Everybody Has the Right to Be Here: Perspectives of Related Service Therapists

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Abstract

This study describes data regarding inclusive related service provision for students with disabilities in public schools. Based on qualitative interviews from 15 related service providers (e.g., speech-language pathologists, occupational therapists, and physical therapists), these data highlight foundational issues that impact the delivery of related services within inclusive educational contexts that is necessary for students with disabilities to benefit from special education. Results of the study document strategies for collaboration, providing flexible service delivery, and negotiating logistical barriers. Implications for the provision of inclusive related services are discussed in order to ensure that 'everyone has the right to be here'.

Key Words: inclusion, related services, service delivery, classroom-based services, in-classroom services.

Introduction

Since the passage of the federal special education law in the United States of America, Education for All Handicapped Children Act (1975), now known as the Individuals with Disabilities Education Act (IDEA, 2004) any child with a disability is entitled to a free and appropriate public education in which the child's educational program is individualized and appropriate related services are provided to support his or her success in the least restrictive environment (LRE). As defined in the IDEA, related services encompass all "supportive services as may be required for a child with a disability to benefit from special education" (Section 300.24 (a)). IDEA lists numerous professional disciplines that might be required to provide these related services, including occupational therapists (OT), physical therapists (PT) and speech-language pathologists (SLP). To adhere to IDEA's least restrictive environment provision, these related service therapists are often required to serve as collaborative team members responsible for creating and delivering special educational services in the general education classroom (Feeney, Riddle, & Benedict, 2000; Gallagher, Tancredi, & Graham, 2018; Giangreco, 1995; Gillon, 2000; Tonennies, Bauman, & Huntenburg, 2002). In this way, special education and needed therapy, as identified by the IDEA is implemented as a service, not a place.

Related Service Delivery Models

In light of IDEA's LRE provision, special education teams and related service therapists around the United States have recognized the need to move away from a pull-out service delivery model, in which students are taken out of the classroom to receive individual or small-group sessions with therapists. Large-scale international research of surveys of over 2,000 school-based SLPs has demonstrated that pull-out service delivery is the dominant model used, yet "There have

been no efficacy studies that have evaluated the claim that 2-3 times a week for 20-30 minutes in group settings outside of the classroom is an effective service delivery model" (Brandel & Loeb, 2011, p.1). Research has found sole use of this model to be problematic because students with disabilities routinely miss important academic content (Cosier & Causton-Theoharis, 2013), social interaction (TASH, 2009) and access to optimal peer models of age-appropriate language, communication, and behavior skills (TASH, 2009).

This withdraw method of service delivery is problematic, according to Gallagher, Tancredi, and Graham (2018), because

> (1) it leaves [inclusive] educational practices that create barriers to children's access and participation in place, (2) reduces exposure to the full school curriculum, (3) suggests that children's needs cannot be met in the regular classroom, and (4) fails to positively enhance the knowledge and skills of the classroom teacher (p. 129).

Instead, related service therapists seek to adopt a more collaborative approach that supports students in the general education classroom (Case-Smith & Cable, 1996; Gallagher, Tancredi, & Graham, 2018; Glover, McCormack, & Smith-Tamaray, 2015; Reid, Chiu, Sinclair, Wehrmann, & Naseer, 2006; Sayers, 2008; Villeneuve, 2009). This type of collaboration approach often means that related service therapists such as OTs, PTs and SLPs will consult with the general and/or special education teachers (consultation delivery), or work with the student or a group of students directly within the general education classroom (classroom-based delivery) (Schraeder, 2013).

Several studies have examined the effectiveness (i.e. student outcomes) of classroom-based versus pull-out service delivery, finding that it is more advantageous for students when related service providers and educators co-teach in the general education classroom (Archibald, 2017; McGinty & Justice, 2006; Throneburg, Calvert, Sturm, Paramboukas, & Paul, 2000). These

studies are consistent with a pilot study done several decades ago which found consultation with the teacher was more effective for students with more significant disabilities than were pull-out services alone (Giangreco, 1986). Research has also evidenced that classroom-based service delivery (a) provides a more efficient workload strategy (Toennies, Bauman, & Huntenburg, 2002); b) increases student literacy and language development (Gormely & Ruhl, 2005); c) increases student time spent in LRE (Schraeder, 2013); and, d) increases the implementation of proactive, quality instruction and services within a responsiveness-to-intervention program (Schradeder, 2013). Classroom-based approaches also enhance skill generalization through their emphasis on naturalistic routines and materials, the involvement of peers as both conversational models and partners, and the involvement of teachers who can extend language instruction throughout the day (Wilcox, Kouri, & Caswell, 1991). The use of an inclusive, classroom-based model of service delivery has been found to positively impact the academic achievement of all students, not just students with disabilities (Burstein, Sears, Wilcoxen, Cabello, & Spagna, 2004; McLeskey & Waldron, 2006; Morris, Chrispeels, & Burke, 2003).

Perspectives of Related Service Therapists and Teachers

In a study conducted several decades ago in which direct pull-out service delivery was compared to consultation and classroom–based delivery, Dunn (1990) found that teachers who received consultation from related service therapists reported greater occupational therapy contributions to their student's IEP goals. These teachers also reported more positive comments about the services provided than the teachers whose students were pulled-out by related service therapists. In a review of 10 studies focused on related service delivery, Sawyer (2008) found that the literature suggested teachers were more satisfied with therapists' services and were more likely

to implement their recommendations within the classroom when collaborative consultation approaches were used. Sawyer's findings regarding teacher views are consistent with Fairbairn and Davidson's (1993) older report, which found, in a survey of 100 teachers who worked with related service therapists, the majority reported they preferred when therapists spent more time in the classroom (i.e. modeling strategies, co-teaching, etc.) rather than pulling children out of the classroom for one-on-one or small group sessions. Several studies that surveyed both teachers and related service therapists show results consistent with these findings, evidencing that both teachers and therapists would like better collaborative working practices, as well as more knowledge about how to implement collaborative practices (Antoniazzi, Snow, & Dickson-Swift, 2010; Dockrell & Lindsay, 2001; Wright & Kersner, 1999).

