B.ED. SPL. EDUCATION

INTERVENTION AND TEACHING STRATEGIES

SES LD 03

MADHYA PRADESH BHOJ (OPEN) UNIVERSITY

INTERVENTION AND TEACHING STRATEGIES

B.Ed. Spl. Ed

(SES LD 03)

MADHYA PRADESH BHOJ (OPEN) UNIVERSITY,
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Bachelor of Special Education

B.Ed. Spl. Ed.

A Collaborative Programme of

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Block 1: Intervention

Unit 1: Concept, Significance, Rationale, Scope, Advantages of Early Intervention

- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
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- **Introduction :**

1.1 There are many different definitions of early intervention but, as is explained in more detail later in the text, for the purposes of this paper we mean 'intervening as soon as possible to tackle problems that have already emerged for children and young people'.

1.2 Differentiating between prevention and early intervention is often quite hard; for example, some programmes and services for children do both at the same time.

1.3 There is a much clearer difference between prevention and early intervention on the one hand, and responses to children's difficulties when they are already well developed, on the other.

Most of the current professional and policy debate is about the potential benefits and the challenges of investing significant resources in the first category when taken as a whole, rather than putting all of them in the second. This is very much the terrain which this paper seeks to explore.

- **Objectives**

Today, it is widely agreed by experts across the world that early intervention can be of enormous benefit to children. That is why, as this paper sets out, the government is investing in a number of evidence-based prevention and early intervention programmes and supporting their roll out across the country

It is also why in the 2007 Children's Plan1 we said that to secure improvements in children and young people's outcomes we would expect Children's Trust Boards to have in place by 2010–11 'consistent high quality arrangements to provide identification and early intervention for all children and young people needing additional help in relation to their health, education, care and behavior, including help for their parents as appropriate'.

It is also why in the 2007 Children's Plan1 we said that to secure improvements in children and young people's outcomes we would expect Children's Trust Boards to have in place by 2010–11 'consistent high quality arrangements to provide identification and early intervention for all children and young people needing additional help in relation to their health, education, care and behavior, including help for their parents as appropriate.

The recently produced Maternity and Early Years review2 makes a strong case for focusing investment in children's earliest years to secure the best outcomes for them. This echoes the findings of the Marmot review.3 The Marmot review highlighted that giving every child the best start in life is crucial to reducing health inequalities across the life course and it made action in this area its top priority. Early action is the key, 'later interventions, although important are considerably less effective if they have not had good early foundations.

Last year, in his progress report on child protection in England, which the Government commissioned following the tragic death of Baby Peter, Lord Laming said 'early intervention is vital – not only in ensuring that fewer and fewer children grow up in abusive or neglectful homes, but also to help as many children as possible to reach their full potential.'6 He called for more to be done to put effective early intervention approaches in place and he observed that if this could be achieved it would not only help children to be safe, it would also help to keep them in education and learning well.

- **Definitions**

Although early intervention is much discussed at present it is not new: it has been suggested that its roots can even be traced back to Fröbel's kindergarten movement in the early 18th century.7 Much more recently, well known interventions include Head Start and the Family Nurse Partnership, which began in the USA in the 1960s and 1970s respectively and continue to this day.

In this country we have provided a comprehensive preventive and early intervention public health programme for children for over a hundred years. Within the broader children's services context, the

importance of early intervention for children has been widely recognised since at least the mid 1980s.8 The professional consensus about this was at the heart of the Every Child Matters Green Paper,9 published in 2003. The Green Paper went on to make clear that delivering early intervention more effectively depended on there being stronger accountability, more integrated services and a workforce with higher levels of skill. Over the last six and a half years there has been significant progress in all three respects and there have been many other positive developments in children's services too, but more remains to be done. In particular, we are yet to extract maximum value for children from the Common Assessment Framework (CAF) and the associated process of the Lead Professional and the Team around the Child. Children's Trusts are also at different levels of maturity across the country. It will also take time for the recommendations of the Social Work Task Force10 and Action on Health Visiting11 to feed through into a better equipped workforce on the ground.

Nonetheless, coherent multi-agency systems of services for children, young people and families are now established or well on the way to it almost everywhere, under the local strategic leadership of Directors of Children's Services and of Lead Members. This provides a firm platform to build on.

Research supports the notion that a high degree of leadership, service development, organization and multi-agency collaboration are essential pre-conditions for delivering more early intervention.12 So the fact our overall system of services for children, young people and families is now far stronger than when the Every Child Matters Green Paper was published six and a half years ago should support moves towards more early intervention.

Some good early intervention activity was going on before Every Child Matters, for example funded through the Children's Fund and the 2004–2010 National Service Framework for Children, Young People and Maternity. As a result of the Every Child Matters reforms, the creation of over 3,500 Sure Start Children's Centres and the development of extended services, even more is underway now. But the Government's view is that we haven't yet capitalised on this progress to move the balance in our children's and families' services system as decisively towards early intervention as research and good practice suggest is necessary and desirable.

Engineering a strategic shift of this kind when the pressures on public funding are intense is challenging, but this paper sets out examples

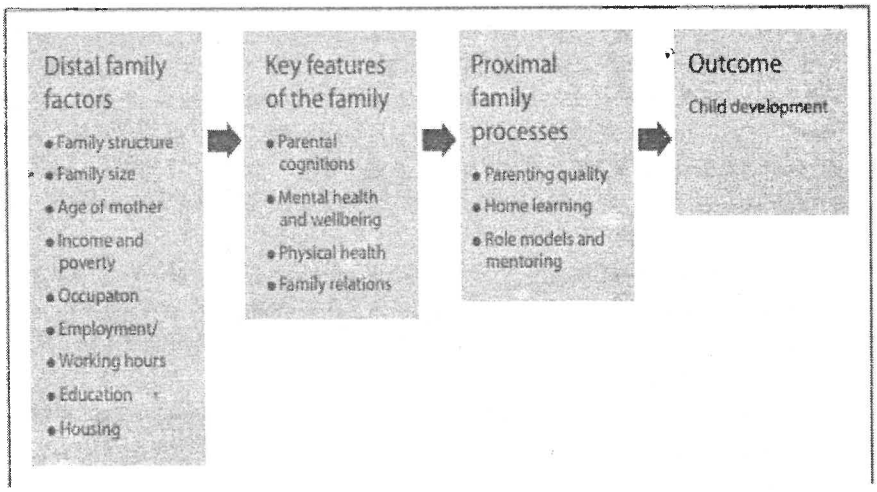
from some places where this is happening now, as well as from others were really significant progress has already been made.
We are clear that there are actions that every local area can take and should take to expand early intervention and to extract more value from the early intervention activity already underway. The paper therefore sets out issues for Children's Trust Boards to consider as they seek to do this. It also spells out what the Government intends to do to promote and sustain early intervention now and in the longer term.
In recent years the term 'early intervention' has been used to describe a wide range of activities, leading to some confusion. After some consideration we have decided to use the same definition in this paper as was adopted in the Policy Review of Children and Young People,13 which was carried out jointly by the Treasury and the then Department for Education and Skills to inform the Government's 2007 Spending Review: Early intervention means intervening as soon as possible to tackle problems that have already emerged for children and young people.
So, when early intervention is understood in this way, it means that it targets specific children who have an identified need for additional support once their problems have already begun to develop but before they become serious. It aims to stop those problems from becoming entrenched and thus to prevent children and young people from experiencing unnecessarily enduring or serious symptoms. Typically it achieves this by promoting the strengths of children and families and enhancing their 'protective factors', and in some cases by providing them with longer term support.
Prevention, protective factors and risk factors:
Protective factors increase the chances of positive life outcomes, which in turn can boost resilience. A review carried out for the 2007 Spending Review concluded that high attainment, good social and emotional skills, and positive parenting were three particularly important protective factors and that they could be mutually reinforcing. Good parenting and good social and emotional skills, for example, both contribute to high attainment.
Early intervention and prevention often overlap in practice. Many services and programmes include elements of both, including maternity services, the Healthy Child Programme and the Family Nurse Partnership.
As with early intervention there is no single agreed definition of prevention, but in this paper it is understood as meaning the process of boosting children's resilience and protecting them from potential

poor outcomes. The success of a preventive strategy is evidenced by a reduction in the incidence and prevalence of a specific problem within a specific group.

Risk factors are often talked about alongside protective factors. They are factors in the environment or that are specific to an individual which predispose some children to, or are associated with, particular physical, social or psychological problems. These risk factors can be eliminated or reduced in terms of their potential impact by prevention and early intervention.

Children's risk factors can be identified from early pregnancy and through childhood and include living in poverty; growing up in a disadvantaged neighbourhood; experiencing problems in school; parental conflict; poor parenting; parental and/or child substance misuse; anti-social behaviour; domestic violence; and low levels and poor quality of formal and informal support.15 Risk factors tend to compound each other – the more risks to which a child is exposed the more likely they are to suffer poor outcomes.

It is important to recognise that risk factors don't automatically translate into the situation that a child actually experiences. This is because their influence on the child is mediated by many other factors, particularly by their family. This is highlighted in the chart below, which shows how wider social forces flow through the family to impact on the child. Parents and other care-givers work to nurture and protect children within wider social forces, but these wider factors also permeate their lives.



- **Summary**

Sometimes the term 'early intervention' is applied to all activities that target children for help when they are very young. When used in this way 'early' refers more to the age of the child than to the stage in the development of their problems.

Longitudinal research17 has found that some indicators of poor outcomes are identified for the first time in children only between the ages of 5 and 16. It is also the case that a 14 year old who begins to develop mental health problems has as much to gain from early intervention – as they would perceive it – as a 2 year old who starts to display signs of communication difficulties. In each case the task for professionals is to spot and respond to problems when they first appear, and that needs to happen with difficulties that emerge during adolescence and beyond.

It follows that early intervention can help children from pregnancy to 18, not only when they are very young. This needs to be factored into the planning and delivery of services, and into staff training.

In recent years growing interest in the potential benefits of early intervention has been accompanied by greater awareness of the importance of supporting children in their early years, starting during pregnancy. Over the last ten years in particular, compelling research has demonstrated that what happens to children when they are very young is a crucial influence on their well-being and achievement through childhood and into adulthood.

The Marmot review on health inequalities recommended giving priority to pre- and post-natal interventions to reduce adverse outcomes of pregnancy and infancy. It pointed to the strong evidence that early intervention through intensive home visiting programmes during and after pregnancy can be effective in improving the health, well being and selfsufficiency of low-income, young first-time parents and their children. Ensuring that parents have access to support during pregnancy is particularly important and such family support needs to start prenatally to improve the health and well-being of mothers.18 There is a strong association between the health of mothers and their socio-economic circumstances. This means that for good infant and maternal health and for tackling health inequalities in different groups and areas, early intervention before birth is as critical as giving ongoing support during their child's early years. Early interventions that begin in pregnancy and the first two years of life are likely to produce the greatest benefits.

This is why the Healthy Child Programme starts in pregnancy and continues until adulthood, recognising that lifestyles, habits and relationships established during childhood, adolescence and young adulthood influence a person's health throughout their life.

It is important to stress that these things are not pre-determined, that children move in and out of risk as they grow up and that children with difficult early experiences quite often overcome them and go on to do well. Nonetheless, the evidence is that children who get off to a flying start are well set up for, if not guaranteed, future success. This is, of course, the rationale behind Sure Start and the Healthy Child Programme.

Therefore, while early intervention has great potential to help children and young people right across the age range, early intervention with young children and – inevitably because of their dependence – their parents, has a particularly important part to play.

There are a number of reasons why early intervention with very young children makes sense:

- Some problems emerge in children when they are very young and the sooner they receive help, the less the damage to their development.
- Neuroscience is showing that the healthy growth of very young children's brains can be impaired by poor early life experiences. In that early period, interactions and experiences determine whether a child's developing brain architecture provides a strong or a weak foundation for their future health, wellbeing and development.
- Research suggests that if a problem is identified early on in a child's life and effective help is given, this can have a positive 'multiplier effect' as the child grows up, so that the eventual benefit is disproportionately great compared either to the original problem that was spotted and successfully treated, or to the scale of the help given.
- **Revision**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

_____

_____

_____

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Points for Clarification

- References / Further Readings

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Unit 2: Types of Early Intervention

- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction:**

Many children with a disability can benefit from some type of early intervention (or therapy). For example:

- **Occupational therapy** can help with fine motor skills, play and self-help skills like dressing and toileting.
- **Physiotherapy** can help with motor skills like balance, sitting, crawling and walking.
- **Speech therapy** can help with speech, language, eating and drinking skills.

