AIMEE PILLER

# IMPLEMENTING SCHOOL-BASED OCCUPATIONAL THERAPY SERVICES

## A Multi-Tiered Approach to Sensory Processing Needs

ROUTLEDGE

"A must-read for anyone in the school setting, *Implementing School-Based Occupational Therapy Services: A Multi-Tiered Approach to Sensory Processing Needs* offers practical strategies to address sensory challenges. Dr. Piller combines research-based insights with real-world applications, making complex concepts accessible. This book empowers occupational therapy practitioners to support all children, fostering inclusive classrooms and promoting independence. Informative and inspiring, it's an essential resource for school personnel."

**Lauren Andelin, OTD, OTR/L, BCP,** *Assistant Professor of Occupational Therapy at Virginia Commonwealth University.*

"This is a must read for all school-based occupational therapists and should be required reading in occupational therapy pediatric coursework. Gone are the days of occupational therapists solely providing direct fine motor interventions in the school setting. Occupational therapy must be prepared to provide all forms of occupational therapy to address academic, behavioral, and social-emotional needs under a multi-tiered system and this book provides a guideline for how to implement such strategies. It provides the necessary background to understand the need for providing appropriate services, how to evaluate for services, and usable strategies to implement at each level. The author clearly has strong knowledge of sensory-based approaches and how to implement them in the school setting."

**Jessica McHugh Conlin, PhD, OTR/L, BCP, OT** *with 25 years of experience in school-based practice.*

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# Implementing School-Based Occupational Therapy Services

This book focuses on providing occupational therapy sensory interventions through a tiered approach to help improve academic participation, covering assessment of the sensory aspects of the environment and population, as well as at the group level.

Chapters showcase how occupational therapy practitioners can effectively contribute to each tier of the multi-tiered system of supports (MTSS) framework, with an emphasis on Tiers 1 and 2. The book also provides evidence-based methods to monitor outcomes of provided interventions and discuss how and when to modify the interventions, and highlights innovative strategies to support a broad range of students, especially those who may need additional assistance but do not qualify for specialized services.

While there are many reasons students might require support, this book zeroes in on sensory processing challenges and their impact on classroom participation and academic performance. By addressing these needs, occupational therapy practitioners can foster a more inclusive, engaging, and supportive learning environment for every student.

**Aimee Piller PhD, OTR/L, BCP, FAOTA,** is the owner and director of Piller Child Development, an outpatient pediatric therapy company with three locations in the greater Phoenix area. She is a practicing occupational therapist with almost 20 years of experience in a variety of pediatric settings including outpatient home health and schools.

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## A Multi-Tiered Approach to Sensory Processing Needs

Aimee Piller

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# Contents


| | | |
|---|---|---|
| | Introduction | 1 |
| 1 | A Brief Review of Legislation Guiding School-Based Occupational Therapy Practice | 5 |
| 2 | Sensory Processing and Its Impact on Education | 30 |
| 3 | Multi-Tiered System of Supports and Occupational Therapy and Sensory Needs | 50 |
| 4 | Assessing the Need for Sensory Interventions | 78 |
| 5 | Designing Interventions to Address Sensory Processing Needs | 115 |
| 6 | Evaluating Outcomes of Interventions | 156 |
| 7 | Working with a Multidisciplinary Team | 179 |
| 8 | Changing the Service Model: Facilitating Lasting Change | 204 |
| | *Index* | *223* |

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# Introduction

I became an occupational therapist in 2006. Wide-eyed, armed with a master's degree in occupational therapy and a bachelor's degree in elementary education, I was on my way to work in schools. I loved education, and I loved even more the idea of helping children who struggled with mainstream education thrive and grow. Working as an occupational therapist in a school setting was my dream, and I could not wait to work with teachers, parents, and especially with students.