Collaboration for Inclusive Service Delivery

As collaborators, related service providers are equal partners in classroom learning experiences, rather than only providing expert advice (Gallagher, Tancredi, & Graham, 2018). Campbell, Missiuna, Rivard, and Pollock (2012) evidenced that related service therapists struggle with how to foster greater collaboration with their general and special education team members. This issue is addressed by extant research, which has evidenced the many elements that help to foster collaboration between teachers and therapists who provide services to students in the LRE. Increased time for therapists and teachers to meet is needed (Bayona et al., 2006; Bose & Hinojosa, 2008; Hartas, 2004; Nochajski, 2002; Wright & Kersner, 1999, 2004), and these meetings should focus on joint problem-solving (Barnes & Turner, 2001). Clear understanding of each other's individual roles and responsibilities is needed, (Hartas, 2004; Wehrmann, Chiu, Reid, & Sinclair, 2006) and specifically, studies have evidenced that in order to collaborate more

effectively teachers need to become more aware of student related service needs (Wehrmann et al., 2006) and therapists need to become more familiar with curriculum and classroom practices (Fairbairn & Davidson, 1993). Finally, the administration needs to support the collaborative process by developing and implementing school policies that encourage teamwork (Hartas, 2004; Villeneuve, 2009).

When the above factors are present within the collaborative processes, teachers and therapists more readily share knowledge and skills (Kersner & Wright, 1996; Tollerfield, 2003; Wright & Kersner, 2004) and the demands of both the general education curriculum and therapy requirements for the student are met with greater outcomes (Tollerfield, 2003; Wright & Kersner, 2004).

Purpose of Study

While there is extant research that addresses the elements needed for successful collaboration between therapists and teachers there is limited research that focuses on the perspectives and attitudes of related service therapists who are actively engaged in this collaborative and inclusive service delivery (Bose & Hinojosa, 2008). This study therefore sought to explore the perceptions of related service therapists regarding their approach to implementing collaborative, inclusive service delivery (i.e. consultative and classroom-based). Our research questions focused on how these therapists (a) described their inclusive, collaborative experiences; (b) how they believed they enacted their collaborative work within inclusive schools; and, (c) what barriers they faced and how they addressed these in order to implement their work.

Method

We employed a qualitative interview study methodology as the best method for gathering rich information from those therapists personally involved in inclusive service provision. Our goal was to "gather descriptive data in the subjects' own words so that the researchers can develop insights on how subjects interpret some piece of the world" (Bogdan & Biklen, 2007, p. 103). We collected stories from a range of similar individuals (Bogdan & Biklen, 2007) who engaged in inclusive service provision.

Participants

To gather a purposeful sample (Bogdan & Biklen, 2007), eligibility criteria were set prior to recruitment. We interviewed related service therapists who fit the following criteria, they: 1) provided consultative and classroom-based services for the majority of their workday (over 50%), 2) represented different types of related service therapists (OT, PT, SLP), 3) served students with a range of federal disability categories, and 4) represented various school settings (e.g., rural, urban, and suburban). The researchers work at universities in the northeast, so we therefore limited our recruitment area to the Northeast region of the United States. We contacted principals in this region who led buildings that provided inclusive special education services to students with disabilities, in which their students received their special education services in the general education classroom for the majority of their day (over 80%) and asked them to nominate related service therapists who conducted services in inclusive general education classrooms and/or provided consultation for at least 50% of their workday.

Twenty-one potential participants were nominated and were sent letters via email explaining the purpose of the study. Of these related service therapist nominees, 15 expressed

interest and met the eligibility criteria. Of the fifteen, four identified as physical therapists, five as occupational therapists, and six as speech-language pathologists. These participants were all white females who provided services to preschool to high school students with various labels of the 13 federal categories of disabilities, served pre-kindergarten to grade 12, and worked across rural, urban, and suburban districts. See Table 1 for participant demographics.

Table 1.

Participant Demographics

Participant's Name	Related Service Type	Years of Experience	Years of Experience with Inclusion	% of Time in I.C.
Terry	PT	16 years	16 years	70 %
Bernice	OT	25	25	80%
Mary	PT	4 years	4 years	90 %
Moe	SLP	10 years	9 years	80%
Nicole	SLP	21 years	15 years	85%
Francine	SLP	2 years	2 years	75%
Kim	OT	13 years	4 years	80%
Cora	PT	3.5 years	3.5 years	67%
Kelsey	OT	30	26	50%
Mary	SLP	24 years	5	50%
Kendra	SLP	9 years	9 years	90%
Vanessa	SLP	30 years	8 years	80%
Paulina	PT	12 years	10 years	75%

| Page | OT | 23 Years | 23 years | 70% |
| Joslyn | OT | 7 years | 6 years | 50% |

Note: PT = physical therapy; OT = occupational therapy; SLP = speech and language pathology; I.C. = inclusive contexts

Procedures

The first author conducted, recorded and transcribed verbatim each of the interviews. Each participant was interviewed twice over the course of 6 months and each interview ranged from 42 to 155 minutes, with an average of 71 minutes. Interviews occurred while participants were out of their school contexts and an interview guide was used to gather information about their workday, collaboration, design and implementation of inclusive therapy services, and stories that reflected moments of success and challenge (see Table 2 for the interview guide). The use of a semi-structured interview guide as a tool ensured that a range of topics were discussed yet provided flexibility for participants to shape the content and have the freedom to respond openly (Bogdan & Biklen, 2007). The interviewer altered the types of prompts and probing questions in order to elicit explanations, details, or examples of practice.

Table 2.

Semi-Structured Interview Guide

Interview Questions:

1. Describe your work in schools.
2. Describe a time that you experienced satisfaction in your work and tell me about it.
3. Help me understand how you came to be interested in providing therapy.
4. Tell me about a time you were proud of the progress a student made. What do you feel you learned from this?
5. Can you tell me about meeting or targeting specific therapy goals in a classroom setting? Give me an example of goals students have and tell me about meeting those goals.

6. Talk about collaborating with others to make this therapy work.
7. If you were giving new therapists advice about conducting inclusive therapy sessions, what advice would you give?
8. What strategies or ideas can you give to other therapists?
9. Can you tell me about a time when you had to take a strong stand about something?
10. Tell me about a time when there has been change in therapy services and what that was like.
11. Tell me about stories of barriers you've faced in your work.
12. What kinds of staff conflicts, if any, have occurred here?
13. Tell me about a time that frustrated you. What do you feel you learned from this?
14. Is there anything else I should be asking you or something that may add to this interview that is important to you?

