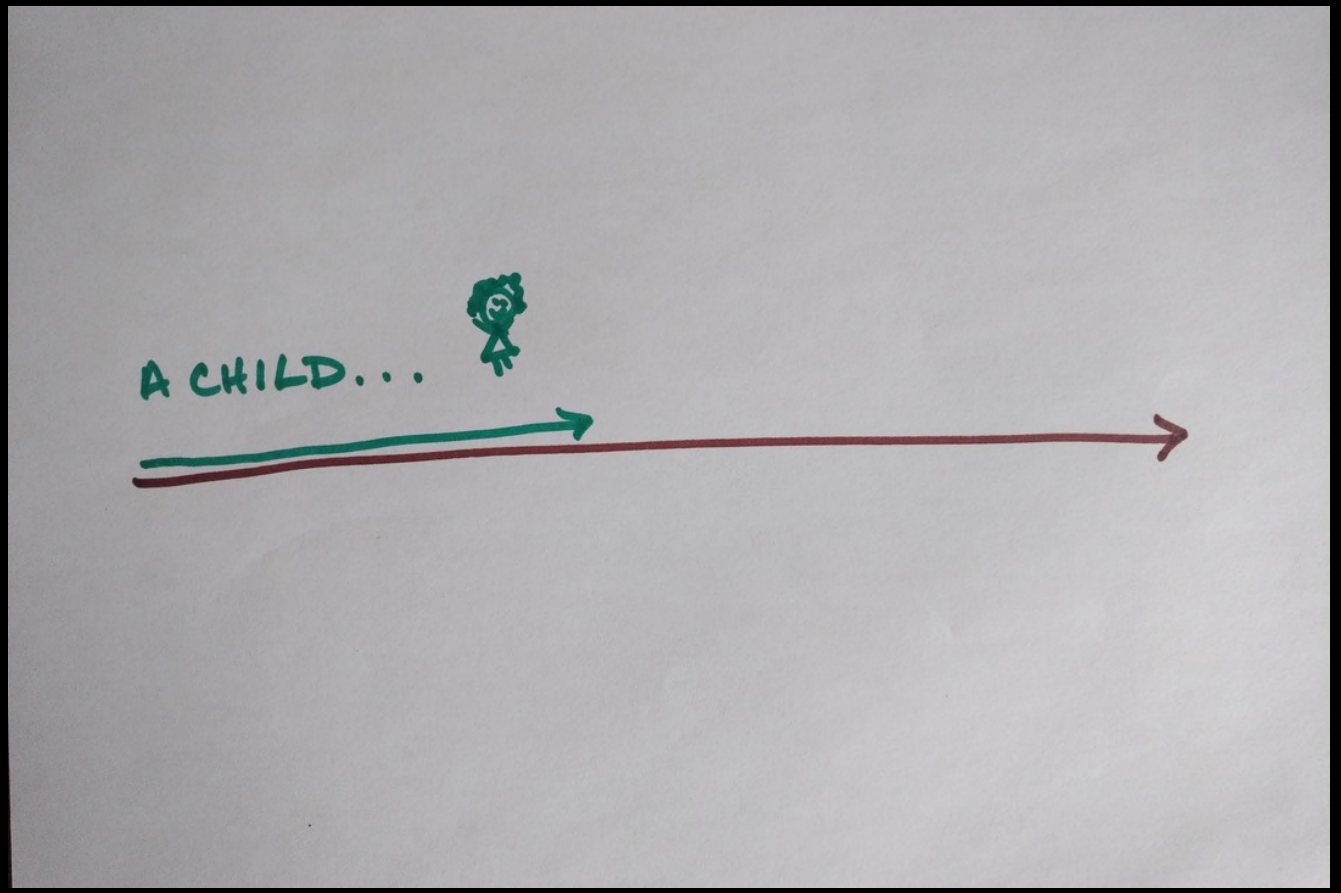
c : the set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic

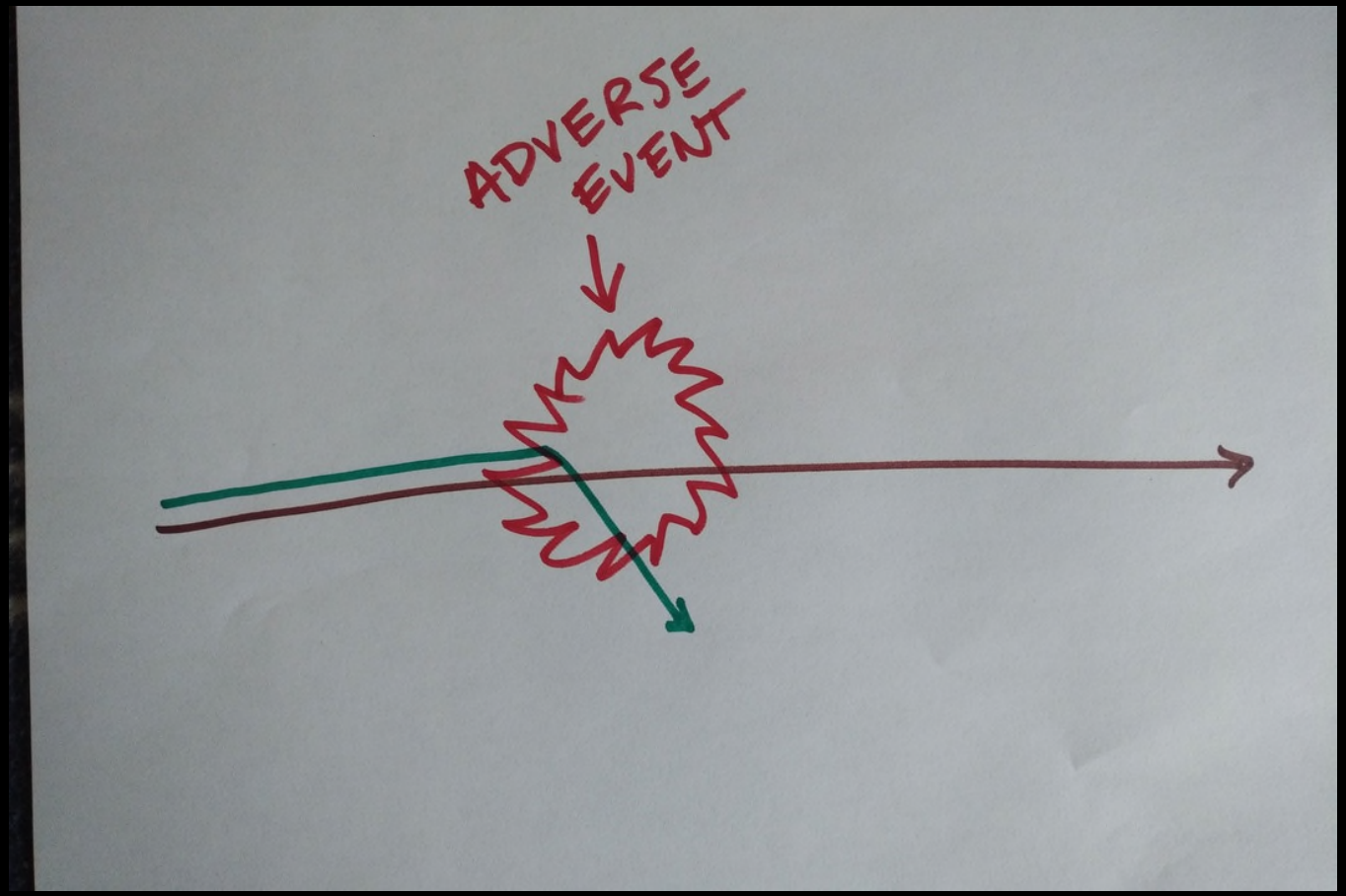
// studying the effect of computers on print *culture*