My first job was in early childhood education at a local public school with a solid reputation for providing high-quality special education services. In fact, many families moved into the district specifically to access these special education services for their children. I was the only occupational therapist working in the early childhood age group, but the district had a team that consisted of one occupational therapist and four occupational therapy assistants. While I served different students, this committed occupational therapy team met every week to collaborate and ensure continuity from preschool through to high school. Looking back, perhaps my ignorance was my best asset. I did not know how the previous therapist had done things at the school. I had no prior experience working as an occupational therapist in a school setting. And I had done my internships in medical settings, so my only reference for schools was from my own educational background. As a young therapist, I was eager to learn and grow. I attended the team meetings each week, even though these were unpaid. I wanted to be part of the team and ensure I knew what was happening with the students and staff. Meeting with the teachers, speech-language pathologists, and other team members allowed me to develop a sense of camaraderie with my colleagues, building my confidence and giving me a feeling of fulfillment.

It was a learning curve, to say the least. I worked hard to understand the student's needs, learn the flow of the day, and understand the special education processes, all while learning to be an occupational therapist. I loved that job and loved my team. Had I not moved across the country a few years later, I would probably still be working there today.

Perhaps it was because I did not know anything different, but I ended up developing a method to implement occupational therapy services using a tiered

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approach. In a way, I provided services in a multi-tiered system of supports (MTSS) long before MTSS was law. The district was very supportive of therapy, which meant I could see almost every student in my caseload for at least 60 minutes a week under their Individualized Education Plan (IEP). This was great for the students, but with only one therapist working four days a week, my schedule quickly became full. I had to develop a better method to meet the service minute requirements and ensure students received high-quality care.

Once a week, I would pull the students out of class to my occupational therapy area and provide very traditional occupational therapy services, working with either one or two students who shared similar goals. As my caseload grew, I became creative with how to best use my time. There was one teacher I worked with closely who was welcoming of my expertise and suggestions, and I asked her if I could come in once a week and run an occupational therapy group focused on motor and sensory needs. She agreed since, while I was running the class, she could either work individually with a student on their goals or plan other lessons. I offered services designed to address the student's goals on my caseload, but all students in the classroom benefited from the occupational therapy group time.

The model proved successful, and other teachers asked me to come in and run an occupational therapy group once or twice a week in their classrooms. This was great for me. I could continue providing highly individualized services to the students on my caseload while also serving other students. I balanced my workload by providing group therapy once a week instead of individual treatment for every service minute. This helped me use my time more efficiently and allowed me the time to service clients one-on-one.

The teachers observed the impact of sensory interventions on their students' success and wanted to provide even more sensory support. Every teacher that year advocated for sensory equipment in their teaching classroom and asked for my input on how to spend their supply budget on these sensory tools. They also saw the value of providing sensory input throughout the day but recognized this required time from classroom staff. The teachers got together as a team and advocated for the administration to provide an additional classroom assistant who reported to me, the occupational therapist. This person's main job was to ensure sensory diets (specified sensory accommodations to meet a student's sensory needs) were implemented according to how I prescribed them, and to work with me to ensure the student's sensory needs were met. The teachers continued to welcome me in their classrooms and wanted my suggestions because they recognized that my support helped their students succeed.

Little did I know, all those years ago, that experience would be the foundation for this book. I implemented Tier 1 and Tier 2 interventions before the idea of MTSS, and I saw the effectiveness of these interventions. So did the teachers. One aftermath of the COVID pandemic is that more and more children have

increased sensory needs. There are so many students, and there are not enough practitioners to service them all.

That is why I have written this book. Based on my experience in implementing this model, much like MTSS, I want to share and help occupational therapy practitioners, teachers, and administrators see the value of occupational therapy as a regular element of the classroom, interwoven throughout the school day.