Data Analysis

The goal of our analysis was to document patterns across and within the therapists' perceptions of inclusive service delivery. After the first researcher transcribed the interviews, we randomly divided the transcripts into three groups, with each one of us reading only our assigned transcripts. Using Strauss and Corbin's (1990) constant comparative method, we coded transcripts independently and used our research questions as a framework to guide our search for patterns that emerged across the data, such as "stories of collaborative success" and "barriers to collaboration". We also looked for unexpected topics that were not anticipated in the interview guide or that seemed contrary to other emerging patterns.

Because qualitative data interpretation is greatly based on the researcher's prior histories and practice (Bakhtin, 1981) it is important to mention here that the three researchers are former K-12 special educators who have significant experience collaborating with related service providers to provide inclusive educational opportunities for students with disabilities. Collectively, these past experiences brought a richness to the interpretation of this data that differs from what other researchers have uncovered, yet our experiences also meant we needed to draw from best practices in qualitative research to maintain the credibility and trustworthiness of our findings

(Lincoln & Guba, 1985). Therefore, we met weekly to share our coding progress, which included selecting codes created in a specific transcript, reading the coded selections together, and discussing why specific codes had been created. During this on-going data analysis process, we created a tabular format of data and a three-level codebook with codes, categories, and emerging themes (La Pelle, 2004).

Findings

Analysis of related service therapists' responses yielded three primary themes that influenced their perceptions of provision of therapy services within inclusive settings. We named the themes: a) "We is greater than I": Collaboration; b) "Tinkering toward all classroom-based therapy": Flexible service delivery; and c) "Balancing is really tricky": Logistical barriers. These themes were further separated into categories that emerged as critical elements and subthemes. We drew upon quotes from various participants to illustrate each theme to help expand our understanding. See Figure 1 for a concept map that visually depicts the findings.

"We is greater than I": The Necessity of Collaboration

Participants revealed that collaboration facilitated their ability to provide inclusive related service provision and develop teachers' capacity to support students' varying needs. Categories that emerged within this theme included consultant role, differentiated conception of responsibilities, and a shared focus and interdependence.
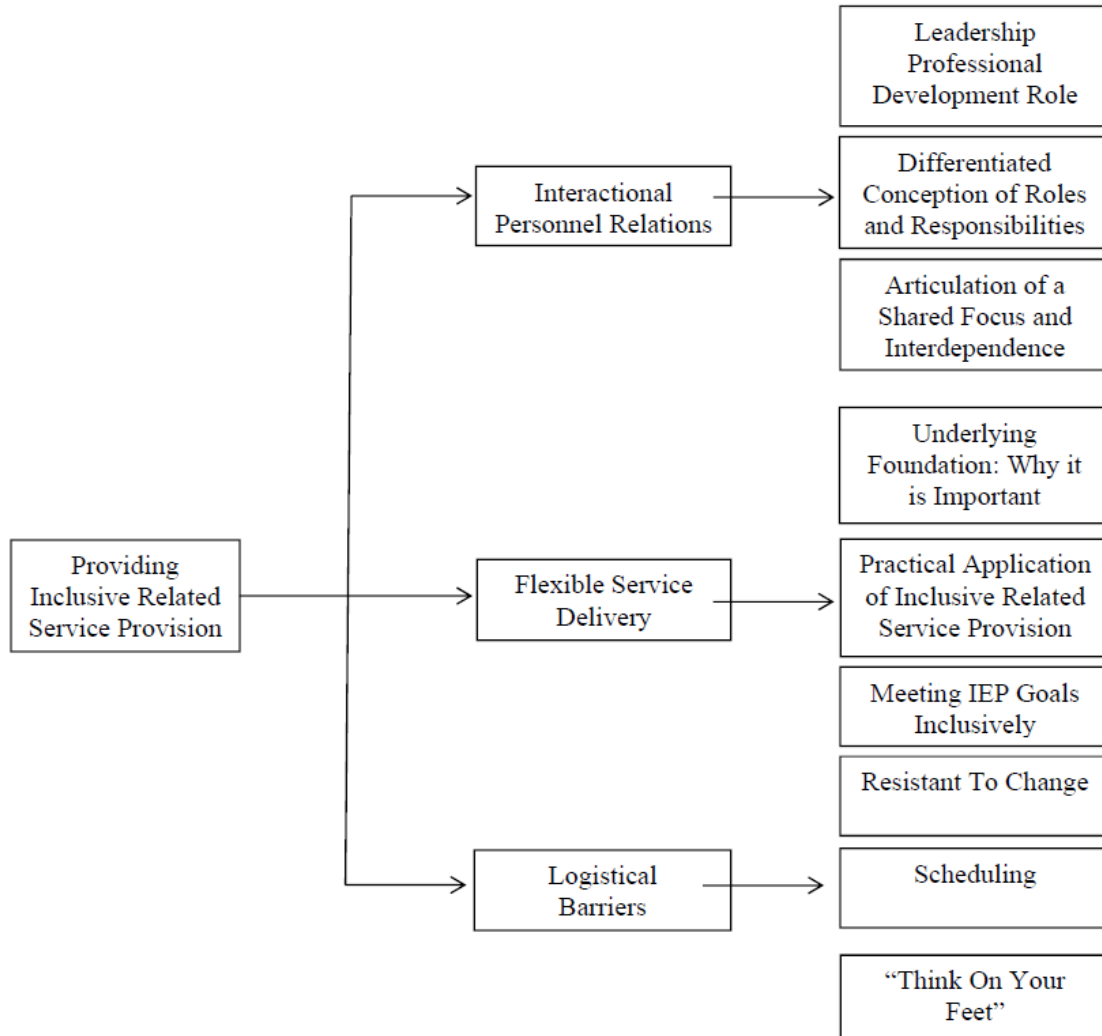
Figure 1: Concept map

Consultant role.

Many of the related service therapists assumed facilitator and leadership roles intended to support other school personnel through consultation. The aim was to increasingly work with teachers to seamlessly provide supports, accommodations, and modifications that linked to both therapy needs for students and the general education curriculum. Across the data, participants articulated that consultation occurred best through questioning, listening, problem solving,

providing new ideas, and celebrating successes. For example, Terry, a physical therapist who had worked within inclusive settings for 16 years at the time of her interviews, explained her use of questioning to work collaboratively with the general education teacher to determine a solution for a student:

> We have a student who uses a walker. We look at his ability to physically maneuver. I said, "Okay how are we going to set up the classroom? What about the materials? His walker can't get over to that table. What could we do differently?" I asked questions to get the teacher thinking about needs of that specific student. Together we found a solution.