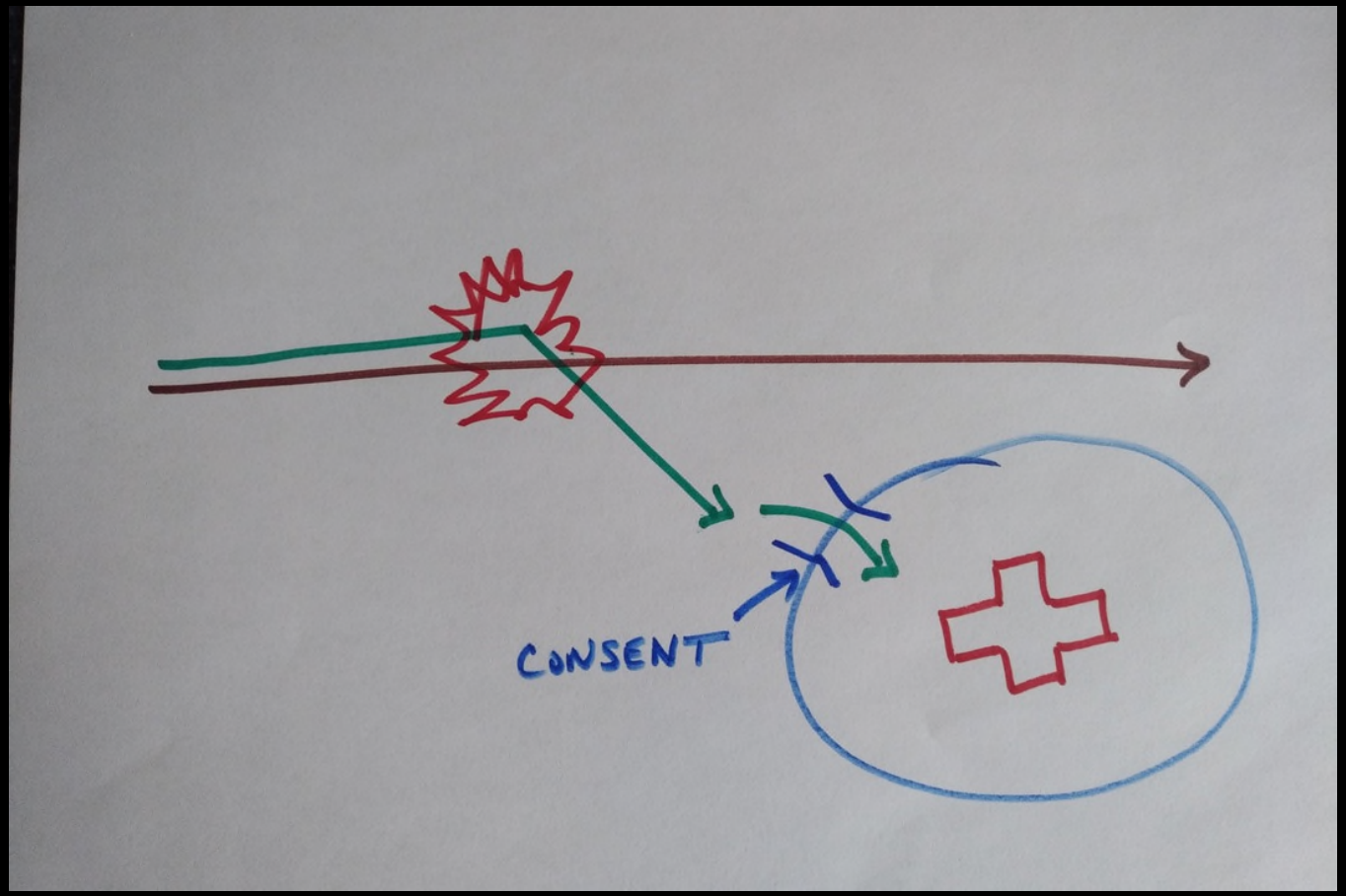
https://www.merriam-webster.com/dictionary/culture