In short, this book will demonstrate how to implement and examine occupational therapy services in the school system under the tiered model. The Every Student Succeeds Act (ESSA) of 2015 outlines the requirements of schools to provide support for all students under an MTSS framework to facilitate academic, behavioral, and social-emotional well-being. Occupational therapists have traditionally practiced under what is now considered Tier 3 of MTSS, providing direct services to individuals who qualified for special education services. However, occupational therapy practitioners have much to offer all students school-wide. This book outlines how occupational therapy practitioners can provide school-based services at each tier (with a particular focus on Tier 1 and Tier 2) to service all students who may need support. While students may be identified as needing support for a variety of reasons, this book will focus on sensory processing to support classroom participation and academic-related occupational performance.

In the first part of this book, I will provide an overview of relevant laws that guide occupational therapy services in the educational system. I will then move to look at how each tier can specifically relate to occupational therapy services and sensory processing needs. Since Tier 3 is considered traditional for occupational therapy services and most practitioners are well-versed in providing this support, I will emphasize and discuss the importance of assessment and intervention at Tier 1 and Tier 2. From here, I will look at how occupational therapy practitioners can implement high-quality interventions at each tier that fit within the occupational therapy framework rather than just sensory suggestions that anyone can provide.

But, why should we focus on implementing services at Tier 1 and Tier 2 levels? As occupational therapists and school personnel, it helps us support more students and moves us from a caseload model to a workload model, decreasing stress and burnout. Due to the high caseloads of therapists, freeing up more time to focus on individuals with higher or more specific needs will benefit everyone. For each of the tiers, I will outline specific evaluation methods, develop treatment plans and interventions, and monitor outcomes to ensure interventions are meeting the goals of ESSA. These will specifically relate to sensory processing needs in the school setting, as this is one of the most common reasons students are referred to occupational therapy services. Finally, I will provide a guide on advocating for occupational therapy interventions at Tier 1 and Tier 2, and offer methods to work with and train school personnel to implement a successful program in the school setting.

Occupational therapy has so much to offer our clients and the educational system. Yet, if we continue to service every client under an individualized model, not only will some students be neglected and miss out on services, but occupational practitioners will become burnt out. They may leave the school setting or, worse, leave the profession. With a slight shift in thinking, occupational therapy has the potential to impact all students, while allowing practitioners to reserve our time for those who have higher needs. When we work with teachers, administrators, and school personnel through an MTSS model, occupational therapy can change the field of education and help ensure success for all students. Occupational therapy can become so much more than just a related service provider – we can become an essential part of the education system.

Chapter 1

# A Brief Review of Legislation Guiding School-Based Occupational Therapy Practice

## Legislation Guiding School-Based Occupational Therapy Practice

In public education, legislation at the federal level guides the implementation and funding of occupational therapy services. Therefore, it is essential that occupational therapy practitioners understand these laws and regulations as they directly impact their practice and the occupational therapy services available in their school settings. In this chapter, we will firstly review the history of occupational therapy in school settings and examine the changes in legislation that guide our practice today. We will then examine the role and responsibility of occupational therapists in creating an inclusive learning environment for all students, supporting students and staff in ensuring everyone has access to education regardless of their sensory or additional needs.

### *A Short History of Occupational Therapy in Public Education*

Before the 1960s, the role of the occupational therapist working within the school system was rare. Unfortunately, this meant that many students with accessibility needs were often excluded or restricted from benefiting from the same level of education as their peers. However, beginning with the Civil Rights movement, the 1960s and 1970s brought about many changes in the United States of America that led to new legislation that ensured equal access to education for many underserved and underrepresented populations. These changes included making public schools accessible to children with disabilities.

Prior to 1975, children with disabilities were often denied access to public education, and some states even had laws prohibiting students with disabilities from attending public school (U.S. Department of Education, 2024). Instead, they may have been sent to special schools, placed in hospitals for children with disabilities, or institutionalized, leaving few children with disabilities to be educated in the public-school setting. While some of these institutions included education for the basic academic skills of reading, writing, and math, the focus

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was on vocational skills building (Rioux & Chandler, 2019). These settings may have had occupational therapists working with the students, but this was not a requirement and often institutions did not have occupational therapists available.