Like Terry, Nicole, a speech-therapist who had provided inclusive service provision for 15 years, likened her questioning to coaching: "There's an element of coaching on my part to ask the questions…it's about how can we support all the learners as well as *this* learner."

In addition to questioning and probing for ideas and strategies that would benefit students, therapists also described the consultative role of listening. Nicole explained, "I really listen to concerns and coach through the difficulties…Teachers say this is what just happened, so I open up that communication and listen deeply." This listening, therapists explained, helped them to collaborate more effectively with the teachers, which in turn allowed them to more effectively support the students.

Therapists also discussed the importance of going beyond questioning and listening in order to take on the role of problem solver in certain situations. For example, Moe, a speech therapist who had provided inclusive services for 9 years, shared a story about problem solving when her team became frustrated with a student's impulsivity with his communication device.

> I said, this little guy is very impulsive and wants to push buttons. Let's step back, think about what we can do…helping guide the teachers through, okay let's let him create a

content page and we pull it down to have more discussion…Otherwise, he gets too

obsessed about the buttons on the device.

Here, Moe coached the team through a situation in which they felt frustrated. Moe explained that

because she wasn't in the classroom all day experiencing the same frustrations as the teachers, she

was able to take a more critical and objective look at the problem. This in turn helped her to find a

creative solution to help the team manage the student's impulsivity.

Like Moe, most of the therapists saw themselves as facilitators when it came to problem

solving due to their consultation role. Nicole, a speech therapist who had worked in inclusive

settings for 15 years, explained, "I'm not looked at as the person who has all the answers. It's

more the person who can help guide them to their own thinking and their own success." This

facilitative role positioned related service therapists as valued members of the team. They

explained they had the ability to offer their own discipline's expertise, as well as provide ideas to

support their colleagues who were managing entire classrooms in addition to individual students.

To illustrate further, a speech therapist Kendra said, "It's about problem solving, getting resources,

and giving support for teachers so that they're not completely overwhelmed."

It was clear that participants believed their consultative role allowed them the opportunity

to provide innovative solutions for challenges when the team's ideas (or patience) had plateaued.

For example, Kendra explained that even though teachers did not have her constant support in the

classroom, she mediated this by providing support strategies. "Teachers don't have that support all

the time. Then I give them three things to try…Here's three examples or modifications that I just

have based on this child's …da, da, da. Do you think any of these would work?" Kendra provided

numerous examples of support strategies she offered to teachers to support specific student needs,

such as "transitional movements to provide gross motor development and body movement…a 20 second stomping or jumping transition…Perfect for a sensory diet during the day."

All of the therapists, however, discussed the importance of a respectful relationship between themselves and the teachers, and expressed the need to be cognizant about how they present ideas. For example, Bernice, a veteran OT who had provided inclusive service provision for 25 years, described a much-needed astuteness during consultation:

> You have to be aware of the investment in terms of what is set up and you can walk into a classroom, thinking I cannot believe they put the table there or are doing that…or put that kid in that corner, what are they thinking, but you cannot. You have to be astute about how you present the ideas because we're coming from different backgrounds, so I rate that piece of being confident and constantly able to approach your team with dignity as key.

Participants described the need to find a balance between respecting the ideas implemented by others while providing innovative suggestions to further support students. Several therapists discussed specific strategies for maintaining this respectful balance, such as beginning a conversation with a teacher highlighting a positive piece of current practice before providing additional recommendations. Some participants noted that this kept the interactions with others positive and empowered, rather than frustrating. Nicole likened her consultant role to a mentorship:

> Being more of a mentor has made an impact on my ability to relate. I try to listen more… then help. My role is facilitative questioning, unless they directly ask me a question and don't know the answer. They're problem-solving themselves. It gives them more power.

Here the participant's words reflect a desire to empower colleagues, while promoting an interdependent environment designed to have a proactive approach to serving students' needs.

In reflecting on this type of mentorship and solution based problem-solving, Kelsey explained, "So far it's had the effect that I wanted, which was that the teacher will call me or will stop me in the hall to ask me or tell me about students' challenges and successes!" In fact, celebrating successes was a theme that emerged across the data. Cora, a physical therapist, illustrated how she made a point to honor successes as well as acknowledge how far teachers and teams had come:

> I ask about moments of success…really honoring the successes that are going on. There are so many cool things going on. They've also had some really challenging times. We've only had full inclusion for three years. So look how far you've come…we're a tight team and we're honoring any huge success.

Differentiated conception of responsibilities.

Several participants revealed that their educational team collaborated effectively as a result of the distinct roles the therapists had as compared to the general and special educators. Bernice shared an experience that demonstrated how her medical background contributed to the educational team.

> We recently had a situation where the child's body appeared very asymmetric and had changed quickly. I asked the family to have the necessary x-rays and therapeutic consultation and realized that in our asking for that, we had actually frightened the classroom team into thinking that what they were doing, how they were carrying the child had actually caused the problem, but when in fact it was actually a result of neurological condition that preexisted. To help the team understand that this was part of the cerebral palsy, not a result of what they were or were not doing was key. It's important to have

people on the team that can work through those medical issues that impact the education

sphere…Really it is a vital connection between teachers, therapists, families, and the

medical side of some kids' care. We're in a unique situation to make this connection.

Related service therapists have discipline specific expertise that is vital in the support strategies

they suggest. Similar to Bernice, Cora described her ability to offer disability specific advice to a

physical education teacher.

> She's a little girl who has rheumatoid arthritis. She's very fragile looking. The gym teacher
>
> is just afraid to have her do anything because she's not sure what she can do. [As] physical
>
> therapists we're a little more willing…we know a little bit better what they might be able
>
> to tolerate in terms of their physical condition.

Cora later described how she gradually increased this student's participation through

implementation of several necessary modifications made in conjunction with the teacher.

Several therapists highlighted that the curriculum was the teacher's expertise, while their role was

to provide therapy supports. Referring to this curriculum component, Page said,

> That portion is curriculum based and is the teacher's specialty. They do that and I step in
>
> with my piece. That's their area of expertise.