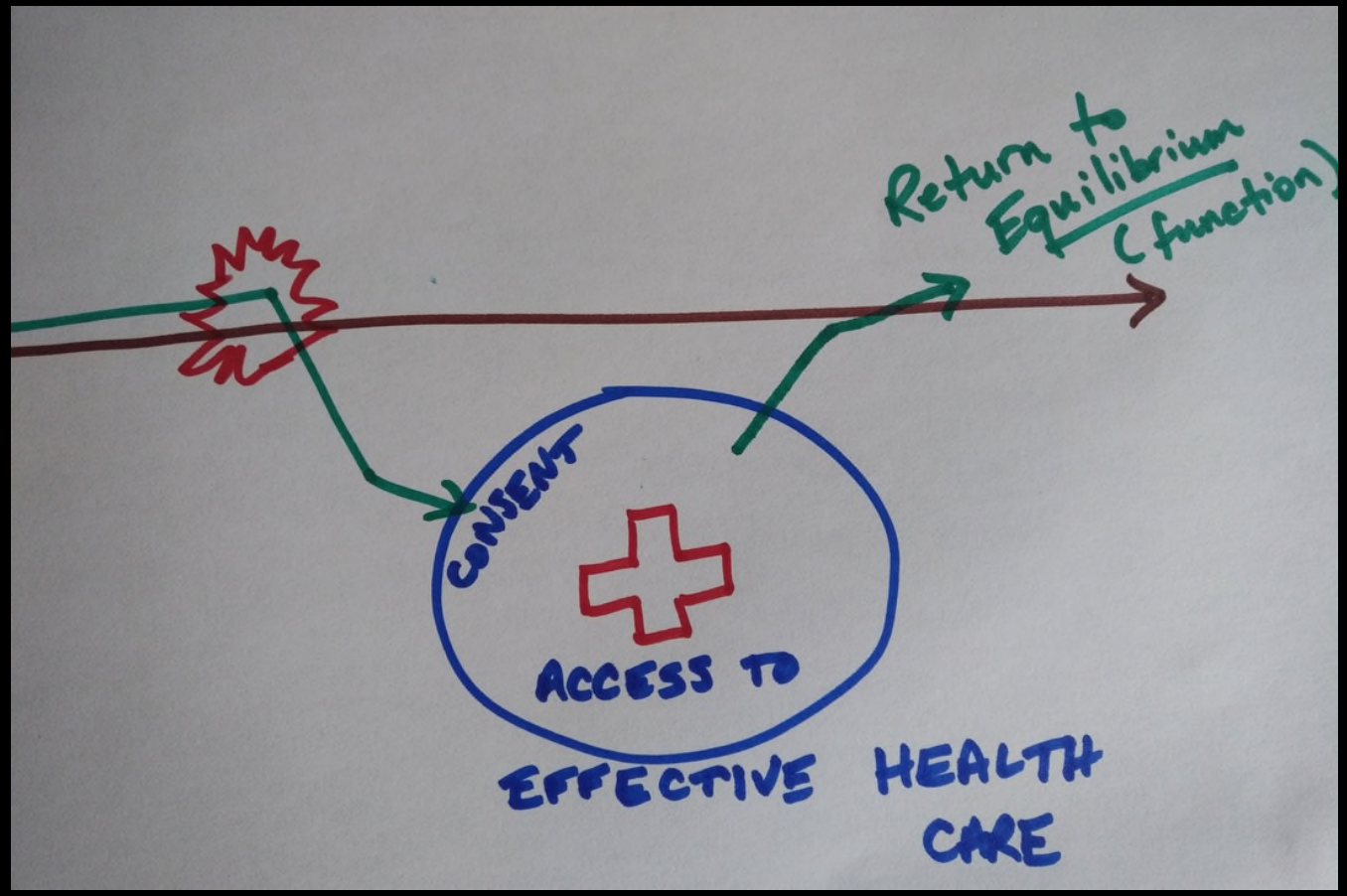
HEALTH CARE - AS A CULTURE




A CHILD...


ADVERSE
EVENT


CONSENT


Return to Equilibrium (function)
CONVENIENT
ACCESS TO
EFFECTIVE HEALTH CARE

HEALTH CARE AND CHILDREN

- In health care, we often need to do things to and for children which are painful, uncomfortable, invasive, and basically harmful. They are just less harmful than the alternative (eg. Standing frames). Therefore we have practices which limit our actions so that we don't cause harm.

- In health care, we seek to promote and re-establish healthy, normative relationships with attachment figures, and then we *discharge* the client/patient (back to equilibrium)

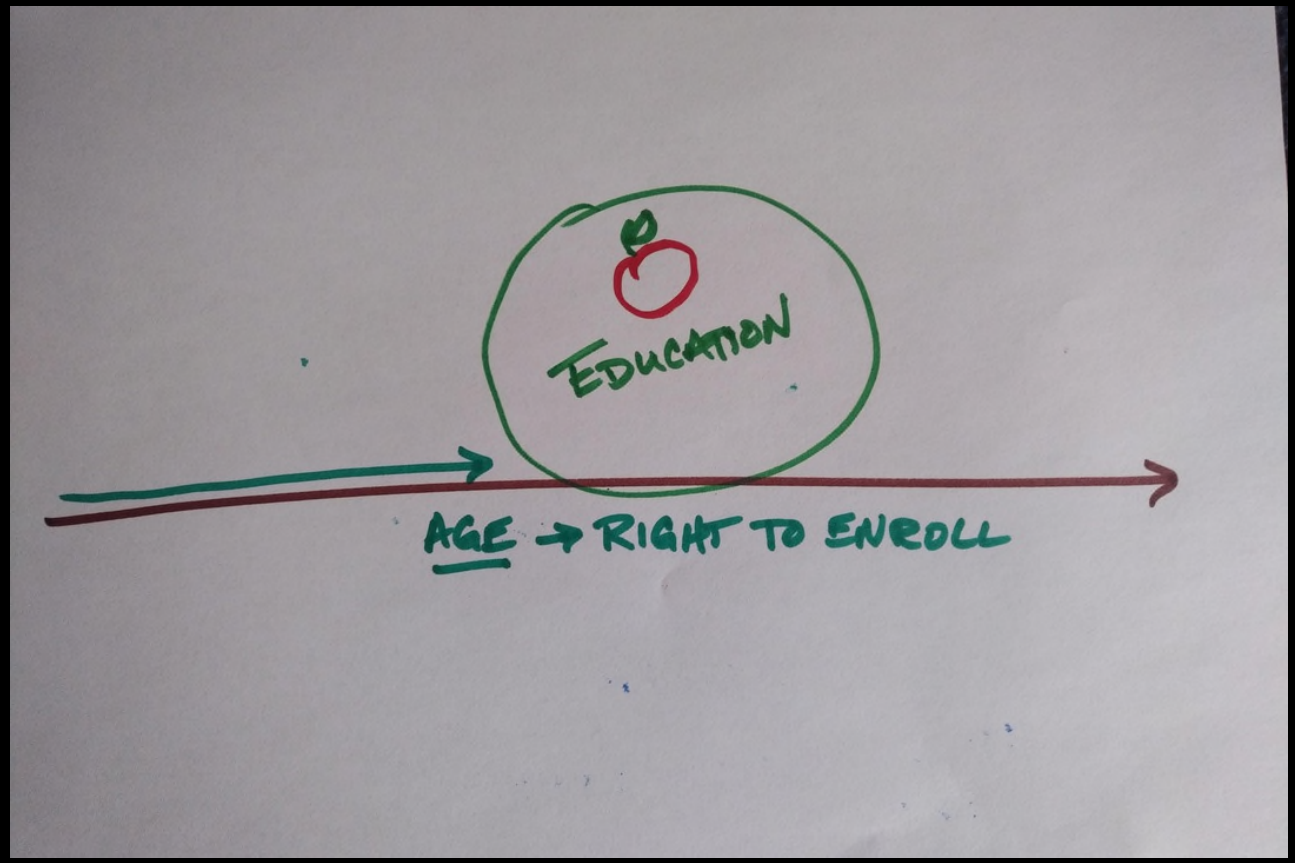
- As therapists, our job is therefore to promote attachment with parents, rather than trying to become a primary attachment figure