You can get these therapies through community health centres, hospitals, specialist disability services or early intervention services. Your GP, paediatrician or other parents can also tell you about private therapists.

Early intervention often combines specialist support and therapies. You might end up using some government-funded services as well as community service organisations and private therapists.

There are also early intervention therapies that provide specialised support for specific disabilities like autism spectrum disorder,cerebral palsy, hearing impairment and vision impairment.

Some families also look into alternative therapies. You should research these carefully to find out what the research says about the therapy and the time and costs involved.

- **Objectives**

All therapies and services for children with disability should be **family focused, well structured and evidence-based**.

An intervention that's evidence-based has been tested to check it does what it claims to do when real people use the intervention.

Here's a list of characteristics to look for when you're choosing an early intervention. The more of these characteristics you find in a service, the better – but **not all interventions will do all these things**.

Family centred
This means that the intervention:

- includes you and other family members so you can work alongside the professionals and learn how to help your child
- is flexible – it can be offered in your home as well as in other settings such as kindergartens and early intervention centres
- provides your family with support and guidance.

Developmentally appropriate
This means that the intervention:

- is specially designed for children with disability
- has staff who are specially trained in the intervention and services they provide
- develops an individual plan for your child and reviews the plan regularly
- tracks your child's progress with regular assessments.

Child focused
This means the intervention:

- focuses on developing specific skills
- includes strategies to help your child learn new skills and use them in different settings
- prepares and supports your child for the move to school
- finds ways of getting your child with disability together with typically developing children (ideally of the same age).

Supportive and structured
This means the intervention:

- provides a supportive learning environment – your child feels comfortable and supported
- is highly structured, well organised, regular and predictable.

- **Definitions**
  Intensive early intervention for children with disability is the most effective kind of intervention. It's not just about the number of hours, though – it's also about the **quality of those hours** and how the therapy engages your child.

Different children respond in different ways to interventions, so no single program will suit all children and their families. Focus on what you want for your child and your family. Learn all you can about the available options. How will they help your child? What will they cost in dollars and time? What funding is available to help cover these costs?

There are good services that aren't funded or listed by government – for example, some home-based programs. These are usually funded by fees and fundraising. This doesn't mean they should be avoided, but the costs can be a strain for some families.

A good intervention involves **regular assessment** to ensure that your child is making progress. The gains might be small at first, but it all adds up. If you think your child isn't making progress, you might need to change or stop the intervention.

- **Summary**

  Early intervention means doing things as early as possible to work on your child's developmental, health and support needs.

  Early intervention services give **specialised support** to children and families in the early years (from birth to school entry). This support might include special education, therapy, counselling, service planning and help getting universal services like kindergarten and child care.

  You can use early intervention services as well as services available to all children, such as child and family health services, kindergartens, community health centres, regional parenting services, child care services, play groups and occasional care.

Therapies and services

Early intervention for children with a disability is made up of therapies and services.

Therapies – or interventions – are the programs or sessions aimed at promoting your child's development.

Services are the places and organisations that offer these therapies. A service might provide one therapy or several types.

Your child can get early intervention therapies and services in many ways, including at home, home via video conferencing, child care and kindergarten or in a specialist setting.

Why diagnosis is important

Early intervention works best when it's targeted at your child's individual needs. For this to happen, you need a diagnosis, which says what disability your child has.

Once you have a diagnosis, your child's specialist or health provider can suggest which early intervention therapy or service might be best for your child. Depending on the needs of your child and family, early intervention might involve a therapist working with your child one on one, a therapist working together with you and your child, or a therapist working in a group session with other children.

If you don't have a diagnosis, or can't get one, that's still OK.
A paediatrician might be able to say that your child is slow in reaching developmental milestones in more than one area, such as speech or mobility, because of developmental delay. Then you can work out which early interventions will best target your child's delays.

- **Revision**

Points for Discussion

Points for Clarification

- References / Further Readings

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Unit 3: Intervention Techniques

- Introduction:
- Objectives
- Definitions
- Summary
- Revision
- Assignment/Activity
- Points For Discussion And Clarification
- References / Further Readings

- **Introduction:**

There are various approaches to supporting individuals in crisis, for example, using non-counseling methods such as psychological first aid, more technical models involving strategies for listening, assessing and acting in crisis intervention, or activities related to responding to trauma. The guidance in this section describes interventions that require specific skills, development training and supervision. Information alone is not sufficient for shelter staff to be able to apply these techniques, and individuals should not conduct crisis intervention without proper training and supervision.

Effective crisis intervention must follow ethical principles which ensure that survivors are not placed in further harm, their decisions and opinions are respected throughout the process and the intervention upholds a rights-based approach. This involves good communication skills, demonstrating empathy, among other support provided by shelter workers.

Strategies for listening in person

Listening involves focusing, observing, understanding and responding with empathy, genuineness, respect, acceptance, non-judgment and sensitivity. A number of specific strategies can be used to promote effective listening during crisis intervention. These include:

- Using open-ended questions - "what" or "how" questions. They are used to encourage sharing of information from a woman or girl about her feelings, thoughts and behaviours, and are particularly useful when exploring problems during a crisis. Open-ended questions encourage the woman to provide a greater depth of information including what situations or events mean to her.

- Using close-ended questions that seek specific details and are designed to encourage a woman or girl to share information about behaviours (such as the abuser's specific actions or behavioural coping strategies used by the woman), as well as "yes" or "no" responses. Closed-ended questions usually begin with action words such as "do", "does", "can", "have", "had", "will", "are", "is" and "was". These questions can be used to gather specific information or to understand the woman's willingness to commit to a particular action (e.g. to complete a safety plan).

- Restating and clarifying what the woman has said can help the shelter staff conducting the crisis intervention to clarify whether she has an accurate understanding of what the woman intended to say, feel, think and do. Restating can also be used to focus the discussion on a particular topic, event or issue.

- Owning feelings and using statements that start with "I" in crisis intervention can help to provide direction by being clear about what will occur (e.g. 'I am going to explain the steps we will take today'), what is being asked of the woman (e.g. 'I would like to ask whether you agree to the steps I have described'). Staff can be trained in various skills for practicing "I"-statements in order to support clear and effective communication with women in crisis. For example, these statements can also help to acknowledge confusion or convey understanding of what is being discussed (e.g. "I am not sure I understand what happened when you left the house" or "I hear how nervous you felt on the day you left home").

- Facilitative listening is a strategy which helps to build trust and strengthen relationships with the woman. It involves focusing entirely on the woman's experience by:

    - Noticing the woman's verbal and nonverbal communication. For example, "I noticed that when you talked about the time you spent with your daughter, your eyes lit up and there was excitement in your voice."

    - Noticing when she is ready to make emotional or physical contact.

    - Using non-verbal cues to show that you are listening (e.g. by nodding the head, making eye contact, facing the woman).

- **Objectives**
  Assessment is an intentional practice that occurs throughout the crisis intervention process, and involves seeking information from a woman or girl (although practices for engaging child survivors are distinct from those working with adults), actively listening and interpreting what she shares in order to understand her emotional state, level of emotional mobility or immobility, options for action, coping mechanisms, support systems and other resources.

Assessment allows staff to draw conclusions about the woman's situation and her responses to it, in order to plan and offer ways to assist her.

It is also used to determine the level of risk and any specific threat of self-harm or being killed by their abuser(s).

During crisis intervention, shelter workers should seek to understand the woman's:

Emotional state. Emotional distress is often an initial sign that a woman is experiencing a crisis, which may appear as though she is emotionally "out of control" or severely withdrawn. Shelter staff can be trained to help a woman to regain control and emotional mobility by assisting her to express her specific feelings using language that accurately reflects the emotion.

Behavioural functioning. Observing a woman's behaviour can help to understand her ability to cope with the situation she is experiencing. For example, noticing whether she is pacing the floor, having difficulty breathing, or sitting calmly, and whether she appears withdrawn or unresponsive. Shelter workers can be trained to assist women to take positive actions that she can able to complete in that moment. For example, asking her to breathe slowly.

Cognitive state. Determining a woman's thinking patterns is essential in assessing her current ability to cope with the situation she is experiencing. When listening to what a woman is saying, staff can be trained to consider whether her verbal communication is coherent and logical, and whether her words make sense.

Acting in crisis intervention

Taking action in crisis intervention involves intentionally responding to the assessment of the woman's situation and needs in one of three ways: nondirective, collaborative, or directive.

Nondirective counseling is preferable when a woman is able to plan and implement actions on her own that she chooses to take. In this case, the shelter worker's role is to assist the woman in mobilizing her existing capacity to solve her own problem. Comments that support a woman's self-determination and action can be helpful in this situation, such as "What do you want to have happen? Is there anyone that could support you with this plan?"

Collaborative counseling involves working together with a woman to evaluate the problem, identify options for addressing

it, and taking actions toward a particular option. Collaborative counseling approaches are helpful when a woman is able to participate in planning and taking action, but is not able to complete the entire process on her own. For example: "You are saying that you have decided to leave your partner, but you are unsure of the legal options available. Let's explore together where you could go for legal advice."

Directive counseling is necessary when a woman is assessed as being immobilized by her experience to the extent that she is unable to cope with the crisis. Shelter staff can be trained to use directive counseling to take temporary control and responsibility for the situation. For example: "What I want you to do right now is breathe with me. That's good. Breathe in for a count of 6 and out for a count of 6." In these situations, shelter workers may move back and forth between directive counseling and collaborative counseling as the woman shows signs of decreased anxiety and increased ability to participate in the process.

It is particularly important for staff to have sufficient training in in this area in order to ensure that directive counseling is used only when necessary, and women are empowered as much as possible within the counseling relationship (James, 2008 *as cited in* Alberta Council of Women's Shelters, 2009).

- Definitions

Six-step model :Front-line shelter staff will need to address the level of distress and impairment of women in crisis by responding in a logical and orderly manner. Training in the use of a standardized model for intervening in crisis situations can help the counselor to be aware of the elements of an effective response to crisis, and to intervene in a way that appropriately supports a woman through the crisis which assists her to maintain ownership of the problem and be empowered toward self-determination (Roberts, 2002 *as cited in* Alberta Council of Women's Shelters, 2009).

A six-step model for crisis intervention is one framework that shelters may implement to respond to crisis. The model focuses on listening, interpreting and responding in a systematic manner to assist a woman or girl return to her pre-crisis psychological state to the extent possible. Emphasis is placed on the importance of listening and assessment throughout each step, with the first three steps focusing specifically on these

activities rather than on taking action. At any point, emerging safety considerations that present risk of the woman being hurt or killed should be addressed immediately.

The model involves the following steps:

Defining the problem to understand the issue from the [woman's] point of view. This requires using core listening skills of empathy, genuineness and acceptance.

Ensuring [the woman's] safety. It is necessary to continually keep [the woman's] safety at the forefront of all interventions. This means constantly assessing the possibility of physical and psychological danger to the [woman] as well as to others. Assessing and ensuring safety are a continuous part of the crisis intervention process.

Providing support, by communicating care for the [woman], and giving emotional as well as instrumental and informational supports.

Acting strategies are used in steps 4, 5, and 6. Ideally, these steps are [implemented] in a collaborative manner, but if the [woman] is unable to participate, it may be necessary to become more directive in helping [her] mobilize her coping skills. Listening skills are an important part of these steps, and the counsellor will mainly function in nondirective, collaborative, or directive ways, depending on the assessment of the woman.