However, the majority of therapists shared a sentiment that having knowledge of grade-level

curriculum was imperative and that the most successful method to gain this information was to ask

the teachers for quick summaries of units or lessons. They believed this knowledge promoted

successful inclusive related service delivery that was intrinsically linked to the general education

curriculum.

> Therapists also articulated a sense of accountability that resulted from collaboration that

improved the type of related services students received in the general education classroom.

Paulina, a PT who had provided inclusive service delivery for 10 years, explained the impact of collaborative inclusive service delivery:

> With a lot of the supports you write [on the IEP], I think everybody puts that away in a file cabinet. You used to forget about it. But this way we're in the classroom, they're seeing what we are doing. We're there seeing them implement [supports] too. We both can kind of correct it gently, model it for each other. I think we're all accountable to each other now.

Paulina also described the expertise of each role working within an overall goal of providing inclusive education.

> We all bring something different to the table, but we're all working toward the same mission. It is based on inclusive ideals; we contribute our own areas of focus.

The collective expertise from each team member in which they are collaborating together and accountable to each other creates an effective education for students with disabilities.

Articulation of a shared focus and interdependence.

Related service therapists shared that relationships with colleagues were more positive when the focus of their energies and work was centered on the child. Interdependence occurred more naturally, as the shared goal was to provide the best possible educational and therapy services for the child. Vanessa, a speech therapist who had provided inclusive service delivery for eight years, described this interdependence as the key to success: "I think with this model…everybody's so involved in the kids' development, and I don't think it has anything to do with what I am doing solely as a therapist…It's really because everybody is sharing goals." Joslyn also said that this shared focus was imperative to collaborative success as well as student outcomes:

We have this student who I would have no clue what he was saying. Then for a teacher to tell me that now he's raising his hand, feeling comfortable, able to put sentences together and be understood. It had nothing to do with me alone. I mean it's everybody working for these kids, including parents. We are doing it together. We have one shared goal.

Even as the therapists described their school settings, it was clear that they believed they shared ownership with other adults too, beyond their team. Mary, a PT who had provided inclusive service delivery for four years, described the sense of interdependence she felt in a general education classroom in which she conducted her related services.

It was *our* classroom. We just had mutual respect. I could say, I have this great idea, I want to do this transition. I have a new activity. I could say, "Oh you are going to sit over there? Can we put all the balls out?" She would say, "sure!" Any time we had an idea for each other, we would just say it. "I was thinking what if we put it like this," I'd say, "That's great or that won't work because (drags this word out)"…and I would explain. It was a collaborative team. We trusted each other well enough to say if something wasn't going well, or if I wanted to do something differently, I would say, "can you do it this way?"

Mary's perspective about open and honest communication demonstrates a clear valuing of connectedness and a shared desire to provide effective supports. Many of the participants expressed that each role (teacher and therapist) was individually important, yet sharing a proactive approach to meeting educational needs was critical. As Francine described, "We is greater than I. It's that simple. And, we have to work toward the same goal of supporting all students."

"Tinkering Toward All Classroom-based Therapy": Service Delivery

While related service therapists stressed the importance of moving towards providing all services in the general education classroom, they each stressed that flexible service delivery was a more accurate representation of what occurred in their practice. Subthemes that arose from the therapists' interviews were the importance of inclusive related service provision (i.e. consultation and classroom-based therapy), how to apply this foundation through practice in flexible ways, and strategies to meet goals from the child's IEP in an inclusive manner.

The importance of inclusive related service provision.

All of the related service therapists discussed the importance of providing inclusive related services within the classroom, whether that be through consultation or classroom-based therapy. Paulina explained that, "The basic philosophy is part of human potential and inclusion regardless of any diagnosis or testing results." Elements of this underlying foundation linked to an inclusive schooling philosophy.

Therapists' use of consultation and/or classroom-based service delivery allowed for students with and without disabilities to have access to a shared academic learning and social context. Participants pointed toward the importance of social interaction. Bernice said, "I like this environment. I like that kids who would have placement in a self-contained classroom in a different school, have this freedom and environment in a typical classroom with peers." This service delivery model allows all students to have access to general education contexts. For example, Moe elaborated on the positive social nature of inclusive service delivery:

They will be in the world and will have to socialize with others, people who are different in the ways they live, work, and communicate. Everybody is in a regular classroom and has the right to be here. Some just need a little more support, and that's what I do.

Underlying elements described by related service therapists all highlighted that an inclusive classroom was critical for embracing diversity and creating more socialization for all students, with and without disabilities. They discussed that the inclusive setting fostered a sense of belonging for all students and increased the students' social capacity to interact with and support one another.

For example, Cora talked about creating a sense of interdependence and support amongst students. She said, "I think the school does a nice job of saying…you watch out for your friends and you know if you see somebody needs help, you help them." She added, "What I really like is…how everybody gets along. The way that the school is set up in terms of having such a variety of socio-economic and ethnicity backgrounds, many different types of disabilities, this is really why inclusive therapy services are so important."

In addition to this social importance, related service therapists discussed how inclusive settings provided greater generalizability for skills. Kelsey, a veteran OT who had provided inclusive services delivery for 26 years, explained, "One sure way to make sure you're not working in a vacuum, is to do it inclusively and then you're actually doing therapy sessions in the class. This promotes the best generalizability of therapy activities."

Vanessa described that when she moved toward a more inclusive, classroom-based practice, the struggles she had encountered when planning pull-out therapy sessions decreased significantly.

> I struggled because I was using too much pull out. I was trying to plan units that linked to the learning the teacher was working on. I was doing extra work, pulling the kids out, and doing activities in my room. Minimal connection to the classroom. Generalizing what we're doing in therapy to the classroom activities is key. I just decided this mattered most. My students needed to stay in the classroom and now my therapy moves to them.

Vanessa decided that connecting her therapy activities to the classroom content, curriculum, and instruction was critical and that students' ability to generalize these therapy activities to natural settings was important. This was her justification for moving toward providing inclusive related service provision. Other related service therapists also described this point; Bernice said:

> Teachers need to see what you're doing more to understand okay, you can do pull-out until the cows come home, but if they [teachers] are not using it, it doesn't get you very far. Like working on upper body…knowing some of the techniques that help and teachers can incorporate that and have better success in achieving the goals.