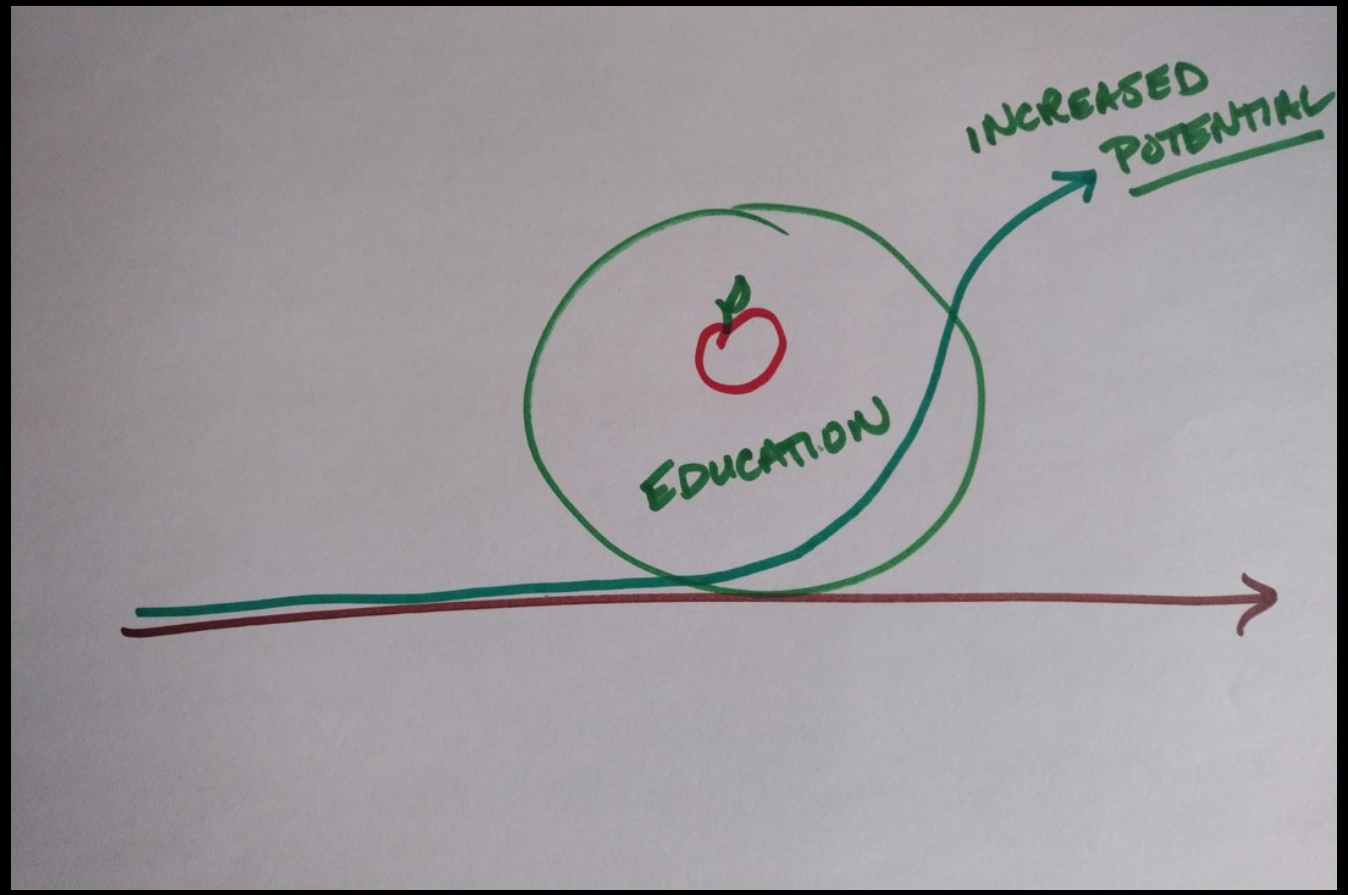
HEALTH CARE IS "WHERE WE LIVE" AS REHAB PROFESSIONALS:

Health Care as a culture

- **Highest priority is CONSENT**
- The need for health care is based on subjective criteria (I am not "okay" and so I need help)
- Goal is health (return to baseline or state of potential or "okay") – which is seen as a **basic human right**
- Uses methods that would otherwise be dangerous – so ethics is major consideration

EDUCATION - AS A CULTURE




INCREASED
POTENTIAL
EDUCATION

EDUCATION AND CHILDREN

- A child's brain also ONLY learns in relationship – so teachers must forge an authentic and appropriate relationship with all their students
- This relationship is complex and multifaceted, because teachers also function *in loco parentis* when a child is in school
- Consent for health care in schools therefore involves both consent from parents and the "acting" parents in school – the teachers
- Education happens to all kids. Consent is implied. Whereas Health Care can "limit" caseload with restrictions to service (and with consent parameters); education cannot because of value of INCLUSION

EDUCATION IS "WHERE TEACHERS LIVE" AS EDUCATORS:

- **Highest value is INCLUSION**
- The need for public education is seen as an objective reality after age 6
- the goal is achieving potential – growth, development, engaged citizens of society, and lifelong ability to keep learning – framed as a **basic human right**
- is only as effective as the relationship between teacher and student

MY LOGISTICAL DILEMMA… FALL OF 2014

- OT with over 20 years experience in all areas of the profession
- is contracted by a large school division (30 schools, rural/urban split, very high needs population, 9000+ students)
- With no clear mandate except to “assess, treat, consult, write reports, support teachers” upon referral

I.E. PLEASE DELIVER HEALTH CARE
–
IN OUR EDUCATION “CULTURE”