Examining alternatives, which may be based on three possible perspectives: a) supporting the [woman] to assess [her] situational resources, or those people known to [her] in the present or past who might care about what happens to [her]; b) helping the [woman] identify coping mechanisms or actions, behaviours, or environmental resources that she might use to help her get through the present crisis; and c) assisting the [woman] to examine her thinking patterns and if possible, find ways to reframe her situation in order to alter her view of the problem, which can decrease her anxiety level.

Making a plan led by the woman, which is very detailed and outlines the persons, groups and other referral resources that can be contacted for immediate support. Provide coping mechanisms and action steps that are concrete and positive for the woman to do in the present. It is important that planning is done in collaboration with the [woman] as much as possible, to ensure she feels a sense of ownership of the plan. It is important that she does not feel robbed of her power, independence, or self-respect. The most important issues in planning are the

woman's sense of control and autonomy. Planning is about getting through the short-term in order to achieve some sense of equilibrium and stability.
Obtaining commitment. Control and autonomy are important to the final step of the process, which involves asking the [woman] to verbally summarize the plan. In some incidents where lethality is involved, the commitment may be written down and signed by both individuals. The goal is to enable the [woman] to commit to the plan, and to take definite positive steps toward re-establishing a pre-crisis state of functioning. The commitments made by the [woman] need to be voluntary and realistic. A plan that has been developed only by staff will be ineffective (*adapted excerpt from* James, R. 2008. Six-step model of crisis intervention. *In Crisis intervention strategies.* (6th ed). Thomson. Belmont, CA: *as cited in* Alberta Council of Women's Shelters, 2009).

- **Summary**

The traditional confrontational model of intervention is as direct as it gets and involves firmly challenging the addictive behaviors by pointing out undesirable behavior and consequences caused by the addict, as well as laying expectations of recovery on the addict's shoulders. Years ago, this model of intervention was harsh by today's standards and involved using indirect force — even forms of manipulation — to usher the addict into some form of treatment and rid him of his substance abuse behaviors, which were viewed then more as character flaws than an illness. The core of confrontation in the mid-1990s was placing blame on the addict and focusing on punishing him until he changed his ways.

Today, confrontation is still highly used among interventionists, but it handled with more care. Generally, addicts respond far better to confrontation when it isn't overtly negative in nature. Often carried out in television

shows and films, confrontations that involve chastising the addict and pointing out everything he does wrong without offering him support and compassion are not typical today, and for good reason — they aren't effective. According to a published study in the Journal of Consulting and Clinical Psychology, intervention methods for 42 problem drinkers were successful in reducing drinking by 57 percent after six weeks; however, drinking was proven to be more frequent, and one-year reports weren't as successful among those who were treated in a directive-confrontational manner by their therapist.

Most confrontational interventions only happen one time, following closed meetings the family and interventionist used to organize the event. If the addict accepts help during the intervention and enters treatment, the rest of the family members and loved ones go on with their lives during treatment. If the addict resists treatment, there may be consequences, such as their family cutting off all contact with him

- **Revision**

Points for Discussion

Points for Clarification

- References / Further Readings

Psychological first aid: Guide for field workers (World Health Organization, War Trauma Foundation and World Vision International, 2011). Available in English.

Anthology Of Resources: Psychological First Aid For Low And Middle Income Countries Project 2009-2010 (War Trauma Foundation and World Vision International, 2011). Available in English.

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Inter-Agency Standing Committee - IASC, 2007). Available in English.

Unit 4: Record Maintenance and Documentation

- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

Introduction:

Documentation and record keeping are important to ensure accountability, facilitate coordination of care between providers and for service improvement. However, the importance of documentation and record keeping may be overlooked/overshadowed by the focus on direct services to clients. As such, proper documentation and record keeping may be neglected.

The following section provides three reasons why it is important to document and maintain proper records:

Continuity of care. Records provide a case history and a more holistic picture in order to follow-up on services or try different approaches to assist the client. This is especially for clients with long-term or complex needs, or who require multiple services. Accurate and up-to-date recording is important especially when there is an emergency and the staff-in-charge is not available (due to illness, vacation, resignation, etc.). Good records and documentation will facilitate communication between service providers to ensure coordinated, rather than fragmented, service.

Accountability. It is important to be able to provide relevant client information at any given time and the organisation's response to their needs. The information may be needed to respond to queries from stakeholders, who may include the client's family, funders, donors or the courts. One important source of information is the client records. Documentation forms the nature of the professional relationship with the client. Information on problems encountered and the agency's response would assist in the event of a crisis or investigations.

Service improvement. Well-documented records can also lead to improved services to the clients by helping the staff organise his/her thoughts. Aggregated client information can also facilitate service 6 planning, service development and service reviews. The information can also form primary data to conduct evidence-based research.

Objectives

Given the diverse nature, size and complexity of client needs and intended client outcomes, there may seem a myriad of information to document and store. What then should be documented.

History and needs of client. At the point of admission, detailed information on the needs and background of the client is documented during intake assessment. Refer to the Guide on Intake and Assessment, NCSS (2006) for more information.

Services rendered. When the client is participating in the service/programme, information on services rendered is documented in the client's care plan. Refer to the Guide on Care and Discharge Planning, NCSS (2007) for more information. Other key information to document, accompanied by supporting documents, is fees charged and subsidies received (for e.g., qualifying information for subsidies under means testing or other sources).

Client outcomes. Agencies should document client outcomes achieved or not achieved during periodic reviews, discharge or follow-up. Additional information may be derived from milestones achieved by the client or caregiver satisfaction surveys. The ability to produce documentation of clients' achievements further enhances the accountability of the programme.

Programme information. Minutes of meetings, case conferences and email exchanges towards critical decision making are important to record. Such documentation, in addition to other sources of information, could provide a background to the reasons why certain proposals were accepted or rejected.

- **Definitions**

Client-related information are usually aggregated periodically (for e.g. quarterly, half-yearly or annually) to provide information on outcomes. The consolidated reports are often provided to stakeholders, such as current and potential clients, funders, donors, media, accreditation bodies, etc. The information on client outcomes and programme effectiveness (or the lack of it) could be used for service planning and improvement, needs assessment, cost-benefit analyses, marketing and publicity, as well as other purposes where necessary.

Different staff would have unique writing styles according to individual preferences. To ensure consistency, it is best to bear in mind the following when documenting case notes:

Concise. Client notes should include only relevant information in appropriate detail, i.e. only provide information that is directly relevant to the delivery of services for intended client outcomes. Staff should try to ensure minimal burden to the client and his caregivers by asking only required information and not asking for them repeatedly. With the client's consent, assessment history should be transferred and verified from a referring provider to the current provider instead of subjecting the client to repeated assessments.

Accurate. Besides providing accurate information, direct quotes from the client, caregivers or other professional staff (such as comments from psychologists or doctors) could be reflected if necessary to provide a full picture of the client. As the information may be shared

with other agencies, the records must be legible; the reference terms used must be consistent and the records free from jargon (meaningless words).

Up-to-date. Progress notes, crisis intervention or incident reports should be written as soon as possible after an event has happened to prevent loss of information due to time lapse. All significant facts should be recorded. Such reports should not assign blame on individuals and be free from irrelevant speculation or offensive, subjective statements.

Meaningful. The notes should capture thoughtful reflective thinking and professional judgement of the intervention and services provided. Notes should distinguish clearly between facts, observations, hard data and opinions. Where opinions or professional diagnosis or 10 recommendation of a particular intervention is made, these should be properly acknowledged, dated and signed. Records requiring validation and authorisation must be properly completed and signed.

Internally consistent. Notes should be structured according to a preset format that may be unique to each organisation or professional group within the organisation (for e.g., use of standard care and discharge plan templates). Acronyms used should be meaningful to all within the organisation. Consistency and standardisation helps to bring clarity to staff and reduces the time taken to search for vital information amidst the huge amount of client information available.

- **Summary**

Record-keeping and documentation are important processes that facilitates:

Continuity of care ı
Accountability
Service improvement

Important information to record includes: ı
History and needs of client ı
Services rendered ı
Client outcomes ı
Programme information
Notes and records should be: ı
Concise ı
Accurate ı
Up-to-date ı
Meaningful ı

Internally consistent

- **Revision**

Points for Discussion

Points for Clarification

References / Further Readings
1. "Code of Ethics of the National Association of Social Workers" (Approved by the 1996 NASW Delegate Assembly and revised by the 1999 NASW Delegate Assembly, Washington D.C. Downloaded from http://www.socialworkers.org/pubc/code/code.asp 2. "Standards for Technology and Social Work Practice", National Association of Social Workers and Association of Social Work Boards, United States of America (2005). Downloaded from http://aswb.org/TechnologySWPractice.pdf 3. "Basic Standards for Clinical Documentation and Record Keeping", by Hillel Bodek, President of The New York State Society for Clinical Social Work, Inc. Downloaded from http://www.clinicalsw.org/basic_standards.html

4. "Protection of Children Scotland Act (POCSA) Volunteer Sector Training Pack and Guide", by The Consortium, (2005). Downloaded from http://www.crbs.org.uk/pocsa/introduction/default.htm 5. "Introduction to Behavioural Health Outcomes", The Commission on Accreditation of Rehabilitation Facilities (1997), United States of America

Unit 5: Implication of Early Intervention for pre-school Inclusion

- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction:**

Today an ever-increasing number of infants and young children with and without disabilities play, develop, and learn together in a variety of places – homes, early childhood programs, neighborhoods, and other community-based settings. The notion that young children with disabilities1 and their families are full members of the community reflects societal values about promoting opportunities for development and learning, and a sense of belonging for every child. It also reflects a reaction against previous educational practices of separating and isolating children with disabilities. Over time, in combination with certain regulations and protections under the law, these values and societal views regarding children birth to 8 with disabilities and their families have come to be known as early childhood inclusion.2 The most far-reaching effect of federal legislation on inclusion enacted over the past three decades has been to fundamentally change the way in which early childhood services ideally can be organized and delivered.3 However, because inclusion takes many different forms and implementation is influenced by a wide variety of factors, questions persist about the precise meaning of inclusion and its implications for policy, practice, and potential outcomes for children and families. The lack of a shared national definition has contributed to misunderstandings about inclusion. DEC and NAEYC recognize that having a common understanding of what inclusion means is fundamentally important for determining what types of practices and supports are necessary to achieve high quality inclusion. This DEC/NAEYC joint position statement offers a definition of early childhood inclusion. The definition was designed not as a litmus test for determining whether a program can be considered inclusive, but rather, as a blueprint for identifying the key components of high quality inclusive programs. In addition, this document offers recommendations for how the position statement should be used by families, practitioners, administrators, policy makers, and others to improve early childhood services.

- **Objectives**

Early childhood inclusion embodies the values, policies, and practices that support the right of every infant and young child and his or her family, regardless of ability, to participate in a broad range of activities and contexts as full members of families, communities, and society. The desired results of inclusive experiences for children with and without disabilities and their families include a sense of

belonging and membership, positive social relationships and friendships, and development and learning to reach their full potential. The defining features of inclusion that can be used to identify high quality early childhood programs and services are access, participation, and supports. What is meant by Access, Participation, and Supports? Access. Providing access to a wide range of learning opportunities, activities, settings, and environments is a defining feature of high quality early childhood inclusion. Inclusion can take many different forms and can occur in various organizational and community contexts, such as homes, Head Start, child care, faith-based programs, recreational programs, preschool, public and private pre-kindergarten through early elementary education, and blended early childhood education/early childhood special education programs. In many cases, simple modifications can facilitate access for individual children. Universal design is a concept that can be used to support access to environments in many different types of settings through the removal of physical and structural barriers. Universal Design for Learning (udl) reflects practices that provide multiple and varied formats for instruction and learning. udl principles and practices help to ensure that every young child has access to learning environments, to typical home or educational routines and activities, and to the general education curriculum. Technology can enable children with a range of functional abilities to participate in activities and experiences in inclusive settings. Participation. Even if environments and programs are designed to facilitate access, some children will need additional individualized accommodations and supports to participate fully in play and learning activities with peers and adults. Adults promote belonging, participation, and engagement of children with and without disabilities in inclusive settings in a variety of intentional ways. Tiered models in early childhood hold promise for helping adults organize assessments and interventions by level of intensity. Depending on the individual needs and priorities of young children and families, implementing inclusion involves a range of approaches—from embedded, routinesbased teaching to more explicit interventions—to scaffold learning and participation for all children. Social-emotional development and behaviors that facilitate participation are critical goals of high quality early childhood inclusion, along with learning and development in all other domains. Supports. In addition to provisions addressing access and participation, an infrastructure of systems-level supports must be in place to undergird the efforts of individuals and organizations providing inclusive services to children

and families. For example, family members, practitioners, specialists, and administrators should have access to ongoing professional development and support to acquire the knowledge, skills, and dispositions required to implement effective inclusive practices. Because collaboration among key stakeholders (e.g., families, practitioners, specialists, and administrators) is a cornerstone for implementing high quality early childhood inclusion, resources and program policies are needed to promote multiple opportunities for communication and collaboration among these groups. Specialized services and therapies must be implemented in a coordinated fashion and integrated with general early care and education services. Blended early childhood education/early childhood special education programs offer one example of how this might be achieved.4 Funding policies should promote the pooling of resources and the use of incentives to increase access to high quality inclusive opportunities. Quality frameworks (e.g., program quality standards, early learning standards and guidelines, and professional competencies and standards) should reflect and guide inclusive practices to ensure that all early childhood practitioners and programs are prepared to address the needs and priorities of infants and young children with disabilities and their families.