Paulina, like Bernice, described that providing services in the classroom provided more opportunity for modeling amongst colleagues, which only benefitted the students, because then the teachers could better implement the strategies throughout the day when the therapist wasn't present.

> It's easier. I think sometimes teachers think that we have…that we're doing something completely different in our room and we have this little magical toolbox…but now I think the teachers are kind of learning, "oh okay well I can do that." That's what we do in class and this is how I can help this child. It is better for the kids. I am in the classroom modeling.

Page also evidenced that her inclusive practice was built on concepts of universal design (Rappolt-Schlichtmann, Daley, & Rose, 2012), when she described how using her expertise to provide supplemental support for one student could ultimately benefit all of the students in the class.

> What I love about that is that not only am I looking at Ruddy and Mike but I'm also getting to see everyone else in the room as they come through the center. I'm going to bring something that everyone will participate in. That can be really effective.

The underlying foundation of providing related therapy services in classrooms was that students with disabilities would have increased access to social interaction, educational goals could be generalized, and supplemental support could be simultaneously provided to all students.

Practical application of inclusive related service provision.

Participants described their therapy sessions in relation to the instructional structure of the class. As Kendra described, "An individual push-in session generally means I'm joining the child in whatever activity their classroom is participating in and looking to achieve their IEP goals through activity modification, through the use of adaptive strategies and therapeutic exercise." But Moe explained that her role varied depending on both the instructional arrangement and the teacher.

> In first grade I always do centers. I work with students with and without disabilities. In fourth grade, I float around the room. It's not a time when the teacher does stations. I target the students on my caseload. I can address their goals but I'm still extra hands.

Bernice gave an example of a classroom where she was responsible for one center each week.

> When we're at our best… teaming, co-teaching happens easily during push-in times. Therapists can push-in to lead an activity, targeted towards specific students. I might

decide that Lucy and Pat are working on lower body strength. I have a learning center at 2:00 on Tuesdays. I'll bring the learning activity and I'm always going to look to target that the skills of those two kids. But all students will get a turn to practice.

Some therapists used sessions to observe, create, and implement student-specific supports that allowed the students to better access the general education curriculum. Nicole explained her perspective of how she conducted this particular type of inclusive service provision:

During planning, offer to run groups and bring materials for small groups. You see this whole sign of relief go through their [the teacher's] body. You explain how the station activity will provide therapy supports and what the other kids will get out of it.

Some therapists also described leading a whole-class lesson. A speech-language therapist, Mary, explained:

When there's a lesson on anything about language, phonics, speaking have the speech therapist come in. They can add a specific element. If they are teaching the letters in kindergarten, they can explicitly model and teach the pronunciation of it so kids with articulation difficulties have embedded targeted instruction.

She also explained the positives of team teaching with educators. "That was great, teaming. We would take turns as far as who was more the lead teacher, and it worked beautifully."

In addition to working with the general and special education teachers, therapists gave examples of collaborating with all of the professionals in the classroom. For example, Vanessa explained:

Everyone is leading a center, and the kids rotate. The teacher sometimes does assessments. There are two classroom aides for two specific students with disabilities. They are running a center planned by the teacher. It's easy to fit me into that kind of model.

Many of the therapists reported diverse methods of implementation that demonstrated their flexibility with service delivery based on the teacher's instructional structure and collaboration practices.

Meeting IEP goals inclusively.

Therapists described that knowledge of the larger IEP goals was critical in planning their classroom-based therapy sessions. Terry explained that a clear and holistic focus about both skills and educational goals aided the decision-making process.

> Certain students are trying to use all their strength trying to hold themselves up, that they can't focus. Is your goal to have them to try to attend? Is your goal to just to have them sit? If we're talking about my goal of sitting, then that's great. But if they're not getting anything out of your lesson… have them sit crisscross for two minutes and then if they can't do it anymore, allow them to lay on their belly. Allow them to side-sit. Whatever positions work. When I find that they're sitting better, maybe do a different position.

Connecting the therapy goal to help students attend to the general education curriculum is key. Therefore, Terry made instructional decisions based on the individual's therapy and educational goals. Similarly, Mary described how therapy links to and impacts academic achievement for students.

> I'll stick my upright posture goals within an academic goal. That could be a big goal. And that way it does hit their academic needs. If they can't sit with an upright posture without upper extremity support then they can't sit at the table to write because they lean…it doesn't free them up for their hand use. That hits how it impacts their educational needs.

This explicit connection between academics and therapy goals was evident across the data, but Francine explained that she adopted this new way of writing IEP goals after she began providing classroom-based therapy:

> I'm finding a shift. They were more therapeutic type related goals. But there's so much, as far as the language and processing piece, that you can incorporate with the curriculum.

Similarly, Cora succinctly said, "It's easy to write goals based on what the expectations are for that grade-level."

Even though the majority of therapists said that they seamlessly met IEP goals within classroom-based sessions, there were exceptions. Both speech-language pathologists and physical therapists provided examples of specific sessions that were not conducted within the course of the typical classroom schedule. Articulation was a specific area that speech-language pathologists felt lent itself to pull-out service delivery during brief and targeted 5 minute sessions. For example, Vanessa explained:

> When a child is just learning a sound or just learning a language structure, I work in those five minutes. If they're working on pronouns I will have pronoun cards…In an in-service, the person presenting had talked about these five-minute drills and how beneficial these are for kids because we used to pull kids out and work for 30 minutes on articulation. Kids aren't really paying attention for 30 minutes. Let's be honest about that! Now I do this for five minutes and know it's better than pulling them out for 30 minutes.

Based on her professional expertise as a speech-language pathologist, Vanessa believed that articulation support needed to occur one-on-one with a student. Yet simultaneously, she described a rich underlying philosophy of inclusion. To negotiate these two beliefs, she decided that she would spend five minutes of her therapy session doing targeted articulation support with

individual students. She also described that when making this decision, she consulted with other professionals in her school.

> I talk with my special education director about the struggles I've had with pull out therapy. We're doing a lot of drill work that doesn't pertain to what's going on in the classroom. It doesn't mean anything to the kids and there's no transfer.