THE REALITY…

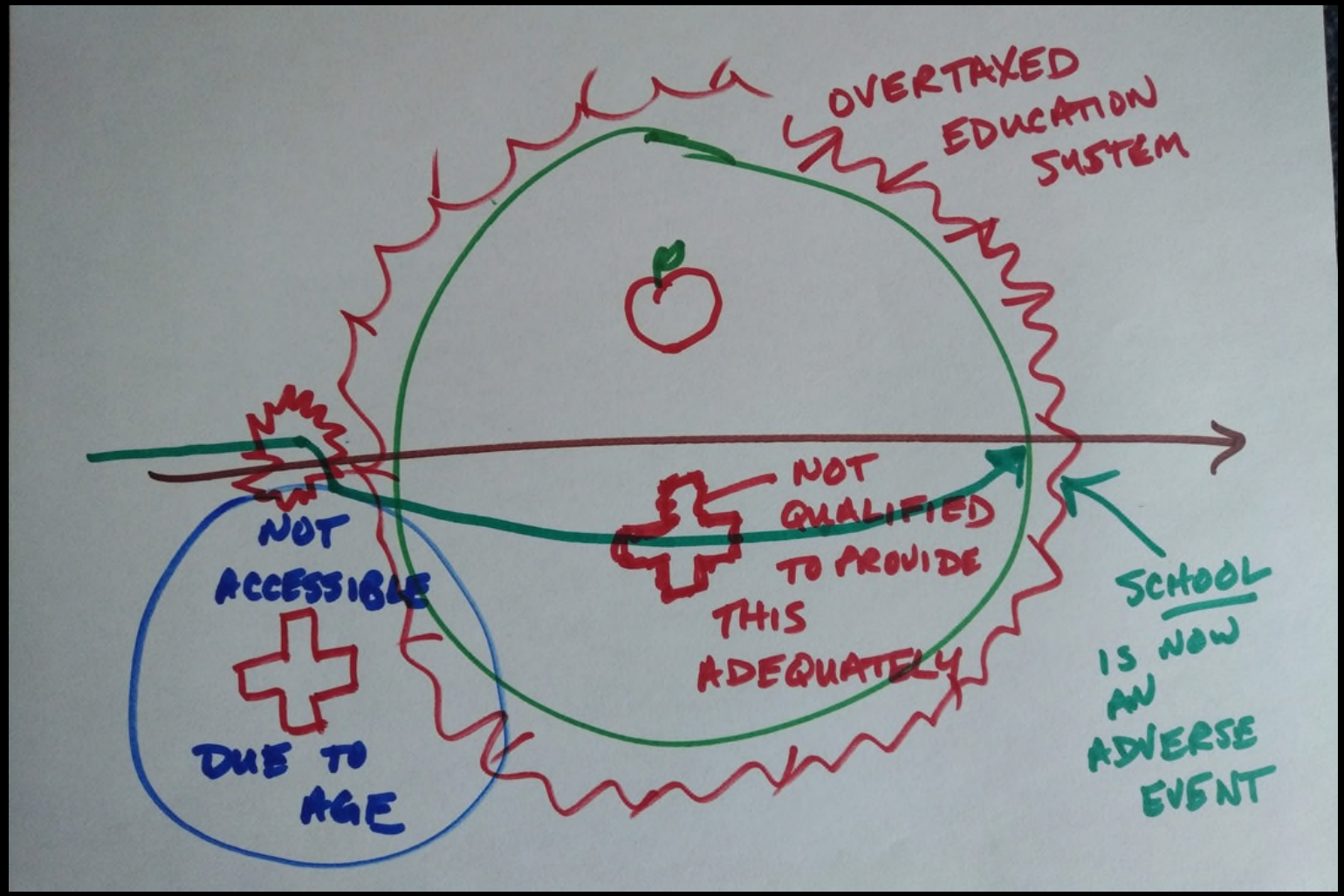
- 5% of 9000 students (incidence of DCD) is 450 students (https://canchild.ca/en/diagnoses/developmental-coordination-disorder)
- 1/68 of 9000 students (incidence of autism) is 132 students (https://canchild.ca/en/diagnoses/autism-spectrum-disorder)
- 1/400 of 9000 students (incidence of CP) is 22.5 students (https://canchild.ca/en/diagnoses/cerebral-palsy)

FAS/FAE, TBI (including a lot of shaken baby), genetic syndromes, ID (diagnosed and yet to be diagnosed), TRAUMA, attachment issues, severe regulation issues, layered cultural misunderstandings, severe isolation and poverty, gang affiliations and prostitution, abuse and neglect, domestic violence, POVERTY…

MY ETHICAL DILEMMA…

My clinical experience is sufficient (i.e. I have made enough mistakes so far) to know:

- This is not a sustainable caseload for any reasonable person
- There are ethical landmines everywhere (consent, confidentiality, expectation of service, supervision of support personnel…)
- that I am outside of Health Care and so all my assumptions need to be questioned


OVERTAXED
EDUCATION
SYSTEM
NOT
ACCESSIBLE
DUE TO
AGE
NOT
QUALIFIED
TO PROVIDE
THIS
ADEQUATELY
SCHOOL
IS NOW
AN
ADVERSE
EVENT

ASSUMPTIONS I HAVE ENCOUNTERED IN BOTH HEALTH AND EDUCATION:

- Some children are disabled enough that they are not ready for school
- These children require health care in order to be "okay"
- Only children who are "okay" are ready for school
- Teachers are not adequately trained to deal with disabled children; I am being asked for my expertise because health care uses methods dangerous to laypersons (NO ONE wants to hurt an already disabled child!!)
- If a child is very disabled, then therapy is a better use of time for them than anything an educator could provide
- School is able to adapt to a range of normal; outside of that, the children need to adapt to school as it is

HARM

- Student becomes a "patient" to teacher, parent, and me (and therefore to the student herself)
- Student is now differentiated from regular students in a way that actually makes people feel they are unable to treat her in the same way as regular children, because this would harm her
- Teachers feel disempowered because the last thing they want to do is harm a disabled child with their incompetence; they withdraw from her in all important teacher ways – usually an EA is now the primary relationship
- The parents are told that health care is being provided at school (but it is at a very low level because of the overall needs)
- The health care system is also told this, and withdraws from providing a duplicate service, reasoning that natural environments are best

IF THE CHILD IS MY CLIENT AS THE SYSTEM ASSUMES S/HE IS:

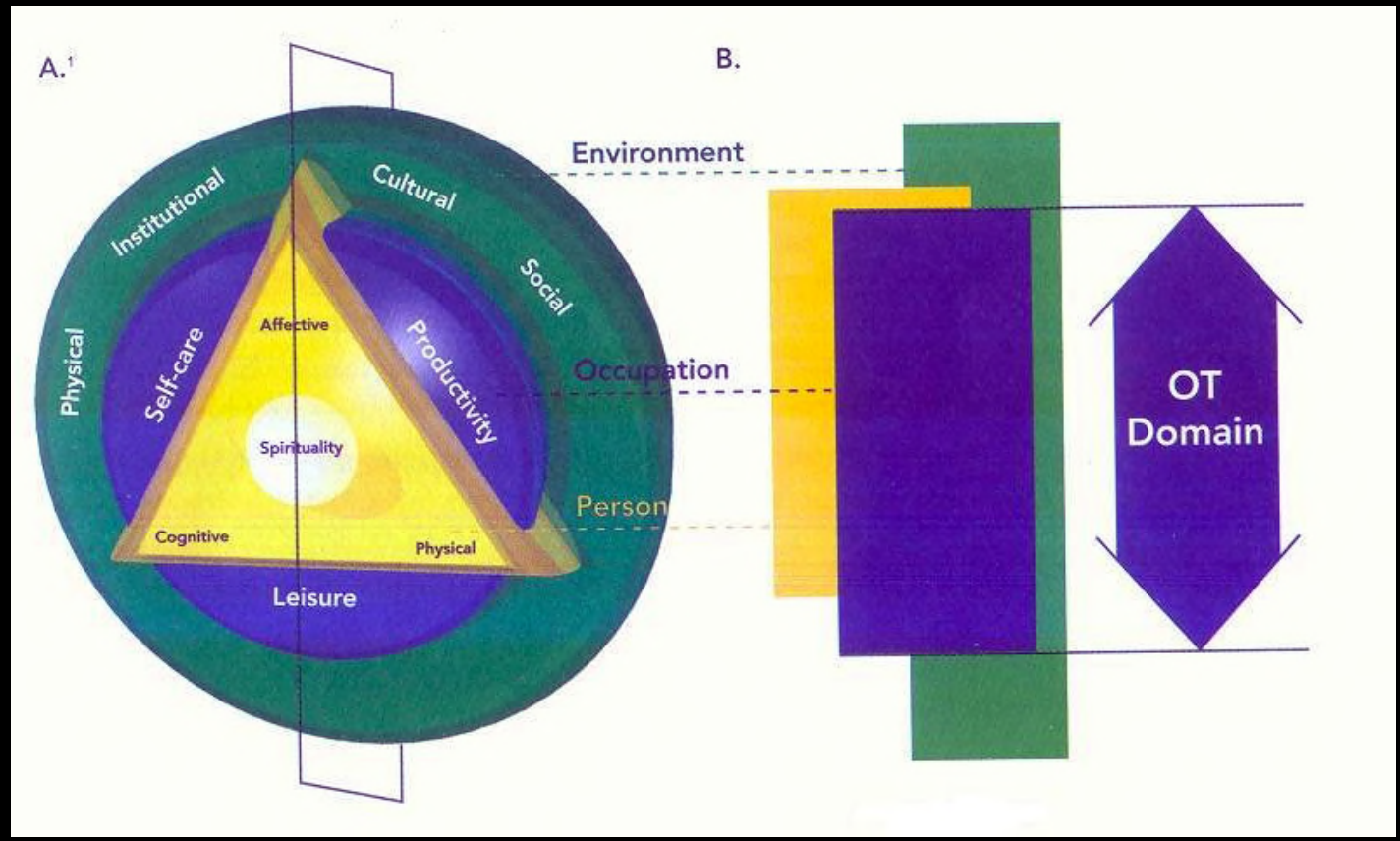
- I am not resourced in a way that is SAFE, effective, sustainable, and which falls within the description of "informed consent"
- I am in direct competition with the teacher for time with the child, resource allocation, energy, and consent from parents for my involvement
- My relationship with the child, or that of my designated support person, is at the expense of a normal teacher student relationship, and stigmatizes rather than includes a child

I SPIN THE PROBLEM

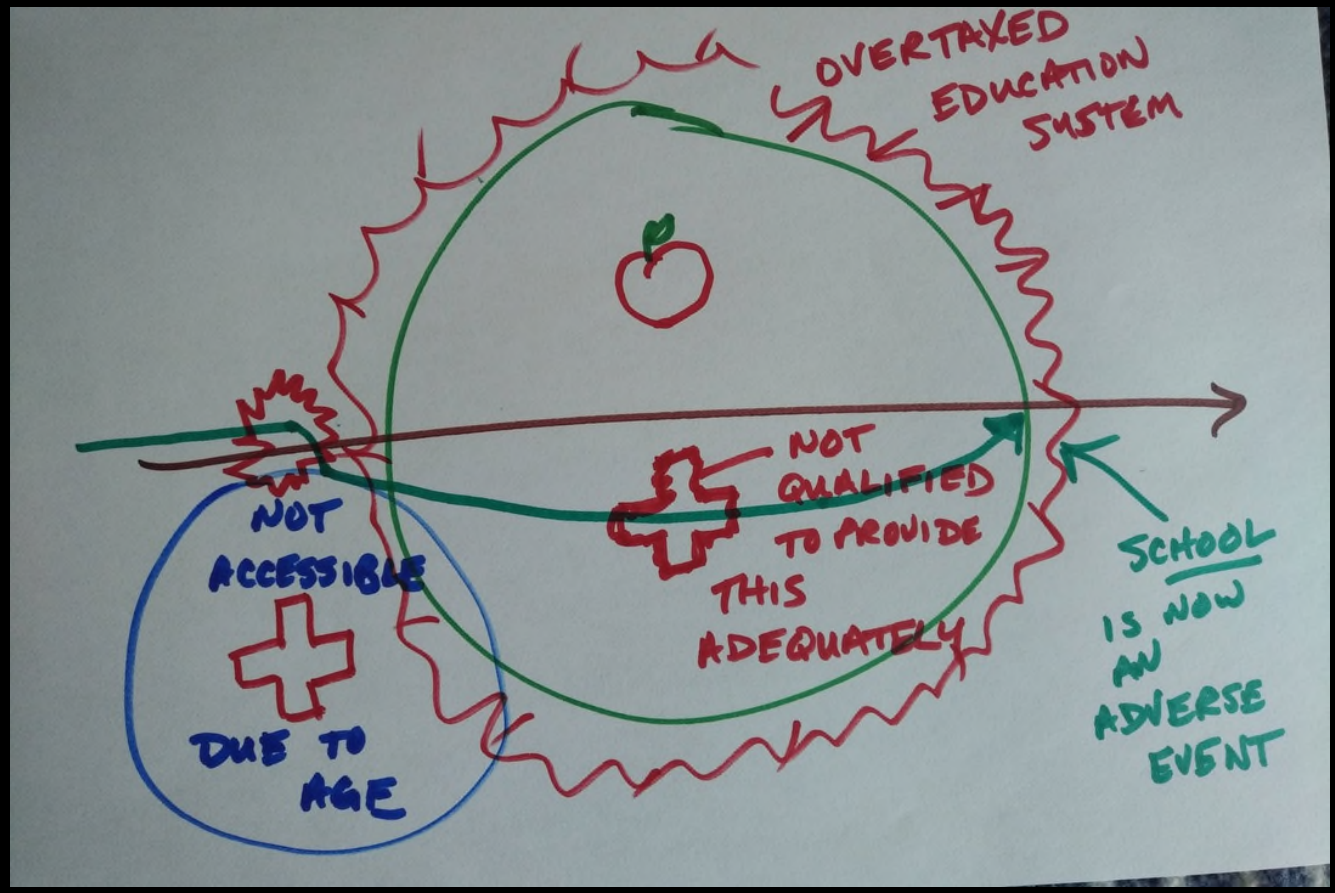
http://i2.wp.com/boingboing.net/wp-content/uploads/2015/06/1e4f_mars_spinning_globe.gif