- **Definitions**

  Create high expectations for every child to reach his or her full potential. A definition of early childhood inclusion should help create high expectations for every child, regardless of ability, to reach his or her full potential. Shared expectations can, in turn, lead to the selection of appropriate goals and support the efforts of families, practitioners, individuals, and organizations to advocate for high quality inclusion. 2. Develop a program philosophy on inclusion. An agreed-upon definition of inclusion should be used by a wide variety of early childhood programs to develop their own philosophy on inclusion. Programs need a philosophy on inclusion as a part of their broader program mission statement to ensure that practitioners and staff operate under a similar set of assumptions, values, and beliefs about the most effective ways to support infants and young children with disabilities and their families. A program philosophy on inclusion should be used to shape practices aimed at ensuring that infants and young children with disabilities and their families are full members of the early childhood community and that children have multiple opportunities to learn, develop, and form positive relationships. 3. Establish a system of services and supports. Shared understandings about the meaning of inclusion should be the starting point for

creating a system of services and supports for children with disabilities and their families. Such a system must reflect a continuum of services and supports that respond to the needs and characteristics of children with varying types of disabilities and levels of severity, including children who are at risk for disabilities. However, the designers of these systems should not lose sight of inclusion as a driving principle and the foundation for the range of services and supports they provide to young children and families. Throughout the service and support system, the goal should be to ensure access, participation, and the infrastructure of supports needed to achieve the desired results related to inclusion. Ideally, the principle of natural proportions should guide the design of inclusive early childhood programs. The principle of natural proportions means the inclusion of children with disabilities in proportion to their presence in the general population. A system of supports and services should include incentives for inclusion, such as child care subsidies, and adjustments to staff-child ratios to ensure that program staff can adequately address the needs of every child.

Revise program and professional standards. A definition of inclusion could be used as the basis for revising program and professional standards to incorporate high quality inclusive practices. Because existing early childhood program standards primarily reflect the needs of the general population of young children, improving the overall quality of an early childhood classroom is necessary, but might not be sufficient, to address the individual needs of every child. A shared definition of inclusion could be used as the foundation for identifying dimensions of high quality inclusive programs and the professional standards and competencies of practitioners who work in these settings. 5. Achieve an integrated professional development system. An agreed-upon definition of inclusion should be used by states to promote an integrated system of high quality professional development to support the inclusion of young children with and without disabilities and their families. The development of such a system would require strategic planning and commitment on the part of families and other key stakeholders across various early childhood sectors (e.g., higher education, child care, Head Start, public pre-kindergarten, preschool, early intervention, health care, mental health). Shared assumptions about the meaning of inclusion are critical for determining who would benefit from professional development, what practitioners need to know and be able to do, and how learning opportunities are organized and facilitated as part of an integrated professional development system. 6. Influence federal and

state accountability systems. Consensus on the meaning of inclusion could influence federal and state accountability standards related to increasing the number of children with disabilities enrolled in inclusive programs. Currently, states are required to report annually to the U.S. Department of Education the number of children with disabilities who are participating in inclusive early childhood programs. But the emphasis on the prevalence of children who receive inclusive services ignores the quality and the anticipated outcomes of the services that children experience. Furthermore, the emphasis on prevalence data raises questions about which types of programs and experiences can be considered inclusive in terms of the intensity of inclusion and the proportion of children with and without disabilities within these settings and activities. A shared definition of inclusion could be used to revise accountability systems to address both the need to increase the number of children with disabilities who receive inclusive services and the goal of improving the quality and outcomes associated with inclusion.

- **Summary**

- **Revision**

Points for Discussion

Points for Clarification

- References / Further Readings

DEC/NAEYC. (2009). Early childhood inclusion: A joint position statement of the Division for Early Childhood (DEC) and the National Association for the Education of Young Children (NAEYC). Chapel Hill: The University of North Carolina, FPG Child Development Institute.

Block 2: Individualized Education Programme

Unit 1: Need, Importance and Historical Perspective of IEP

- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction :**

Individualized Education Programs, or IEPs as they are commonly called, are an integral part of the U.S. education system. They are the written documents that direct the provision of special education services to students with disabilities who need them. Increasing numbers of students in U.S. public schools have been deemed to need special education services, in a wider variety of categories, including learning disabilities, speech-language impairments, other health impairments, mental retardation, emotional disturbance, autism, visual impairments, hearing impairments, and others, totaling 13 separate categories in 2004. IEPs are considered a centerpiece of the special education process and, thus, necessary to understand for obtaining a perspective on special education as a whole.

- **Objectives**

The Individualized Education Program (IEP) is a written document required for each child who is eligible to receive special education services. It is provided to a student who has been determined first to have a disability and, second, to need special education services because of that disability. The IEP, the team that develops it, and what it must contain are governed by Part B of the Individuals with Disabilities Education Act (IDEA) and amendments to it. The IEP provides information on children's current levels of performance and directs the special services and supports that are provided to students who have IEPs. It includes provisions for defining annual goals, evaluating progress, and formalizing what is to be a free and appropriate public education (FAPE) for the student with the disability.

IEPs have several required components. Among the information that is to be included in IEPs are the following: (1) present levels of academic achievement and functional performance, (2) measurable annual goals, (3) special education, related services, and supplementary aids and services, (4) amount of time students will not participate in general education classes, (5) participation in state or district-wide academic assessments (including accommodations to be provided and reasons for using an alternate assessment if the child will not participate in the regular assessment), (6) initiation date and projected duration of IEP, (7) transition services, and (8) how student progress toward annual goals will be measured and when periodic reports will be provided to parents. Access to and participation in the general curriculum and use of research-

based procedures are emphasized in the preparation of IEPs (Yell, Shriner, & Katsiyannis, 2006). States or districts may add to the basic components as they see appropriate, but failure to include all required components has been a source of litigation (Yell, 2006).

- **Definitions**
- The passage of the 1975 Education of the All Handicapped Children's Act (EHA), also commonly known as Public Law 94–142, contained the first requirement for the development of the Individualized Education Program (IEP) for a child with a disability requiring the provision of special education services. Subsequent to the 1975 EHA, reautho-rizations of the law refined and adjusted the IEP requirements. Public Law 99–457 (EHA Amendments of 1986) added requirements for early intervention services for infants and toddlers. Public Law 101–476 (EHA Amendments of 1990) renamed the law as the Individuals with Disabilities Education Act (IDEA). Public Law 105–017 (IDEA Amendments of 1997) initiated alignment of IDEA with the Elementary and Secondary Education Act and required participation of students with disabilities in state and district-wide assessments. Public Law 108–446 (IDEA Amendments of 2004) adjusted the name of the law to the Individuals with Disabilities Education Improvement Act and further aligned its requirements to those of the Elementary and Secondary Education Act, particularly its accountability requirements.

- With each reauthorization, IEP requirements were adjusted to address the new focus and challenges or needs that were identified during the time since the previous reauthorization. The IDEA amendments in 2004 introduced several adjustments to the IEP, with the intention of addressing the need for increased accountability in line with the requirements of the Elementary and Secondary Education Act, known as No Child Left Behind. The 2004 reauthorization also introduced an easier IEP process, including less paperwork and the need for fewer meetings (President's Commission on Excellence in Special Education, 2002; Yell, 2006).

- Among the 2004 provisions were the ability to excuse from required IEP team membership anyone deemed to be unnecessary if agreed to by both school personnel and the child's parents, dropping the requirements to have short-term objectives (except for those students participating in the state alternate assessment) and allowing IEPs to be changed without reconvening the IEP team between annual

meetings, as long as the IEP team and the parents agreed. In an attempt to study the idea of having IEP teams meet only every three years rather than the required annual meetings, a pilot program for up to 15 states was initiated in 2004 to test the implementation and consequences of three-year IEPs.

The legal requirements for the Individualized Education Program (including the IEP team and the document itself) encompass not only what must be included in the IEP (see Definition) but also specifics of the process. The IEP team must meet to write the IEP within 30 calendar days of the date that the child was determined to be eligible for special education services. The team must include the child's parents (or guardians), a special education teacher, a general education teacher, a school or local education agency administrator, a person who is able to interpret evaluation results, and, if appropriate, the child. An individual may fill more than one role. The child's participation is required when the IEP includes a focus on transition services, which must start by age 16. Other individuals may be members of the team, as desired by the parents or school.

Each year, at a minimum, the IEP must be reviewed and revised as needed (unless there is participation in the three-year IEP pilot program; see Legislative History). Attention is paid especially to the IEP goals, progress toward them, and whether they need to be revised, and the placement of the child (where and for how long the child is in specific settings within the school, such as the general education classroom, special education room, or other placements). Every three years, the IEP team must meet to examine reevaluation results, used to determine whether the child continues to meet criteria to be designated as having a

disability that requires special education services.

- **Summary**

The actual processes and procedures used in schools and districts to ensure that IEP teams carry out the letter and intent of the law vary and have been the subject of relatively little research. Concerns about the legal requirements have arisen because of perceptions that they have compromised the quality of IEPs (Beattie, Jordan, & Algozzine, 2006). At the same time, the 2004 reauthori-zation of the law focused on ways to make the process of developing and revising the IEP more efficient and on ways to reduce paperwork in developing IEPs. In practice, states or local education agencies often require or recommend a form to use in developing the IEP so that it meets federal and state requirements. Computer-based IEP development software gained popularity with the perception of increasingly complex IEP requirements. With improvements over time in technology and programming, computer-based IEPs came to be viewed as having the potential to aid in the production of well-thought through IEPs (Wilson, Michaels, & Margolis, 2005).

IEPs are implemented by carrying out the directives of the IEP. Ideally, everyone responsible for implementing the IEP for an individual child has access to a copy of the IEP, and each person knows which responsibilities to implement (Beattie et al., 2006). Along with providing the designated services, supports, and accommodations that are described in the IEP, the IEP defines how the child's progress toward meeting the goals stated in the IEP will be measured. Progress reports designed to indicate the extent to which the child is making sufficient progress to reach goals by the end of the year are given to parents. These progress reports on IEP goals are to be made as often as the parents of children without disabilities are informed of their children's progress.

Despite their importance to the special education process, IEPs often have been inaccessible to those who should use them. Some educators and administrators have treated them as though they define the curriculum for the child with disabilities who requires special education services, rather than as the delineation of the services, supports, and framework for access to the general curriculum provided in the least restrictive environment for each child. In the early 2000s the IEP continued to be the subject of revisions each time IDEA is reauthorized, all the while retaining its central position in the special education process.

- **Revision**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

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Points for Clarification

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- References / Further Readings

Beattie, J., Jordan, L., & Algozzine, B. (2006). *Making inclusion work: Effective practices for all teachers*. Thousand Oaks, CA: Corwin Press.