It was not until 1975 that Congress passed the Education for All Handicapped Children Act (EHA) (Public Law 94–142) to ensure that all children had access to public education. This was the precursor to the Individuals with Disabilities Education Act (IDEA), which now guides the provision of occupational therapy services in the school setting and makes offering occupational therapy services a requirement for schools (Coates, 1985). As occupational therapists, it is important to look back at the history and contents of these legislations to understand the significance of our role within the school setting, inspiring us to strive for continuous change. Let us review these past laws to reflect on their impact in our work today.

#### *Individuals with Disabilities Education Act (1975)*

Originally known as the Education for All Handicapped Children Act (EHA) (Public Law 94–142), the Individuals with Disabilities Act (IDA) was implemented in 1975. This law aimed to ensure that every state was required to offer public education to all children, regardless of disability status. Before the implementation of EHA, nearly two million children were excluded from receiving an education, making this new legislation hugely impactful. One of the primary focuses of this law was to protect the rights of children and families, meaning that it was the responsibility of the state to identify and meet the needs of children with disabilities. The state, and consequently schools, were encouraged to support and improve the results and outcomes of children from birth through to graduation, and to guide them in their transition beyond school into their young adult lives (U.S. Department of Education, 2024).

In 1990, the United States Congress passed an amendment that expanded EHA, known as the Individuals with Disabilities Education Act (IDEA). This law addressed early intervention, specialized instruction, and related services. The major difference between EHA and IDEA was an expansion of who was eligible for special education services. IDEA also included additional age groups beyond school-age children, including infants and toddlers. Further, IDEA focused on keeping children in their neighborhood schools rather than requiring them to travel to schools far from their homes, and it required that children with disabilities were educated in the least restrictive environment (LRE), ensuring access to non-disabled peers (U.S. Department of Education, 2024).

Under this new law, occupational therapy was identified as a required related service to support students with disabilities in their access to and participation in special education services. IDEA differentiates occupational therapy from special education services but includes it as a requirement. Despite EHA allowing all children with disabilities to access public education, many students

were still excluded from a range of education services. The implementation of IDEA helped resolve these issues. Consequently, the changes in the law meant that schools had to increase their education services to include children with disabilities.

The immense impact of both EHA and IDEA on children within the US school system cannot be understated. With the addition of EHA and IDEA, more than 7.5 million children could access educational services and other services to increase functional outcomes and results in preparation for adult life. The statistics speak for themselves: after the implementation of IDEA, graduation rates and postsecondary education enrollment increased nationally (Rioux & Chandler, 2019; U.S. Department of Education, 2024).

Now, let us dive deeper into what IDEA states and stands for. By understanding this legislation fully, we will be able to frame our role as occupational therapists in the school setting, reminding us of the key principles to consider when working with the young people we encounter.

### *Individuals with Disabilities Education Act (IDEA)*

IDEA is divided into four parts.

- **Part A**: Outlines the importance of providing education for all students, specifically focusing on ensuring those with disabilities are given the same rights as all other children.
- **Part B**: Outlines how these services should be implemented for school-aged children.
- **Part C**: Outlines the early intervention services aimed at children from birth through to two years of age.
- **Part D**: Outlines federal grant funding and supports the education of students with disabilities.

We will now explore each of the first three parts of IDEA in depth, explaining how this law should impact the practice of occupational therapy in the school setting (U.S. Department of Education, 2019).

#### PART A

Part A outlines the importance of providing education for all students, specifically focusing on ensuring those with disabilities are given the same rights as all other children. This means all children have the right to a "free and appropriate education," also known as FAPE (Rioux & Chandler, 2019).