This example demonstrates that therapists aimed to meet IEP goals in an inclusive setting. When exceptions arose due to specific skills that needed targeted one-on-one attention, therapists worked to make sure the session outside the classroom was brief or if possible, occurred within the classroom context or at a table inside the classroom. This way even when one-on-one attention was utilized, the student was able to return to the general education activity immediately. As Kendra explained, "We are tinkering toward all classroom-based therapy, but it's flexible in nature."

Defining roles.

Many therapists also described having conversations with teachers about their role in the classroom. These talks included scheduling, curriculum and content, and how therapists could have a meaningful co-teaching role within the classroom. Some therapists described the pitfalls of the one teach, one assist, which is a side-by side support role (Friend & Bursuck, 2018). This assist role was often filled by the therapists and many described feeling like an assistant in a teacher's classroom without a meaningful role. For example, Paulina explained:

> You need to be careful to not become a glorified teaching assistant. You need to be careful about the time of day that you're pushing in and to make sure you have a useful therapy service delivery role. Obviously you have to pay specific attention to the student's IEP

goals. That is the key to our services. Make certain that it's during time that you can meet
those goals in addition to working within the classroom, with the curriculum, and the other
kids. Being an assistant is not the best way to use the expertise of a therapist.

Paulina recognized that her role as an assistant did not fully utilize her specialized knowledge. She
and other participants articulated that the most effective inclusive therapy sessions occurred when
meaningful roles were determined by the therapist and teacher. This included analyzing the
situation to determine accommodations and supports that could be effective for students.
When the therapist was merely utilized as a "glorified teaching assistant" the sessions were
ineffective to support inclusive ideals.

"Balancing is Really Tricky": Navigating Logistical Barriers

Each participant elaborated on the complexities and realities of schooling, and how logistical
barriers often impacted implementing inclusive service provision. These barriers included
resistance from administrators or teachers regarding service delivery changes, scheduling conflicts
that caused practical applications to change and impacted time for meeting with teachers. Across
the data, therapists highlighted that flexibility was a critical element needed to navigate these
logistical barriers as was the importance of leadership that supported an inclusive philosophy

Resistance to change.

Therapists discussed the need to balance the teacher's willingness to change with the
mission of providing classroom-based services. Participants discussed providing services in
classrooms where the teacher was resistant to changing the ways that therapy had previously been
delivered. Terry, a physical therapist, articulated what she perceived as the rationale for resistance.

It gets to the point that you felt like you weren't really wanted in the classroom. They

might not like me that much…Sometimes it's their insecurities with teaching, the content,

the lesson, the lack of planning. They don't want you watching them. They don't want you

seeing how they handle a tough situation. Some are set in their ways…change is difficult.

Therapists explained that teacher resistance often stemmed from factors related to trust,

confidence in making decisions, and planning. Taken collectively, these individualized factors

impact how collaboration between related service providers and teachers impacted changing

service delivery models.

Therapists also described that the administrative philosophy and vision for the school

directly impacted others' willingness or resistance to change. Cora explained that her school had

just hired a new administrator and the staff was unsure whether this meant their inclusive therapy

services would be placed in jeopardy.

The district director tells us we're to do push in therapy. That's what we believe in. The

new director just came. We are worried her vision won't align. What's her philosophy?

Will pushing into classrooms be out the window? Will it be different? Who knows. Change

is hard, especially when we have the best interests of students in mind.

Participants often described administrators as agents who impacted the type of therapy service

delivery implemented. Mary explained that her administrator did not understand her role.

She insisted that if I'm pushing in I'm working on curriculum. I explained that's not true.

I'm not qualified to work on curriculum. Instead, I provide modifications and supports so

students can better get that content from the curriculum. That's a big difference.

Mary needed to define her role as a therapist working in a general education classroom to an

administrator who was unclear about inclusive therapy services. She stressed the importance of her

administrator understanding that as a related service provider, her goal was to maintain a therapeutic focus (Ehren, 2000). She also described types of modifications recommended to support specific students' IEP goals that seamlessly worked in conjunction with the curriculum. It was clear that Mary projected a therapeutic focus, yet shared in the responsibility of success for students.

Kendra described an administrator who framed the change in therapy service delivery as an experiment.

> The principal said, "try it." She gave me the freedom. It was an ideal situation, she said it was an experiment and there might be bumps along the way, but we have to figure it out. I was able to learn a lot. She gave me the freedom. It gave me the confidence to do this.

> To Kendra and her colleagues, it was important for the administrator to acknowledge the difficulties related to change and clearly express to the staff that the change in service delivery would be a continual process based on individual circumstances. Kendra also noted that the administrator included both teachers and therapists in the conversation. This created a vision in which inclusive practice was seen as truly collaborative, and the expected process of success and failure would be shared by both teachers and therapists.

Vanessa similarly explained her administration's inclusive vision: "My principal and my special education director really want both special education teachers and therapists to be in the classroom. That is their message across the board. It is clear. We need to figure out how."

Working in complex schooling institutions.

Related service therapists described that schedules were a barrier, and they had to work around these complexities while still managing to provide classroom-based services. For example,

Terry explained how working with students in the same grade-level could prove difficult due to whole-school scheduling:

> It's hard if all the first grade classes are following the same schedule. It's also hard [when]…you're seeing two third graders in different classrooms and you have to push-in. You just have to keep trying to find a way to make it work by being creative.

In order to creatively address this issue Terry explained that she often designed supports for students to have the educator implement. Moe had a similar scheduling issue that she had to solve:

> ELA [English Language Arts] is at the same time, and that's a good therapy time. The schedule is a real blockage. Teachers allow me to flop times, so I see kids during different subjects…that works.

Terry negotiated with teachers to provide therapy sessions at different times so she could see students during different subjects, depending on targeted goals. Both Terry and Moe needed to be creative in changing schedules so that they could continue to provide inclusive related services.

Many therapists discussed that even when they provided services in the classroom they did not always have face-to-face time with their particular students for the full class. This is a significant change from pull-out therapy provision when therapists removed and worked directly with the students with disabilities. Francine articulated this point:

> So I wasn't able to work with [students with disabilities] necessarily for the full time. We have different stations and I developed the lesson for my station with the classroom… but again because it rotated, I wasn't with my kids who are identified the whole time.

As addressed earlier in this paper, this type of change means that therapists often undertake a type of support and consultation that is different from the direct side-by-side support model

traditionally used. It also means that the therapist has to plan with curriculum and classroom practices in mind.