CAN THE EDUCATION SYSTEM ITSELF BECOME MY "CLIENT?"

(CMOP-E https://vula.uct.ac.za/access/content/group/9c29ba04-b1ee-49b9-8c85-9a468b556ce2/Framework_2/pdf/The%20Canadian%20Model%20of%20Occupational%20Performance%20and%20Engagement.pdf)



CHANGING WHO THE CLIENT IS…



THE OCCUPATIONAL PERFORMANCE PROBLEM OF EDUCATION - TODAY

(from the Education Act https://publications.saskatchewan.ca/#/products/87171)

Right to attend school at cost of school division
142*(1) Subject to the other provisions of this Act, every person who has attained the age of six years but has not yet attained the age of 22 years has the right:*

(a) to attend school in the school division where that person or that person's parents or guardians reside; and

(b) to receive instruction appropriate to that person's age and level of educational achievement.

AND

Pupils with intensive needs
178(1) In this section and sections 178.1 and 370:

"assessment" means an evaluation of a pupil's capacity to learn based on one or more of the following:

(a) the pupil's cognitive functioning;

(b) the pupil's social-emotional functioning;

(c) the pupil's behavioural functioning;

(d) the pupil's physical functioning; (« *évaluation* »)

"pupil with intensive needs" means a pupil who has been assessed by a board of education or the conseil scolaire in accordance with this section and the regulations as having a capacity to learn that is compromised by a cognitive, social-emotional, behavioural or physical condition. (« *élève a besoins particuliers* »)

AND

(9) A board of education or the conseil scolaire, as the case may be, shall take steps to *reasonably accommodate a pupil with intensive needs in the regular program of instruction.*

(italics mine)

OPENS THE DOOR TO MORE ETHICAL PRACTICE (DO NO HARM)

- To CHILDREN (by asking the education system to adapt to their needs, rather than the reverse)
- To TEACHERS (by helping them do their job, instead of asking them to use their resources to allow me to do mine in their territory)
- To PARENTS (by accurately conveying what the mandate of the education system is, and helping them advocate to health care for what they need)
- To the SYSTEM (by engaging with decision makers, administrators, and citizens precisely about the true needs of children in all of their natural environments)
- To HEALTH CARE PROFESSIONALS IN EDUCATION (by acting congruently with our ethics and creating sustainable practices that are actually helpful to the client)

SO I CREATED A TOOL

- With the help of an amazing Intensive Supports team in SRPSD
- Introduced to teachers in May 2019, in use this fall on a trial basis
- Still in draft form with lots of changes happening and planned
- The tool is basically the outworking of a paradigm shift around medical model vs educational model
- Is meant to accurately describe students and allow reasonable accommodations to meet needs without "health care" in schools, as a prerequisite to education access
- …Unless safety is an issue (as per the Education Act) in which case Health Care is consulted outside of Education

SCAFFOLDING TOOL FOR EDUCATION PLANNING (STEP)

A map to align educational accommodations with student needs

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Attic Therapy
While under contract with
Saskatchewan Rivers Public School Division 119

Supervisory support and administrative direction provided by
Tom Michaud, Superintendent of Schools, Intensive Supports

May 2019

Creating this tool would not have been possible without the collaborative professional expertise of the entire Intensive Supports Team at Saskatchewan Rivers Public School Division, 2017 - 2019:

Callie Bruner
Krista Cochrane
Kelly Gerhardt
Heather Jeancart
Sherry Just
Randy Krammer
Jan Kulpa
Christina Lepage
Bryn Michalchuk
Cheryl Mullner
Laura Nicholson
Kate Pashovitz
Tracy Rouault
Lambert Schwartzenberger
Danica Shultz
Kendra Sittler-Gane
Cheryl Turner
Geri Woods
Angela Yeaman

As well as
the dedicated administrators, educational support teachers, classroom teachers and support staff of the entire division.

Physical therapy expertise and professional support provided by
Dan Lundell
Attic Therapy