President's Commission on Excellence in Special Education. (2002). *A new era: Revitalizing special education for children and their families.* Washington, DC: U.S. Department of Education, Office of Special Education and Rehabilitative Services.

Wilson, G. L., Michaels, G. A., & Margolis, H. (2005). Form versus function: Using technology to develop Individualized Education Programs for students with disabilities. *Journal of Special Education Technology, 20(2)*, 37–48.

Yell, M. L. (2006). *The law and special education* (2nd ed.). Upper Saddle River, NJ: Pearson.

Yell, M. L., Shriner, J. G., & Katsiyannis, A. (2006). Individuals with Disabilities Education Improvement Act of 2004 and IDEA regulations of 2006: Implications for educators, administrators, and teacher trainers. *Focus on Exceptional Children, 39*(1), 1–24.

Unit 2: Steps and Components of IEP

- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction:**

Each public school child who receives special education and related services must have an Individualized Education Program (IEP). Each IEP must be designed for one student and must be a truly *individualized* document. The IEP creates an opportunity for teachers, parents, school administrators, related services personnel, and students (when appropriate) to work together to improve educational results for children with disabilities. The IEP is the cornerstone of a quality education for each child with a disability.

To create an effective IEP, parents, teachers, other school staff--and often the student--must come together to look closely at the student's unique needs. These individuals pool knowledge, experience and commitment to design an educational program that will help the student be involved in, and progress in, the general curriculum. The IEP guides the delivery of special education supports and services for the student with a disability. Without a doubt, writing--and implementing--an effective IEP requires teamwork.

This guide explains the IEP process, which we consider to be one of the most critical elements to ensure effective teaching, learning, and better results for all children with disabilities. The guide is designed to help teachers, parents and anyone involved in the education of a child with a disability-develop and carry out an IEP. The information in this guide is based on what is required by our nation's special education law--the Individuals with Disabilities Education Act, or IDEA.

The IDEA requires certain information to be included in each child's IEP. It is useful to know, however, that states and local school systems often include additional information in IEPs in order to document that they have met certain aspects of federal or state law. The flexibility that states and school systems have to design their own IEP forms is one reason why IEP forms may look different from school system to school system or state to state. Yet each IEP is critical in the education of a child with a disability.

- **Objectives**

The purpose of this guidance is to assist educators, parents, and state and local educational agencies in implementing the requirements of Part B of the Individuals with Disabilities Education Act (IDEA) regarding Individualized Education Programs (IEPs) for children with disabilities, including preschool-aged children.

Definitions

The writing of each student's IEP takes place within the larger picture of the special education process under IDEA. Before taking a detailed look at the IEP, it may be helpful to look briefly at how a student is identified as having a disability and needing special education and related services and, thus, an IEP.

Step 1. Child is identified as possibly needing special education and related services.

"Child Find." The state must identify, locate, and evaluate all children with disabilities in the state who need special education and related services. To do so, states conduct "Child Find" activities. A child may be identified by "Child Find," and parents may be asked if the "Child Find" system can evaluate their child. Parents can also call the "Child Find" system and ask that their child be evaluated. Or —

Referral or request for evaluation. A school professional may ask that a child be evaluated to see if he or she has a disability. Parents may also contact the child's teacher or other school professional to ask that their child be evaluated. This request may be verbal or in writing. Parental consent is needed before the child may be evaluated. Evaluation needs to be completed within a reasonable time after the parent gives consent.

Step 2. Child is evaluated.

The evaluation must assess the child in all areas related to the child's suspected disability. The evaluation results will be used to decide the

child's eligibility for special education and related services and to make decisions about an appropriate educational program for the child. If the parents disagree with the evaluation, they have the right to take their child for an Independent Educational Evaluation (IEE). They can ask that the school system pay for this IEE.

Step 3. Eligibility is decided.

A group of qualified professionals and the parents look at the child's evaluation results. Together, they decide if the child is a "child with a disability," as defined by IDEA. Parents may ask for a hearing to challenge the eligibility decision.

Step 4. Child is found eligible for services.

If the child is found to be a "child with a disability," as defined by IDEA, he or she is eligible for special education and related services. Within 30 calendar days after a child is determined eligible, the IEP team must meet to write an IEP for the child.

Step 5. IEP meeting is scheduled.

The school system schedules and conducts the IEP meeting. School staff must:

- contact the participants, including the parents;
- notify parents early enough to make sure they have an opportunity to attend;
- schedule the meeting at a time and place agreeable to parents and the school;
- tell the parents the purpose, time, and location of the meeting;

- tell the parents who will be attending; and
- tell the parents that they may invite people to the meeting who have knowledge or special expertise about the child.

Step 6. IEP meeting is held and the IEP is written.

The IEP team gathers to talk about the child's needs and write the student's IEP. Parents and the student (when appropriate) are part of the team. If the child's placement is decided by a different group, the parents must be part of that group as well.

Before the school system may provide special education and related services to the child for the first time, the parents must give consent. The child begins to receive services as soon as possible after the meeting.

If the parents do not agree with the IEP and placement, they may discuss their concerns with other members of the IEP team and try to work out an agreement. If they still disagree, parents can ask for mediation, or the school may offer mediation. Parents may file a complaint with the state education agency and may request a due process hearing, at which time mediation must be available.

Step 7. Services are provided.

The school makes sure that the child's IEP is being carried out as it was written. Parents are given a copy of the IEP. Each of the child's teachers and service providers has access to the IEP and knows his or her specific responsibilities for carrying out the IEP. This includes the accommodations, modifications, and supports that must be provided to the child, in keeping with the IEP.

Step 8. Progress is measured and reported to parents.

The child's progress toward the annual goals is measured, as stated in the IEP. His or her parents are regularly informed of their child's

progress and whether that progress is enough for the child to achieve the goals by the end of the year. These progress reports must be given to parents at least as often as parents are informed of their nondisabled children's progress.

Step 9. IEP is reviewed.

The child's IEP is reviewed by the IEP team at least once a year, or more often if the parents or school ask for a review. If necessary, the IEP is revised. Parents, as team members, must be invited to attend these meetings. Parents can make suggestions for changes, can agree or disagree with the IEP goals, and agree or disagree with the placement.

If parents do not agree with the IEP and placement, they may discuss their concerns with other members of the IEP team and try to work out an agreement. There are several options, including additional testing, an independent evaluation, or asking for mediation (if available) or a due process hearing. They may also file a complaint with the state education agency.

Step 10. Child is reevaluated.

At least every three years the child must be reevaluated. This evaluation is often called a "triennial." Its purpose is to find out if the child continues to be a "child with a disability," as defined by IDEA, and what the child's educational needs are. However, the child must be reevaluated more often if conditions warrant or if the child's parent or teacher asks for a new evaluation.

4. A Closer Look at the IEP

Clearly, the IEP is a very important document for children with disabilities and for those who are involved in educating them. Done correctly, the IEP should improve teaching, learning and results. Each child's IEP describes, among other things, the educational program

that has been designed to meet that child's unique needs. This part of the guide looks closely at how the IEP is written and by whom, and what information it must, at a minimum, contain.

- **Summary**

By law, the IEP must include certain information about the child and the educational program designed to meet his or her unique needs. In a nutshell, this information is:

- **Current performance.** The IEP must state how the child is currently doing in school (known as present levels of educational performance). This information usually comes from the evaluation results such as classroom tests and assignments, individual tests given to decide eligibility for services or during reevaluation, and observations made by parents, teachers, related service providers, and other school staff. The statement about "current performance" includes how the child's disability affects his or her involvement and progress in the general curriculum.
- **Annual goals.** These are goals that the child can reasonably accomplish in a year. The goals are broken down into short-term objectives or benchmarks. Goals may be academic, address social or behavioral needs, relate to physical needs, or address other educational needs. The goals must be measurable-meaning that it must be possible to measure whether the student has achieved the goals.
- **Special education and related services.** The IEP must list the special education and related services to be provided to the child or on behalf of the child. This includes supplementary aids and services that the child needs. It also includes modifications (changes) to the program or supports for school personnel-such as training or professional development-that will be provided to assist the child.
- **Participation with nondisabled children.** The IEP must explain the extent (if any) to which the child will not participate with nondisabled children in the regular class and other school activities.
- **Participation in state and district-wide tests.** Most states and districts give achievement tests to children in certain grades or age groups. The IEP must state what modifications in the administration of these tests the child will need. If a test is not appropriate for the

child, the IEP must state why the test is not appropriate and how the child will be tested instead.

- **Dates and places.** The IEP must state when services will begin, how often they will be provided, where they will be provided, and how long they will last.
- **Transition service needs.** Beginning when the child is age 14 (or younger, if appropriate), the IEP must address (within the applicable parts of the IEP) the courses he or she needs to take to reach his or her post-school goals. A statement of transition services needs must also be included in each of the child's subsequent IEPs.
- **Needed transition services.** Beginning when the child is age 16 (or younger, if appropriate), the IEP must state what transition services are needed to help the child prepare for leaving school.
- **Age of majority. Beginning at least one year before the child reaches the age of majority, the IEP must include a statement that the student has been told of any rights that will transfer to him or her at the age of majority. (This statement would be needed only in states that transfer rights at the age of majority.)**
- **Measuring progress. The IEP must state how the child's progress will be measured and how parents will be informed of that progress.**

More information will be given about these IEP parts later in this guide. A sample IEP form will be presented, along with the federal regulations describing the "Content of the IEP," to help you gain a fuller understanding of what type of information is important to capture about a child in an IEP. It is useful to understand that each child's IEP is different. The document is prepared for that child only. It describes the individualized education program designed to meet that child's needs.

While the law tells us what information must be included in the IEP, it does *not* specify what the IEP should look like. No one form or approach or appearance is required or even suggested. Each state may decide what its IEPs will look like. In some states individual school systems design their own IEP forms.

Thus, across the United States, many different IEP forms are used. What is important is that each form be as clear and as useful as possible, so that parents, educators, related service providers, administrators, and others can easily *use* the form to write and implement effective IEPs for their students with disabilities.

By law, certain individuals must be involved in writing a child's Individualized Education Program. These are identified in the figure at the left. Note that an IEP team member may fill more than one of the team positions if properly qualified and designated. For example, the school system representative may also be the person who can interpret the child's evaluation results.

These people must work together as a team to write the child's IEP. A meeting to write the IEP must be held within 30 calendar days of deciding that the child is eligible for special education and related services.

Each team member brings important information to the IEP meeting. Members share their information and work together to write the child's Individualized Education Program. Each person's information adds to the team's understanding of the child and what services the child needs.

***Teachers* are vital participants in the IEP meeting as well. At least one of the child's*regular education teachers* must be on the IEP team if the child is (or may be) participating in the regular education environment. The regular education teacher has a great deal to share with the team. For example, he or she might talk about:**

- **the general curriculum in the regular classroom;**
- **the aids, services or changes to the educational program that would help the child learn and achieve; and**
- **strategies to help the child with behavior, if behavior is an issue.**

The regular education teacher may also discuss with the IEP team the supports for school staff that are needed so that the child can:

- **advance toward his or her annual goals;**
- **be involved and progress in the general curriculum;**
- **participate in extracurricular and other activities; and**
- **be educated with other children, both with and without disabilities.**

Supports for school staff may include professional development or more training. Professional development and training are important for teachers, administrators, bus drivers, cafeteria workers, and others who provide services for children with disabilities.

The child's *special education teacher* contributes important information and experience about how to educate children with

disabilities. Because of his or her training in special education, this teacher can talk about such issues as:

- how to modify the general curriculum to help the child learn;
- the supplementary aids and services that the child may need to be successful in the regular classroom and elsewhere;
- how to modify testing so that the student can show what he or she has learned; and
- other aspects of individualizing instruction to meet the student's unique needs.

Beyond helping to write the IEP, the special educator has responsibility for working with the student to carry out the IEP. He or she may:

- work with the student in a resource room or special class devoted to students receiving special education services;
- team teach with the regular education teacher; and
- work with other school staff, particularly the regular education teacher, to provide expertise about addressing the child's unique needs.