Two therapists discussed how their districts used a different type of 3-1 service delivery model in which therapists would have inclusive classroom-based therapy sessions for three weeks with one week of pure consultation and evaluation time. Nicole explained:

> We have a 3-1 service delivery model. In three weeks out of every month we provide our direct services…That last week is based on what the teachers need in their room. We provide consultation. We do evaluations and there's a lot of professional development during that time, too. We can be really flexible with our scheduling.

Therapists who employed the 3-1 service delivery model described their practice as being vitally important to both their students and the teachers at their school. They articulated the types of consultation, advice, training, and support they provided to teachers in more concrete ways that signaled that this schedule was meaningful, practical, and provided time for professional development and collaboration.

While participants described having dilemmas with the schedule, they each described ways to work flexibly and the need to "think on your feet" within the school schedule in order to meet students' inclusive therapy goals. Moe explained,

> You have to be flexible and prepared, which sounds contradictory. You don't know exactly what's on the other side of the door. That's the flexible part. You have to think on your feet and do whatever it takes to get your job done because my goal is to get these kids whatever they need to be successful in academic parts and social situations with friends. Being very flexible and prepared. Balancing is really tricky. You can't be prepared enough.

Here we see that therapists' jobs are situated within complex social institutions. Given these realistic circumstances, they are driven to provide inclusive therapy services within complex school schedules.

Discussion

Limitations and scope of study.

We recognize the limitations of the study's findings. The first limitation is due to our methodology, as we were unable to develop relationships with participants over time. We conducted two interviews with each, using a semi-structured interview guide to obtain comparable data across subjects. We utilized probes to allow participants to elaborate on personally meaningful topics, offering each the chance to shape the direction of the interview. Second, our findings are based on the perspectives of 15 related service therapists who are white women. Although our sample included participants who worked in school districts across different states, with a range of disability categories and with preschool age through high school age students, a broader sample, or an increased number of participants, would have increased generalizability of the findings.

Understanding Elements that Facilitate or Inhibit Inclusive Related Service Provision Collaboration.

Participants expressed that inclusive service delivery was most effective when professionals within the team recognized, valued and combined each other's expertise in order to best support the students. This understanding adds to the extant research that identifies the role of perceived professional competency and confidence as critical to successful collaborative

relationships within schools (Brownell et al., 2006; Butera, 2005; Damore & Murray, 2009; Hantizidimantis, 2011). Therapists also expressed that more collaborative and proactive approaches to supporting students were evidenced when the roles and areas of expertise of related service therapists and teachers were explicitly defined; this aligns with literature that purports this clarification is required to provide appropriate services for students with disabilities and enhanced collaboration between professionals (Giangreco, Prelock, Turnbull, 2010). This perspective is consistent with extant research (Hartas, 2004; Kersner, 1996; Law et al., 2000; Wehrmann, Chiu, Reid, & Sinclair, 2006). When defining specific roles and expertise, therapists found this meant they had to move away from more traditional therapist roles like providing only direct or one-on-one services to students. Researchers have noted that this collaboration moves related services from the "advice giving" role to that of an equal partner in the learning experience (Gallagher, Tancredi, & Graham, 2018, p. 130). Within inclusive settings therapists discussed that their roles often included creating resources and providing supports and modifications that teachers would then implement, running stations, team-teaching or even leading mini-lessons in the general education classroom. This is contrary to some previous research, which has documented the therapy fields' preferences for providing withdrawal intervention or isolated services (Brandel & Loeb, 2011; Ritzman, Sanger, & Coufal, 2006; Weintraub & Kovshi, 2004).

Flexible service delivery.

The importance of inclusive therapy provision was evidenced across participants. Therapists believed that (a) skills and IEP goals could be best generalized when worked on within naturalized, general education environments, (b) peer models and socialization were critical, and (c) that discipline specific expertise could value all students within classrooms. This overarching

inclusive vision also meant that to best meet each student's individual needs, therapists often provided a combination of classroom-based and consultation services. This is consistent with extant research (Ehren & Whitmire, 2009; Giangreco, Prelock, Reid, Dennis, & Edelman, 2000) which evidences flexible service delivery is critical to supporting students effectively.

Logistical barriers.

Participants were forthcoming in explaining the numerous complexities and realities of schools that collectively diminish ease of implementation of inclusive therapy sessions such as resistance to change, which is well documented in research (Fullan, 2009) and the need for flexibility to navigate the difficulties of structural or logistical barriers. Consistent with previous research (Hartas, 2004, Villeneuve, 2009) participants explained the need for clear leadership and vision to help successfully implement inclusive therapy services. Both the logistical barriers and those elements therapists described as necessary to address them evidence that implementing effective inclusive service delivery is often best addressed through whole-school structural decisions aimed at creating wholly inclusive schools. This is well documented in whole-school inclusive reform literature (McLeskey, Waldron, & Redd, 2012; Theoharis, Causton, & Tracy-Bronson, 2016). When service delivery models are woven into the structural fabric of schools, there is a framework of inclusion and a common mission strongly supported by the leadership.

Recommendations for Future Research

The findings in this study provide a glimpse into the ways related service therapists in the United States perceive their negotiations of the complexities and realities of inclusive schooling environments. In-depth case studies from a variety of countries would provide insights into the

ways in which people with different professional roles promote generalizability of therapy skills and would allow researchers to observe the participants in practice to more fully understand how inclusive service delivery is implemented. Second, qualitative interviews conducted with general educators and special educators who work on teams with an inclusive related service provider would allow for deeper understanding of the collaboration needed. The findings of the current study are encouraging in that they reveal the very realistic logistical barriers present in many schools across the United States, yet the potential of related service therapists who are interactive, collaborative, flexible, and proactive in delivering inclusive related service provision.

Conclusion

There is an ever-present shift for all therapists to meet students' goals within general educational settings and this article aligns with research that has shown that specialized therapy goals can be targeted effectively by utilizing classroom-based therapy sessions (Ritzman, Sanger, & Coufal, 2006; Sekerak, Kirkpatrick, Nelson, & Propes, 2003). Therefore, examining the experiences of therapists who are practicing in collaborative and inclusive services in order to expand the depth of knowledge and research available about inclusive related service provision is imperative. With proactive planning, collaboration, and a shared and supported vision, inclusive related service provision allows us to ensure that "everyone has the right to be here."

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