There are a few key aspects to consider when dealing with IDEA and FAPE. First, the family is an integral part of the educational team. They are required to be included in their child's educational process, and educational teams must

work with parents and caregivers to ensure their needs are heard, understood, and addressed. Secondly, whole school approaches should be developed to ensure that all children can access the provided education and curriculums. In addition to general education and curriculums, the school must provide individualized, specialized instruction when needed. This means that schools need to take an inclusive approach to education and focus on implementing instructional methods designed for various learning styles and needs.

Education is typically managed at the local school district level, with guidelines provided by individual states. However, IDEA is clear that state and local school districts must implement services under IDEA, with the federal government providing assistance and guidance in implementing the provisions outlined by the law. Therefore, each school district is responsible for ensuring their school meets the requirements for servicing all students, regardless of disability, in compliance with federal law. Children must have an identified disability that impacts their access to education from peers of the same age in order to be eligible for services under IDEA.

*Eligibility Categories According to IDEA* There are 14 different eligibility categories in IDEA for special education services, which are classified as low-incidence, medium-incidence, and high-incidence disabilities. Table 1.1 details these, including a summary of each eligibility criteria.

## PART B

Part B of IDEA addresses how schools should implement the assistance offered to children with disabilities, ensuring that the education provided in the school environment is accessible to all.

In accordance with Part A of IDEA, the full law allocates funds for a variety of services that children may need to access education, including requirements for staff and the individualized education program (IEP). Within IDEA, procedures are outlined that indicate the rights of parents should they be in disagreement with the IEP team, including procedural safeguards, mediation, due process, and appeals. Importantly, parents have a right to seek an outside independent educational evaluation (IEE).

IEEs may occur in any area that is tested, including occupational therapy. Occupational therapists working outside of schools may perform in IEEs and provide recommendations related to education when evaluating children through this method. If occupational therapists who work in private practice perform IEEs, they must have an understanding of the laws and requirements of occupational therapy services at the federal, state, and district levels, which may differ significantly from the medical model requirements in the private outpatient therapy setting. In a school setting, the IEE becomes part of the student's school

*Table 1.1* Categories of Special Education with Incidence Level (U.S. Department of Education, 2019)

| *Category* | *Incidence Level* | *Summary of Eligibility Criteria* |
|---|---|---|
| Hearing impaired | Low | Includes conductive and sensorineural loss<br>Measured in terms of decibels<br>Varies by state |
| Deafness | Low | Unaided minimum, pure tone average 66–70dB |
| Visual impairment (including blindness) | Low | Based on visual acuity and visual field<br>Varies by state |
| Deaf-blindness | Low | Meets criteria for hearing impairment and visual impairment |
| Orthopedic impairment | Low | Orthopedic impairment caused by congenital anomalies, disease, or other causes<br>Evidence of severe orthopedic impairment, motor impairment with deficits in quality, speed, or accuracy by at least two standard deviations in fine motor, gross motor, or self-help; condition is permanent (longer than 60 days) |
| Traumatic brain injury | Low | Nonspecific and varies by state |
| Multiple disabilities | Low | Varies by state based on a combination of disabilities and severity |
| Autism | Medium | Impairments in social interaction and communication, restricted, repetitive, or stereotyped patterns of behavior |
| Developmental delay | Medium | Delay in one or more of the following areas: cognitive development, physical/motor development, communication development, social/emotional development, and adaptive development; varies across states as to severity |
| Intellectual disability | Medium | Subaverage intellectual functioning and adaptive functioning; severity can vary by state, but generally should be at least two standard deviations below the mean |
| Emotional disturbance | Medium | Serious behavior problems that are present over a long period of time (typically more than six months); specificity and severity varies by state |
| Specific learning disability | High | Varies by state, but is often based on data from Response to Intervention (RTI); discrepancy is present between intellectual ability and achievement (often at least 1.5 standard deviations below the mean) |
| Speech language impairment | High | Includes articulation, voice, fluency, and language disorders; varies by state, but is typically based on standardized, norm-referenced assessments |
| Other health impairment | High | Acute health problems that result in limitations to strength, vitality, and limited or heightened alertness to the environment; includes attention-deficit disorder (ADD) and attention-deficit/hyperactivity disorder (ADHD) |

record and evaluation report, and the IEP team has to consider its outcomes. However, the IEP team does not have to accept the results and recommendations.