Another important member of the IEP team is the *individual who can interpret what the child's evaluation results mean* in terms of designing appropriate instruction. The evaluation results are very useful in determining how the child is currently doing in school and what areas of need the child has. This IEP team member must be able to talk about the instructional implications of the child's evaluation results, which will help the team plan appropriate instruction to address the child's needs.

The *individual representing the school system* is also a valuable team member. This person knows a great deal about special education services and educating children with disabilities. He or she can talk about the necessary school resources. It is important that this individual have the authority to commit resources and be able to ensure that whatever services are set out in the IEP will actually be provided.

The IEP team may also include additional *individuals with knowledge or special expertise about the child.* The parent or the school system can invite these individuals to participate on the team. Parents, for example, may invite an advocate who knows the child, a professional with special expertise about the child and his or her disability, or others (such as a vocational educator who has been working with the child) who can talk about the child's strengths and/or needs. The school system may invite one or more individuals who can offer special

expertise or knowledge about the child, such as a paraprofessional or related services professional. Because an important part of developing an IEP is considering a child's need for related services (see the list of related services in the box on the previous page), related service professionals are often involved as IEP team members or participants. They share their special expertise about the child's needs and how their own professional services can address those needs. Depending on the child's individual needs, some related service professionals attending the IEP meeting or otherwise helping to develop the IEP might include occupational or physical therapists, adaptive physical education providers, psychologists, or speech-language pathologists.

When an IEP is being developed for a student of transition age, *representatives from transition service agencies* can be important participants. (See the box below for more information about transition.) Whenever a purpose of meeting is to consider needed transition services, the school must invite a representative of any other agency that is likely to be responsible for providing or paying for transition services. This individual can help the team plan any transition services the student needs. He or she can also commit the resources of the agency to pay for or provide needed transition services. If he or she does not attend the meeting, then the school must take alternative steps to obtain the agency's participation in the planning of the student's transition services.

And, last but not least, the *student* may also be a member of the IEP team. If transition service needs or transition services are going to be discussed at the meeting, the student must be invited to attend. More and more students are participating in and even leading their own IEP meetings. This allows them to have a strong voice in their own education and can teach them a great deal about self-advocacy and self-determination.

- **Revision**

Points for Discussion

Points for Clarification

- References / Further Readings

Excerpt from Introduction to Special Education: Making a Difference, by D.D. Smith, 2007 edition, p. 56-59.

Unit 3: Developing, Implementation and Evaluation of IEP for PwID and its associated conditions

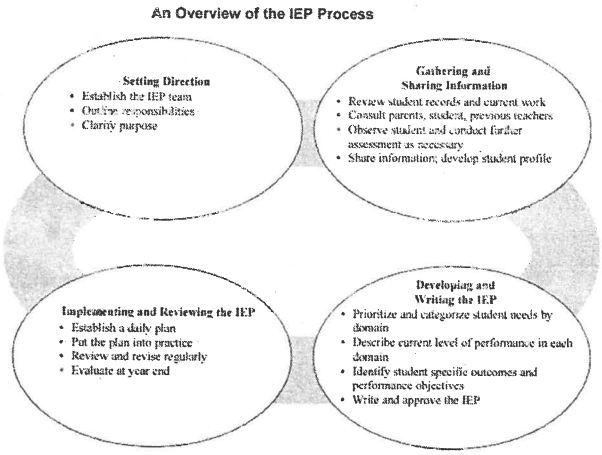
- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction:**

If the IEP process is to be efficient and effective, working with a clear sense of direction from the outset is essential. This entails deciding on members of the team, clarifying member roles and responsibilities, and defining the task.

An IEP is more likely to be implemented successfully if all members involved in its implementation are part of the planning team, and see the process as a way of attaining student goals that all of them share. The team is composed of people who have the knowledge and skills to identify student needs and to develop a plan to meet them. The composition of each IEP teams varies, reflecting the individual needs of each student and the resources available in the school or division. A typical IEP team comprises an in-school team, whose members are responsible for decision making, and a support team, comprising professionals who may be asked to join the team when the in-school team requires consultation. Individual planning should reflect the student's strengths, needs, and preferences whether or not the student participates in team meetings.

- **Objectives**



The four stages of IEP development and implementation. The chart above outlines four stages of IEP planning: • setting direction • gathering and sharing information • developing and writing •

implementing and reviewing This chapter explores these four stages of planning in the order in which they are most likely to be followed for a student who has not previously had an IEP.

- **Definitions**

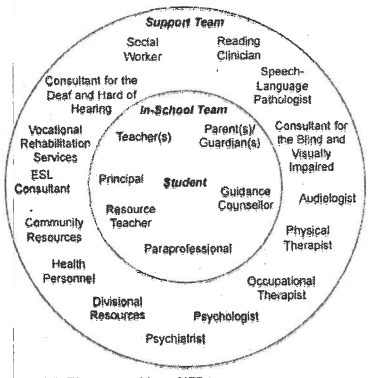


Figure 3.2: The composition of IEP teams.

Support Team Members of the support team can help determine the learning strengths and needs of the student within their areas of expertise. They can assist the in-school team in • developing strategies for incorporating therapy into classroom routine • training staff to implement strategies • providing technical assistance and advice about materials and resources • accessing specific community-based resources as required It is essential that all members have a clear understanding of their responsibilities on the IEP team. They should consider themselves as active and equal members whose expertise is recognized. One of the first tasks of the team, therefore, is to identify the case manager and assign specific roles and responsibilities to each member. Roles and Responsibilities The case manager oversees the work of the team as it develops the IEP. It is critical that a case manager be identified early in the process. In most instances, case managers are responsible for • distributing a written and timed agenda prior to meetings • maintaining contact with parents • organizing and chairing IEP meetings • coordinating development of the IEP • ensuring that a process to monitor progress and achievement is established • documenting and distributing revisions to the IEP • ensuring IEP meeting records are kept and distributed • facilitating group decision making • initiating and maintaining contact with external agencies

In-School Team The in-school team consists of the student, parents, and school staff. The members of this team are the key decision makers in the IEP process. Student Students can be involved in their

educational planning in many ways. Students participate as team members if they can contribute by expressing their needs and preferences, and can benefit by a discussion of the strategies and behaviours that enhance their learning. Students' engagement in learning is tied to their sense that programming goals reflect their aspirations. If students would not benefit from participating in planning meetings, they can be involved in other ways. It is important to consult with them before meetings to determine their preferences. Following the meeting, ensure that they • understand the purpose of their IEP • understand how the outcomes of the IEP will help them to attain their personal goals

Parents Parents are advocates for their child's best interests. It is essential that they have opportunities to be full and equal partners in the planning process. Parents contribute invaluable information about the student's learning approaches, interests, and about ways to avoid potential problems. The information they provide helps to ensure continuity in programming. They also play an important role in reinforcing the goals of the IEP at home. Enlisting parents as active members of the team contributes to an effective IEP. Parents are more likely to participate actively in IEP meetings when they understand the process. The school team can encourage the participation of parents by • arranging meetings when it is possible for parents to participate • providing a comfortable, non-threatening environment • discussing the purpose of each meeting and determining ways parents can contribute • providing parents with an agenda • seeking parental input and valuing their contributions and priorities • avoiding jargon and explaining all terms and assessment data that may be difficult to understand • sharing roles and responsibilities School Staff While the staff members on the in-school team vary from student to student, the typical team includes the classroom teacher, the principal or a designate, the resource teacher, the guidance counsellor, and/or paraprofessionals who will assist in implementing the plan. It is important to note that the classroom teacher retains primary responsibility for the student's learning. Students with IEPs remain part of the classroom community. The support team consists of a wide range of professionals who may be consulted by the school team throughout the IEP process depending on the student's needs. Setting direction also involves reflecting on the focus and scope of the IEP, which will need to be determined for each individual student. All IEPs are bound by a common purpose: to set out a plan that identifies and meets the individual learning needs of students. At this stage, it is helpful for the team to develop a common understanding of the domains that are likely to have the highest priority in the IEP. Domain refers to the specific area of development that might be targeted in the IEP. Examples of domains

include communication, social, academic, motor, cognitive, self-management (or self-help), community, vocational, and recreation/leisure. The broader the range of student needs, the more domains the IEP will address. An IEP will focus on the curricular domain when a student needs an adaptation in a particular academic or vocational subject area. Several domains are addressed when a student has a severe multihandicapping condition. Clarifying the purpose of the IEP in this way helps team members to focus and unify their efforts in the stages of the IEP development to follow.

- **Summary**

  The purpose of gathering and sharing information is to develop a student profile that will form the basis of the IEP. If the IEP is to meet the student's needs, it must be based on a solid understanding of the student's current levels of performance and a clear sense of those needs. The team will need to gather information such as the student's attendance record, school behaviour, communication skills, learning approaches, mobility, self-concept, and aspirations. Effective IEPs reflect an understanding of the whole student. Identifying areas of concern early in the IEP process allows team members to focus on these areas in collecting assessment information. One of the keys to an effective planning meeting is ensuring that members come to the meeting with all essential information.

  The records of a student's school experience and performance in previous years contain information that is essential for IEP planning. Sometimes teachers may feel reluctant to read student records, in the interest of giving a student a "fresh start." To optimize the student's opportunities to learn, it is essential that the IEP team profits from and builds on the information collected about the student's past learning. Student records reviewed by the team include • cumulative files • reports from consultant staff and outside agencies • recent and relevant medical information • report cards • previous IEPs • classroom assessment and performance records Team members will also review and analyze student portfolios and other work samples.

  Each of the people working with a student can provide information about the student's responses, behaviour, and performance. Consultation is also essential to gather information about the instructional and assessment strategies presently being used with the student. During the consultation process • parents can provide a unique perspective on their child's development and learning • previous teachers and paraprofessionals can provide information about strategies (effective and ineffective) • students can share

preferences and perceptions of their learning strengths and needs (ask them to share learning logs, questionnaires, and personal reflections) • other professionals may be consulted (e.g., occupational/physical therapists, social workers, psychologists, and speech-language pathologists).

This information relating to the student's current levels of performance forms the basis for determining student specific outcomes and serves as a baseline for measuring student achievement at the end of the school year. The assessment data collected allows teachers to assess not only how the student is performing, but also whether various instructional strategies and classroom practices are effective in furthering the student's learning.

After surveying the information available, team members may decide that further assessment is necessary to help them understand the difficulties the student is experiencing, or ways these difficulties can be addressed. Further testing may include standardized tests, criterion-referenced tests, living/vocational skills assessments, multiple intelligences or learning approaches inventories, and ecological assessments. These assessments may be conducted by the resource teacher, the classroom teacher, or members of the support team. Team members must be prepared to present the results of tests and their interpretations in clear, unambiguous language. It is essential that all information be in a form that is readily understood by all team members, particularly the parents and the student.

Each team member shares pertinent information with the team. This information is synthesized and summarized in a student profile. Because the profile provides a comprehensive and concise description of the student's current levels of performance, it serves as a reference for the team in determining needs and in generating student specific outcomes for the IEP. The student profile may contain the following elements: • background/history • learning approaches • interests • medical information

• diagnostic summary • strengths

• current levels of performance (in relevant subject areas or domains)

• needs

•long-term vision of team's goals for student

- **Revision**

Points for Discussion

Points for Clarification

Unit 4: IFSP – Planning and writing

- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction:**

If your young child has a visual impairment, you may have found that a program of early intervention services will help you meet her needs. Once she has been found eligible for these services, you will be meeting with the professionals who will provide them to discuss the specific needs of your child and your family. This team will create a document known as an Individualized Family Service Plan (IFSP). The IFSP, which is mandated by Part C of the Individuals with Disabilities Education Act (IDEA), describes your child's current situation and prescribes the services needed to support both your child's development and your family's efforts to help her development. The IFSP explains the following:

why your child needs services
what kind of services will be provided
who will provide them and how often
where the services will be provided

- **Objectives**

A wide range of services may be provided through early intervention, depending on your child's needs, including:

- audiological services to determine your child's hearing ability
- vision services to assess whether or not he has usable vision and what sort of low vision devices he may require
- occupational and physical therapy
- speech and language therapy
- special education services
- medical and nursing services
- nutritional services
- psychological and social work services
- health services necessary for your child to benefit from other early intervention services
- family training, counseling, and home visits
- transportation to enable your child and family to receive early intervention services
- respite care and other family support services

The law requires that early intervention services be provided in what are considered "natural environments"—that is, places where your child would normally be found. These might include your home, a child care center, or a

preschool, rather than in a service provider's office or at a vision care agency.