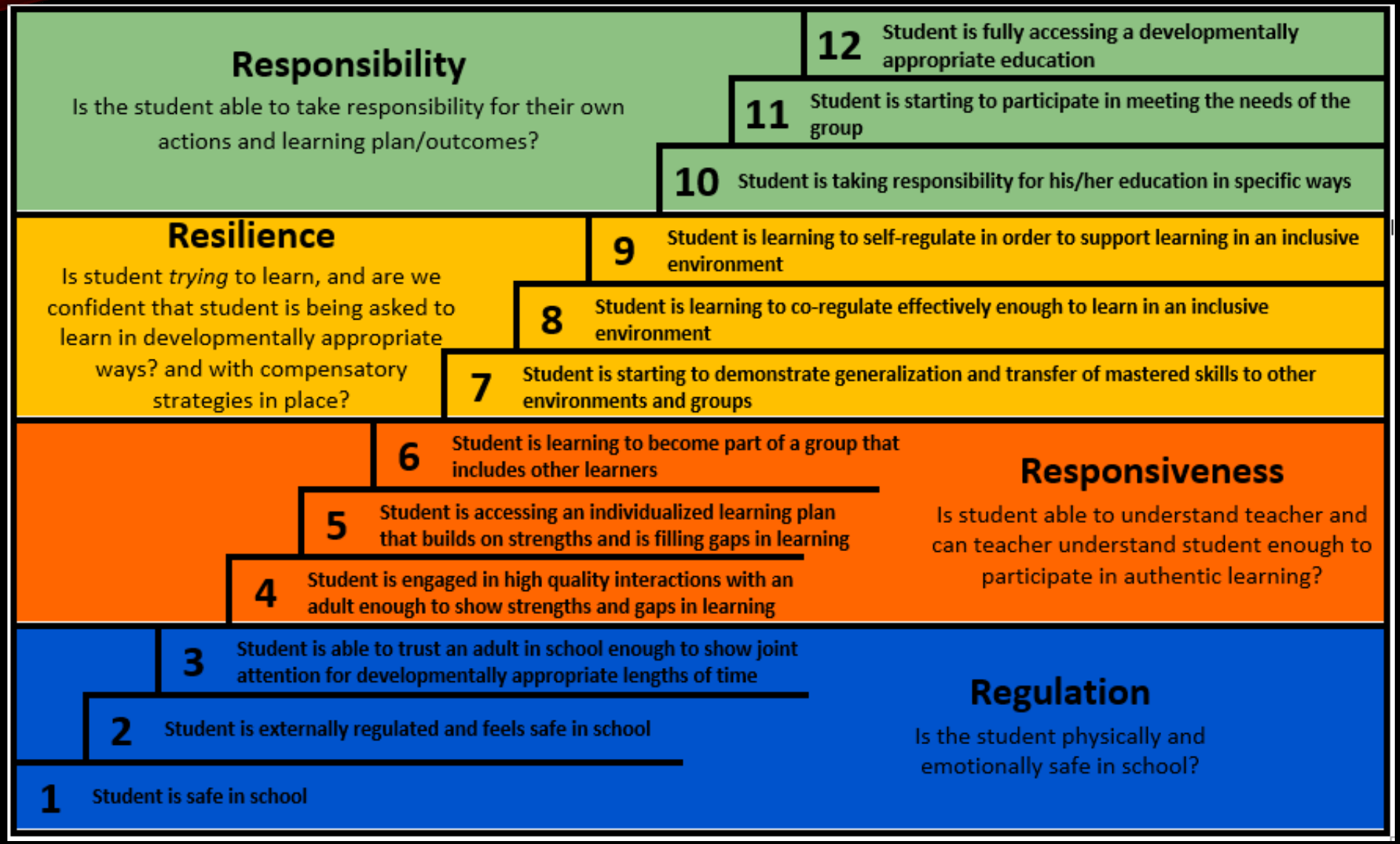
Thank you.

FEATURES OF STEP MODEL

- Acknowledges the actual, functional needs of children in schools, but only to describe, not treat.
- Acknowledges the roles and responsibilities of the education system, because the teachers are my clients, and they need my help.
- Based on attachment theory, learning theory, neurodevelopment models, motor learning approaches, functional and natural environments and tasks, and other overlapping knowledge bases between therapists and education providers.

MOST IMPORTANTLY

The entire point of STEP is to "map" students relative to their proximity to an *authentic, effective, mutually understandable teacher student relationship,* which is the whole point of our education system, and what **all** disabilities threaten


Responsibility
Is the student able to take responsibility for their own actions and learning plan/outcomes?
12 Student is fully accessing a developmentally appropriate education
11 Student is starting to participate in meeting the needs of the group
10 Student is taking responsibility for his/her education in specific ways
Resilience
Is student *trying* to learn, and are we confident that student is being asked to learn in developmentally appropriate ways? and with compensatory strategies in place?
9 Student is learning to self-regulate in order to support learning in an inclusive environment
8 Student is learning to co-regulate effectively enough to learn in an inclusive environment
7 Student is starting to demonstrate generalization and transfer of mastered skills to other environments and groups
6 Student is learning to become part of a group that includes other learners
5 Student is accessing an individualized learning plan that builds on strengths and is filling gaps in learning
4 Student is engaged in high quality interactions with an adult enough to show strengths and gaps in learning
Responsiveness
Is student able to understand teacher and can teacher understand student enough to participate in authentic learning?
3 Student is able to trust an adult in school enough to show joint attention for developmentally appropriate lengths of time
2 Student is externally regulated and feels safe in school
1 Student is safe in school
Regulation
Is the student physically and emotionally safe in school?

SHOWING PROGRESS IN AN EDUCATIONAL FRAMEWORK (ABILITY FOCUSED)

Return to STEP Overview

Regulation

Step 2: External Regulation

Student is externally regulated and feels safe in school

C-Team Summary

Step 2 Rubric: Student is externally regulated and feels safe in school Student Levels of Achievement			
1	2	3	4
Student enters the school in a dysregulated state most of the time, and has great difficulty comprehending offered regulation techniques, and therefore does not respond well, often leaving in the same state as he/she arrived.	Student enters school in a dysregulated state most of the time, Still acting out rather than signalling need most of the time, but will accept and respond to regulation techniques within an hour, and will leave most of the time in a better regulated state than arrival.	Student enters school and immediately makes physical connection with adult regulation partner. More signalling of needs than "acting out." Child clearly enjoys offered regulation techniques whether or not he/she has asked for them. Most days student leaves better regulated.	Student enters school with a clear expectation of entering into a trusting state of joint attention. Student signals needs for regulation as they occur, with no desperation and with enjoyment of offered help. Some joint play is possible (engagement or back and forth).
Go to STEP 1		Student is ready to proceed to: Step 3 - Student is able to trust an adult in school enough to show joint attention	

Student descriptors:

Student is dysregulated upon entering the school building. Supports typically provided to his/her age group are ineffective in reducing behaviours that could be harmful to self or others, and which display considerable distress.

Return to STEP Overview

SHOWING PROGRESS IN AN EDUCATIONAL FRAMEWORK (ABILITY FOCUSED)

Return to STEP Overview

Targeted areas of change:

- Provide a stable attachment figure who will externally regulate the student:
  - Until he/she is able to cope with demands of a school environment
  - for a developmentally appropriate length of time (in order to support an education plan)
- Coach the attachment figure as to role and tools for external regulation that are safe for staff and all students
- Provide a safe environment and structure that student can reasonably cope with in terms of overall stimulation (including length of time in building)
- Reduce performance demands on student to minimum
- Adapt safety plan to account for this STEP.

Focus of education plan:

- Life and health of student, staff, and other students
- Dignity
- Access to school building and necessary spaces
- Human rights within the context of education

Tools available to education team:

- **Step 2 Parent Information Page**

Return to STEP Overview

WHAT NEXT?

I am asking for your help in:

- Completing research as to the evidence bases for the STEP model
- Completing research as to efficacy of STEP as a paradigm shift for Health and Special Education professionals in the education sector
- Opening up more conversations between health and education as to the most effective roles and methods of collaboration, between our cultures, for Saskatchewan's residents

THANK YOU

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