Table 1.2 below outlines the required components of the IEP, highlighting which areas are the responsibility of the occupational therapist within the program. These components are there to support the student needing individualized assistance to meet their goals.

Whilst focused on public education, Part B also allows students who attend private schools or are home schooled to access services through their local school districts. Child find is a program that helps to identify children who may

*Table 1.2* Required Components in IEP

| *Component* | *Brief Description* | *Occupational Therapist May be Responsible for Portions* |
|---|---|---|
| Statement of present levels of academic achievement and functional performance | Includes how disability may impact participation in general education | Yes |
| Measurable annual goals | Academic and functional goals that address the child's needs<br>Benchmark short-term objectives outline steps to meet goals | Yes |
| Progress reporting | Summary of child's progress towards goals and how progress will be measured | Yes |
| Statement of special education, related services, and supplemental aids and services | Includes services the child will receive and when those will begin | Yes |
| Statement of modifications or supports | Description of modifications or supports provided to the student to facilitate progress toward goals | Yes |
| Explanation of the extent to which the student will participate in the general education classroom | Amount of time the child will participate with nondisabled peers | May make recommendations |
| Individual accommodations | Accommodations needed to measure performance and achievement | May make recommendations |
| Transition services and post-secondary goals | Required for students at age 16 | Yes |

have disabilities and may need specialized instructions (U.S. Department of Education, 2017a). Many community organizations, local educational agencies, state educational agencies, and early intervention programs assist with Child find. In addition, private medical providers, including occupational therapists, may also refer children to a local school district for evaluation. This helps to ensure that even children who do not attend a local public school can access services under IDEA.

Another important aspect of Part B is the provision of transitional services to help students progress to adulthood and post-graduation. These services must be in the IEP by the time the student reaches 16, and the student should be part of the planning and goal-setting process for transition services (U.S. Department of Education, 2020).

Finally, a fundamental aspect of IDEA is that children should be educated in the least restrictive environment (LRE), meaning that students who have disabilities should spend as much time in the general education classroom with nondisabled peers as possible. The LRE allows students to engage with peers socially, establish peer role models, and help students prepare for life in the community. In addition, nondisabled peers also have an opportunity to connect with students with disabilities, promoting community and acceptance. In these situations, support can, and should be, provided in the general education setting to help students participate. Services, including occupational therapy, should also strive for LRE when providing services to support learning and participation within the classroom with peers.

Typically the LRE is where students with disabilities spend time in classrooms and other spaces with students without disabilities, but the LRE must be considered on an individual basis, which is determined by the IEP team (Schneider & Chandler, 2019). Some students with sensory processing differences may have difficulties with auditory and tactile sensitivities. The busy mainstream classroom may actually be more restrictive, due to their sensory processing, than a smaller, more individualized classroom. Therefore, it is important to consider each student's needs, rather than just considering the general education setting as the LRE.

### PART C

Part C of IDEA outlines the services for children from birth until their third birthday, often known as early intervention services. Once a child becomes three years old, they move to Part B of IDEA. One of the main goals of this portion of IDEA is to set children up for success early, maximizing their potential, helping families meet their children's needs, and reducing the costs of special education and related services later down the line.

Part C uses a multidisciplinary approach when evaluating which services are required to meet the diverse needs of infants and young children. The

intervention approach is family-centered for both the evaluation and intervention planning, and it emphasizes a coaching model to help caregivers learn to implement strategies provided to them by professionals. The services for children receiving treatment under Part C of IDEA are outlined in an Individualized Family Service Plan (IFSP), and these services aim to address specific needs in physical, cognitive, communication, social/emotional, and adaptive development (U.S. Department of Education, 2019).