The first step in writing the IFSP will be for the members of your child's team to conduct various types of assessments to identify your child's individual strengths and needs. As part of the assessment process, the team members will talk to you about your child and your hopes and concerns about her. The IFSP will include information about your child's

- current level of development in the following areas:
  - physical development
  - cognitive development
  - communication development
  - social and emotional development
  - adaptive development
- fine and gross motor skills
- vision
- hearing
- overall health

  The plan must also include
- information about your family's concerns, priorities, and resources for promoting your child's development

  Based on the information that has been gathered, the team, of which you are an important member, will then decide and write into the IFSP
- the main outcomes expected for your child
- ways in which your child's progress will be measured
- specific services that will be provided, their frequency, and how they will be delivered
- the environments in which services will be provided
- the dates and duration of services
- steps that will be taken to support your child and family's transition out of early intervention services

  As part of this process, a service coordinator is assigned to help your family by making sure that the IFSP is put into effect and to coordinate the services outlined in the plan. The IFSP team needs to meet a minimum of once every six months to review the plan and make any changes that are needed.

- **Definitions**

Your baby's needs can't be separated from the needs of the rest of the family. In recognition of this, early intervention services are designed to

support your family as well as your child. There are other reasons why early intervention so strongly involves the family, including:

- You, as a parent, are your child's best teacher. Your family needs to continue working with your child at home on the lessons and skills that the early intervention team have introduced. This process is called reinforcement.

- Repeating at home the lessons and skills your child is in the process of learning will help him to learn new activities and information more effectively, and to develop new skills.

To make the most of early intervention, discuss what you believe is important for your child to do and to learn with the service coordinator and other professionals working with your child. You have the right to request services that will help your child to succeed in reaching those goals. You can also ask these professionals about other sources of information that you think you need.

- **Summary**

  The IFSP must include the following information:

  1. Information about the child's present levels of physical (including vision, hearing and health status), cognitive, communication, social or emotional, and adaptive development based on information from that child's evaluation and/or assessments;
  2. With agreement from the family, a statement of the family's resources, priorities, and concerns related to enhancing the development of their child as identified through the family assessment;
  3. The measurable outcomes or results expected to be achieved for the child (including pre-literacy and language skills as developmentally appropriate for the child) and family, including the criteria, procedures, and timelines that will be used to determine (1) the degree to which progress toward achieving the results or outcomes identified on the IFSP is being made; and (2) whether modifications or revisions of the outcomes or services are needed;
  4. The early intervention services, based on peer- reviewed research (to the extent practicable) and resources necessary to meet the unique

needs of the child and family to achieve those outcomes or results. For each early intervention service, the IFSP must include:

1. The length (length of time during each session), duration (projection of when the child is expected to achieve the outcome on his/her IFSP), frequency (number of days or sessions), intensity (individual or group), and method of delivering each service (how a service is provided);
2. The location (actual place or places) of the services;
3. If a service is not provided in a natural environment, a justification as to why the service will not be provided in the natural environment, the plan to transition the service to the natural environment within six months or sooner, and strategies to support generalization and attainment of the outcome in a natural environment

5. Other Services, including medical or other services the child or family needs or is receiving through other sources, but that are neither required nor funded under Part C, early intervention. For services not currently being provided, include a description of the steps the service coordinator or family will take to secure those other services.
6. The name of the AzEIP service coordinator;
7. The steps to be taken to support the smooth transition of the child from early intervention services by age 3 to (i) preschool services under IDEA, Part B to the extent those services are appropriate or (ii) other services that may be available. Those steps include:
    1. Discussions with, and training of, parents, as appropriate, regarding future placements and other matters related to the child's transition;
    2. Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting;
    3. Confirmation that child find information about the child has been transmitted to the school district and ADE, unless the family has opted out of this automatic referral;
    4. With parental consent, child information has been sent to the school district or other early childhood programs to ensure continuity of services from AzEIP to those other programs, including a copy of the most recent evaluation and assessments of the child and the family and most recent IFSP developed; and
    5. Identification of transition services and other activities that the IFSP Team determines are necessary to support the transition of the child; and

8. Signature of the parent, which provides consent for the early intervention services.

- **Revision**

Points for Discussion

Points for Clarification

Unit 5: Application of IEP for Inclusion

- **Introduction:**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction:**

An IEP is a document that describes an educational program that has been developed for one specific student with special needs. It includes only the details of the educational program that have been modified or adapted. IEPs must also identify the support services required to implement the program.

IEPs for special needs students are a requirement under the School Act, mandated by Ministerial Order M19/00 (see Chapter 6). This order directs school boards to ensure that an IEP is in place for a special needs student as soon as practical after a student's special needs are identified. The order requires that the IEP be reviewed annually and, when necessary, revised or cancelled. It also requires that parents, and students where appropriate, must be consulted about the preparation of the IEP.

The duty to consult with parents in the preparation of the IEP is an important statutory right. In Hewko v B.C., 2006 BCSC 1638 the court held that the School Board had failed to meaningfully consult with Darren Hewko's parents over his plan. The court held that the Abbotsford School District had breached its statutory duty to consult in failing to seriously consider, and hwere possible integrate, the parent's home based program as developed by the home based consultant. There was evidence that this program could produce beneficial instruction for Darren Hewko. The District was ordered to meet with its obligation by meaningfully consulting with the parents.

Each student's IEP will be different, reflecting their personal learning needs. Some students require only small adaptations and minimum levels of support. These students with special needs can achieve the expected learning outcomes for their grade level and/or courses. Some students with more complex needs will require modifications to their education programs. Some or all of the learning outcomes for these students may differ from the curriculum. Some students may have both adaptations and modifications in their IEPs. IEPs may be brief or detailed as appropriate, and are designed to enable learners to reach their individual potential.

From school entry to school leaving, developing and implementing an appropriate IEP is critical for supporting student learning and long-term success. It's also the foundation for reporting. Participating in

the development of your child's IEP is critical. Your role in planning, making the plan work, and ensuring that quality educational opportunities are available to your child will lead to the future you want for your family and for your child.

- **Objectives**

The term inclusion captures, in one word, an all-embracing societal ideology. Regarding individuals with disabilities and special education, inclusion secures opportunities for students with disabilities to learn alongside their non-disabled peers in general education classrooms. Honestly establishing a successful inclusive classroom varies in complexity, based upon the challenges created by the disability at hand. However a knowledgeable approach and positive attitudes on the parts of parents and teachers proves vital to triumphing over any obstacles which may emerge.

- **Definitions**

A knowledgeable approach and positive attitude toward inclusion begins by understanding the concept and the theory behind it. Why integrate children with special needs into a general education classroom? Who benefits? What results? Special education professional Gretchen Walsh M.S. Ed., who runs the Academic Support Center at Notre Dame College, gives a concise synopsis when she says "Inclusion is important because through our diversity we certainly add to our creativity. If you don't have a diverse classroom or a diverse world, you don't have the same creative levels and I think our strength lies in our diversity."

According to the Individuals with Disabilities Education Act (IDEA), students with special needs have the right to receive necessary curricular adaptations. Adaptations include accommodations and modifications. Students who receive accommodations are held to the same academic expectations as their general ed classmates; on the other hand, modifications entail making changes that lower these expectations. Curricular adaptations vary based upon each learner's individual needs. Individualized education programs (IEPs) list what accommodations or modifications a student should receive.

The Individualized Education Program (IEP) has been referred to as "the cornerstone" or "centerpiece" of the Individuals with Disabilities Education Act (IDEA). It is the statutory vehicle for ensuring that a student with a disability receives a free appropriate public education in the least restrictive environment. The IEP is an individualized

document, written for each student, memorializing the educational program that is designed to meet each child's unique needs. All students who receive special education services must have an IEP. The IEP is developed during an IEP meeting with the full participation of the parents and the student, when he or she is old enough to contribute.

The types of instructional strategies found in inclusive classrooms, including peer tutoring, cooperative learning groups and differentiated instruction, have been shown to be beneficial to all learners. For example, Slavin, Madden, & Leavy (1984) found that math scores for students with and without disabilities increased by nearly half a grade level as a result of working in cooperative learning groups. Peer tutoring resulted in significant increases in spelling, social studies and other academic areas for students with and without disabilities (Maheady et al, 1988; Pomerantz et al, 1994). The use of graphic organizers, study guides, and computer accommodations resulted in significantly improved performances on tests and quizzes for students with and without disabilities (Horton, Lovitt, & Berglund, 1990). In addition, children with intellectual disabilities educated in general education settings have been found to score higher on literacy measures than students educated in segregated settings (Buckley, 2000). Quality inclusive education doesn't just happen. Educating children with disabilities in general education settings with access to the general education environment requires careful planning and preparation (Deno, 1997; King-Spears, 1997; Scott, Vitale, & Masten, 1998). Research shows that principals, special education directors, superintendents, teachers, parents and community members must all be involved and invested in the successful outcome of inclusive education (Villa, 1997; Walther-Thomas, 1997). Teachers — both general and special education — must collaborate to create learning strategies and environments that work for all students. Related service personnel, including speech therapists, occupational therapists, physical therapists and school psychologists will be expected to deliver their services in the general education environment rather than in pull-out rooms and will need to incorporate their services into the general education curriculum and schedule (Ferguson, Ralph, & Katul, 1998). Educators must rethink assessment, as No Child Left Behind and IDEA 2004 both call for more extensive evaluation of student progress, including the use of standardized assessment. Research highlights the benefits of efforts on the part of schools to find meaningful and creative ways for parents of children with disabilities to participate and contribute in the

school community (Ryndak & Downing, 1996.) The benefits of strong family-school partnerships are well documented in the literature. Student academic achievement is higher when parents are involved; in fact, the higher the level of parent involvement, the higher the level of student achievement

"Quality inclusive education doesn't just happen. Educating children with disabilities in general education settings with access to the general education environment requires careful planning and preparation." 14 (Dauber & Epstein, 1993; Henderson & Berla, 1994; Christenson & Sheridan, 2001). Other benefits of strong family-school collaboration include improved student attendance, higher aspirations for postsecondary education and career development (Caplan, et. al., 1997), improved social competence, (WebsterStratton, 1993) and lower rates of high-risk behavior on the part of adolescents (Resnick et al., 1997).

The Individuals with Disabilities Education Act (IDEA) strongly emphasizes the involvement of families at every step of the special education process, from referral to evaluation, to Individualized Education Program (IEP) development, to monitoring progress. Yet, many parents of students with disabilities are not fully participating members of their child's IEP Team. Data from the first year of the Special Education Elementary Longitudinal Study (SEELS) funded by the Office of Special Education Programs (OSEP) as part of the national assessment of the 1997 Individuals with Disabilities Education Act (IDEA 97), showed that: • Nearly 90 percent of elementary and middle school students with disabilities had a family member attend their IEP meeting but only two-thirds of parents reported collaborating with school district personnel on the IEP development. •

Parents of students with specific learning disabilities and speech/language impairment were the least likely to attend IEP meetings or training sessions. Since these two disability categories comprise 70 percent of all students (ages 6-21) served under IDEA, the SEELS study implies that the majority of students with disabilities have the least involved families. • Only 25 percent of students had an adult family member who had participated in an informational or training session on understanding their rights and responsibilities under IDEA. Those who attended viewed the meetings as very helpful (49%) or somewhat helpful (44%). A national survey by Public Agenda,

When 'Its Your Child: A Report on Special Education from the Families Who Use It, revealed that a large majority (70%) of the

parents surveyed say that too many children with special needs lose out because their parents don't know what's available to them. More than half (55%) said that parents have to find out on their own what services and supports are available. This finding underscores the need to provide more training and information to parents on how the special education process works and their rights under IDEA. A lack of information about the special education process can lead to conflicts between parents and schools. In studies of conflict resolution in special education, breakdowns of communication between parents and schools were often caused by "parents not being adequately informed as to what limits are contained in IDEA and School district personnel not being adequately informed about the extent and complexity of the . . . federal statues and regulations" (Feinberg, et al. 2002). This book is our attempt to provide parents with tips and strategies for making inclusive education a reality for their children. It is our hope that these tips will prove useful for families as they advocate for their children, and will allow parents to come to the IEP table as true and equal partners in the IEP process.