Some components of the IFSP include the following.

- The child and family demographic, health, and social information, including details on what the transition will look like when the child turns three years of age.
- The functional abilities of the child, summarizing present development levels, including hearing, vision, physical health, strengths, and needs. This section also includes a summary of functional abilities in social-emotional skills (positive social-emotional skills), cognition (acquiring and using knowledge and skills), and adaptive skills (taking appropriate actions to meet needs).
- An outline of the family and child's routines, including self-care, play, and sleep.
- Information on the service coordinator, as well as identified goals and additional resources available to the family. These goals should be developed in collaboration with the parents.
- Activities, procedures, and services that should be implemented to achieve goals.

(U.S. Department of Education, 2019)

### REAUTHORIZATION OF IDEA (2004)

IDEA brought about incredible changes for students across the country, but more updates and adaptations were required. Congress reauthorized IDEA in 2004 with many expansions to the current law to meet the needs of students and to align with other federal laws, such as the No Child Left Behind Act, 20 U.S.C. § 6319 (2002). Some of the main additions included early intervening services and increased standards and accountability. Early intervening services are an essential component of this expansion as they provide services and support to children who may not have been previously identified under special education services (U.S. Department of Education, 2024).

However, more change was to come with the Every Student Succeeds Act over a decade later, which continues to directly inform our practice as occupational therapists in school settings.

### *Every Student Succeeds Act (ESSA, 2015)*

The Every Student Succeeds Act (ESSA) was signed into law in 2015. It was written to support and advocate for the success of all students in school settings. It focused on supporting equity in education, protecting disadvantaged students and those with high needs. To achieve this, it offered support for expanding preschool programs as well as additional funding for low-income students, promoting high academic standards and statewide assessment requirements (U.S. Department of Education, n.d.). One important aspect of ESSA is that specialized instructional support personnel, including occupational therapists, must be involved in program development and the implementation of accommodations (Schneider & Chandler, 2019). ESSA requires the development and monitoring of goals through progress monitoring, but it allows the districts to develop their own goals and ways to monitor progress (Cahill, 2019). One way this can be achieved in ESSA is through Response to Intervention (RTI).

### *Response to Intervention (RTI)*

Response to Intervention is designed to assist students before they reach a level of failure. Based on the student's needs, it provides high-quality instruction that is more individualized than the general curriculum, allowing the student to receive support that is specific to their areas of difficulty. Response to Intervention goes hand-in-hand with Positive Behavioral Support (PBS) to assist learning and behavior within the school setting.

With RTI and PBS, interprofessional teams work together to develop evidence-based interventions to support the student. To begin, the team has to identify and describe the student's academic and behavioral performance. This enables the team to effectively analyze areas of difficulty and establish a baseline of the student's performance. Over a period of time, several team members gather data at different points throughout the school day and week, helping them to develop a hypothesis as to why there is a concern for the student. From these results, the team identifies a specific performance or behavior to monitor, and they develop an intervention plan to address this based on the hypothesis that was previously formulated. Once the plan is executed, it is monitored to determine if it should be continued, changed, or discontinued (Cahill, 2019). In Chapter 6, we will explore progress monitoring and monitoring outcomes in more detail, but let us now turn to the latest part of ESSA: the multi-tiered system of supports (MTSS).

### *Multi-Tiered System of Supports (MTSS)*

The multi-tiered system of supports (MTSS) is part of ESSA that took full effect during the 2017–2018 school year. In contrast to previous legislation and

assistance offered, MTSS allows for all students to benefit from support through a tiered system, which is factored based on their specific needs. In addition to this, MTSS provides not just academic support to students, but also both social and emotional support (Walker et al., 2023).

Similar to RTI, MTSS is an interprofessional model where a team of school personnel work together to find solutions that support students towards success. However, another key difference is that it expands the RTI model by seeking to provide services and support through what is known as early intervening services. Previously, in order to qualify for special education services, students often had to exhibit a delay that is well below their expected grade level. In MTSS, the goal is to support a student before they are at a point of failure, and a huge benefit of MTSS is that it can be provided to students in the general education model. By providing support early, rather than waiting for students to fail, the hope is that more students will be successful in the general education model and not need higher intensity, specialized instruction.

Members of the MTSS team include teachers, speech-language pathologists, occupational therapists, physical therapists, psychologists and counselors, and many other school personnel. The team works together to identify problems, suggest solutions, develop and implement a plan for the student, and evaluate its effectiveness. Key components of MTSS are universal screening of all students to identify those who may need additional support, evidence-based interventions, and systematic data collection for progress monitoring. Three tiers are considered under this model, which we will now outline and define.

**Tier 1** interventions are universal learning supports that are classroom-wide, encompassing the needs of around 80% of students in the school, but are interventions provided to all students. The interventions are designed to be preventative and proactive to support students at all levels, including those identified as needing specialized instruction. Interventions such as universal learning designs fall under Tier 1.

**Tier 2** interventions are targeted group interventions, which can apply to approximately 10–15% of students. These students have been identified through universal screenings as potentially being at risk of falling behind. The interventions are targeted at specific needs through a small group model, with the small group's needs being fairly cohesive. For example, students who struggle with attention and have identified sensory processing needs may be placed into a group model for intervention separate from a small group of students who were identified as being at risk for falling behind in math. Interventions focus on the child's strengths and help to provide support for potential areas of concern. Therefore, students in the group who were identified as having attention difficulties due to sensory processing needs would have interventions targeted at sensory processing, tailored to the group needs, with the goal of improving attention in the classroom. The group identified as having difficulties in math would receive interventions designed to improve math skills. While the same

*Table 1.3* Multi-Tiered System of Supports (MTSS)

| *Tier Level* | *Description* | *Components (American Institute for Research [AIR], 2024)* | *Role of Occupational Therapist (Piller et al., 2023)* |
|---|---|---|---|
| Tier 1 | Universal/core instruction | Evidence and research-based<br>Problem-solving teams<br>Universal screening<br>Progress monitoring<br>Professional development | Training and education for teachers<br>Universal screenings<br>Modifications to the school environment<br>Population-based interventions |
| Tier 2 | Small group targeted interventions | More intensive<br>Small groups<br>Differentiated instruction | Design and monitoring of group interventions<br>Episodic problem-solving with staff |
| Tier 3 | Intensive intervention | Individualized and group<br>Connections to community agencies | Direct and consultative services typically under an IEP |

(Cahill, 2019; Walker et al., 2023; Piller et al., 2023)

students may be in both groups, goals and activities during the group time would be very different to address the needs of the group they are currently in.

**Tier 3** interventions are offered to students under IDEA when a student has been identified as needing individualized and intensive support. This is a small percentage of students, less than 5% of the general population within a school setting (American Occupational Therapy Association [AOTA], 2012; Cahill, 2019). The specifics of each tier will be addressed further in Chapter 3, but Table 1.3 summarizes each tier for reference below.

### *Other Important Legislations and Considerations for School-Based Practice*

Outside of the school setting, the majority of occupational therapy services are provided under a medical model. School-based practitioners have a unique role in providing educationally relevant occupational therapy services. However, in many school districts, occupational therapy services are still covered by Medicaid funds. Therefore, the occupational therapy practitioner must provide documentation that meets the guidelines of both the school setting (often district-dependent) and state Medicaid requirements.

#### FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)/ HEALTH INSURANCE AND PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

In educational settings, the Family Educational Rights and Privacy Act of 1974 (FERPA) 20 U.S.C. § 1232g (1974) protects the rights and privacy of students