- **Summary**

The complexity involved in integrating students with disabilities into general education classrooms can make this process seem intimidating or overwhelming to a general education teacher. If you feel this way, take comfort in the realization that you are not alone. Actually the fact you find yourself currently exploring this website indicates you are journeying down the right path. As already noted, a knowledgeable approach proves vital to a thriving inclusive environment.

Communicate with your child. Ask how school is going. Ask your child what he or she would like to change, what they would like to be different in school. Find out what they like and dislike. Ask them what they want and what they need.

Be prepared to share relevant information about your child with the team. Consider putting together a portfolio of your child's home experiences, including photos or videos of your child engaging in family life and activities

Be sure to write down any questions you may have before the meeting so you do not forget. These questions can be part of a written agenda you submit to the school before the meeting

Call or make an appointment to introduce yourself to each of your child's teachers. Don't forget the "specials" teachers (art, music, physical education, etc.) and related services staff (occupational therapist, speech therapist, physical therapist, etc.). Find out from

them how they think your child is doing at school, what their concerns are, and what help or resources they may need to do their job. Ask them to share their vision for your child for next year.

Visit your child's classroom. Visit the cafeteria during lunch, visit the playground to see what happens at recess. Observe what's going on with your child in all settings while they are at school (but don't overstay your welcome and respect the teacher's space).

Organize all records pertaining to your child. It is helpful to put records in a three-ring binder, arranged either chronologically, or by section (evaluations, IEPs, report cards, etc).

Keep good records of all communication in connection with your child. After each telephone call or meeting, write down everything that was said, creating a contemporaneous business record. Get into the habit of documenting each important conversation with a follow-up letter but respect each teacher's busy schedule. Don't burden them with unnecessary contacts.

Read all of the prior evaluations. Decide if additional evaluations are needed and how that information will be obtained. Do you fully understand your child's diagnosis? Do you understand the words used in the reports? Don't be afraid to ask someone to explain any jargon. Get a written copy of the results of any assessments. If needed, schedule a meeting with the appropriate school personnel to discuss assessment results.

Bring in any evaluations that were done privately if you want the school team to consider them. Make sure they have copies at least 5 days in advance of the meeting so they have time to review them. Remember, by law, the team only has to consider the evaluation, not follow the recommendations.

If you disagree with the school's evaluation, you may request (in writing) an independent educational evaluation at the district's expense. The district is required to pay for the evaluation unless they are willing to bring you to a due process hearing to prove that their evaluation was appropriate.

Prior to the IEP meeting, let the school know in writing what you will be recommending for your child. Send in a proposed agenda. Be clear on what your expectations are. Bring documentation of what your child needs to be successful in school.

Check to see who has been invited to the IEP. Is everyone who is important to your child's educational program going to be there? Is everyone who is legally required to be there planning to attend? Think carefully before you allow someone to be excused. Check the

law to see who is required to be at the meeting. Let the school know if you are planning to bring someone to the meeting

Know your rights. Download or write for a free copy of the IDEA and read it. Visit the websites for the US Department of Education as well as your State Department of Education (SDE). Sign up for training to learn about your legal rights. Become empowered with knowledge. and a copy of your state's special education regulations from your SDE. If you don't understand the law, call the SDE and speak to a representative. There are consultants who can answer your questions and explain the process in straightforward terms.

Speak with other parents about their IEP meetings. Ask them if they will share their experiences. Get their impressions (both positive and negative) of the services they received. Participate in local parent groups so you have a network of parents to rely on. You will benefit from hearing about other parents' experiences.

Consider placement in regular education for your child. A regular class placement, commonly called "inclusion," is defined by Office of Special Education Programs as 80% or more of the day in a regular class. Don't be afraid to insist that this be considered. The law says that to the maximum extent appropriate, children with disabilities shall be educated in their neighborhood schools and attend regular classes (the classes he or she would have attended if born without a disability) with supplemental aids and services necessary for success. There is ample research to show that inclusion is good for all kids — with and without disabilities. Make the commitment and decide what supports your child needs to be successful. It is never too late to start.

- **Revision**

Points for Discussion

Points for Clarification

- References / Further Readings

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Block 3: Teaching Strategies and TLM

Unit 1: Stages of Learning

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

Many students would likely cite a desire to learn as the primary reason for committing four years to a college education. But what do we really mean when we use the word "learn"? It is something we all do from the moment of birth, so most of us likely take this very complex process for granted. How many of you have spent time trying to understand the meaning of learning, or how it occurs? Although many of us have a general sense of what it means to learn, there are often many assumptions involved. Teachers often assume that, because they are "teaching," students must be learning. Students assume that, because they have read their text and memorized facts, they have learned something. What should we expect to learn from a college education? What are the roles of students and teachers in the learning process? Are certain kinds of learning and thinking more valuable than others? What does sophisticated thinking look like and what are the developmental stages for getting there? What kinds of skills and knowledge do employers desire in their perspective employees? How do grades reflect a student's thinking and learning? What role does higher education play in modern society? These are but a few questions to consider while reflecting on the purpose of a college education. The past few decades have seen considerable advances in understanding the brain and learning. These new findings have significant implications for what instructors teach and how students learn, and I have changed the way I approach teaching. As I began to revise my courses to include new instructional methods, I realized the need to add some readings and classroom discussions to help students understand their vital role in the learning process. I initially sought to find an

existing document that would provide a concise summary about learning. After not finding a suitable overview, I decided to write one myself. So, the purpose of this document is to provide a brief overview of learning, how people learn, and the importance of learning as a lifelong objective. This summary is distilled from a number of books, papers, and web pages related to learning, thinking, and educational practices. Although intended for students, the document might also be useful to instructors as they consider what they teach and how to teach it. Feedback, both positive and negative, is welcomed to help guide future revisions of this "work in progress." A review by J. Serie greatly improved this document. However, any errors are the sole responsibility of the authors. THE CURRENT SITUATION The American education system is considered among the best in the world. More than 50% of our nation's high school graduates continue on to college and each year our universities and colleges enroll thousands of students from other countries. Despite these statistics, several recent studies have shown that many college seniors have neither good general knowledge nor the necessary skills for reasoning in today's society (Fink 2003). As an example, Saunders (1980) compared U.S. students who had completed a yearlong economics course with those who had never taken a course in economics. At the end of the course, the test scores of those students who had completed the economics course were only 20% better than those who had not taken the course, and this difference dropped to less than 10% seven years after completion of the course. Equally shocking are the results of a study of critical thinking and college faculty in California. Although most of the faculty (75%) claimed to value critical thinking and to promote it in the classroom, less than 19% were able to provide a clear explanation of critical thinking, and less than 10% were able to identify criteria for evaluating the quality of students' thinking (Paul et al. 1997). The results of these studies, and many others, strongly suggest that our current instructional practices are not working and that many students are not learning, or retaining what they do learn (Fink 2003).

- **Objectives**

There have been calls for new kinds of learning from many different parts of society (Fink 2003). College teachers have expressed frustration about attendance in class, uncompleted reading assignments, and student focus on grades rather than learning. Student surveys indicate that courses are not interesting, that students fail to recognize the value of what they are learning, and that many faculty rely too heavily on lectures for transmitting information. Recognizing the need for greater accountability by our public schools systems, a significant number of state legislatures have begun to

link appropriations to performance. A number of national organizations have also called for change. An Association of American Colleges report in 1985 recommended that the central theme of any curriculum should be to teach students "how to learn." Surveys of professional organizations indicate that besides specific competencies and skills, today's employers seek workers with people skills (e.g., teamwork, communication, leadership) along with a desire and ability for lifelong learning. The 1996 National Science Foundation report on Shaping the Future (of science, mathematics, engineering, and technology education) urges faculty to promote new kinds of learning that include developing skills in communication, teamwork, and lifelong learning. Gardiner (1994) compiled a list of "critical competencies" for citizens and workers from leaders in business, industry and government: • personal responsibility, • ability to act in principled, ethical fashion, • skill in oral and written communication, • interpersonal and team skills, • skills in critical thinking and problem-solving, • respect for people different from oneself, • ability to change, • ability and desire for lifelong learning. Fink (2003) summarized Dolence and Norris' 1995 report on Transforming Higher Education in the information age as follows: "Society and individual learners now have different needs, both in terms of what people need to learn and how they can and should learn." For all the reasons given above, and for many others, the focus of education is shifting from "teaching" to "learning" today. Faculty roles are changing from lecturing to being primarily "designers of learning methods and environments" (Barr and Tagg 1995, cited in Fink 2003). Brookfield (1985) argues that the role of teachers is to "facilitate" the acquisition of knowledge, not "transmit" it, and the NRC (2000) recommends that the goal of education shift from an emphasis on comprehensive coverage of subject matter to helping students develop their own intellectual tools and learning strategies. If you ask most college teachers what is the greatest gift that they could give their students, you will rarely hear an answer that includes mention of specific discipline-related content. Most will answer "the desire and skills for lifelong learning." It's not that it isn't important to learn some facts while in college; these will likely be necessary for future employment. More important though is having the skill to learn on one's own after leaving college. This single, The 2002 panel report by the Association of American Colleges and Universities (Greater Expectations: A New Vision for Learning as a Nation Goes to College) defines student-learning needs for the 21st century. To prepare students for "emerging challenges in the workplace, in a diverse democracy, and in an interconnected world" colleges and universities should place new emphasis on educating students to be "intentional learners" who are purposeful and self-directed, empowered through intellectual and practical skills, informed by knowledge and ways of knowing, and responsible for personal actions

and civic values (AACU, 2002). Becoming an intentional learner means "developing self-awareness about the reason for study, the learning process itself, and how education is used." Intentional learners are integrative thinkers who "see connections in seemingly disparate information" to inform their decisions. Self-directed learners are highly motivated, independent, and strive toward self-direction and autonomy. They "take the initiative to diagnose their learning needs, formulate learning goals, identify resources for learning, select an implement learning strategies, and evaluate learning outcomes" (Savin-Baden and Major 2004). Specifically, the AACU report recommends that students should learn to: • effectively communicate orally, visually, in writing, and in a second language • understand and employ quantitative and qualitative analysis to solve problems • interpret and evaluate information from a variety of sources • understand and work within complex systems and with diverse groups • demonstrate intellectual agility and the ability to manage change • transform information into knowledge and knowledge into judgment and action

- **Definitions**
- The stages of learning are phases that athletes experience as they progress through skills. As a coach, if you are aware of your athletes' level of readiness, you can help them advance more quickly.

  Several models are used describe these learning stages. The most popular are the Gentile 2-stage model and the Fitts and Posner 3-stage model. The Gentile model takes into account the learning environment, whereas the Fitts and Posner model does not.
- There is no definitive point at which an athlete transitions into any the phase, but descriptions help coaches know about where athletes are and which level of activities they are able to accomplish.

Three stages of learning have been identified:

- **Cognitive or Understanding Phase**

In the first stage of learning performances are inconsistent and not success is not guaranteed. Performing the skill requires all of the athletes attention and so they rely on the coach for cues. This is a process of trial and error with a success rate of 2 or 3 out of 10 attempts. Correct performances must be reinforced through external feedback.

- **Associative or Verbal Motor Phase**

Performances are becoming more consistent as **motor programmes**are being formed. While the simpler parts of the skill now look fluent and are well learned, the more complex elements requires most of the spare attention. The athlete is starting to get a sense of internal 'kinaesthetic' feedback when they perform the skill well. They are starting to detect and correct their own errors and success rate has risen to 5-7 out of 10.

- **Autonomous or Motor Phase**

In the final stage of learning, performances have become consistent, fluid and aesthetically pleasing. The motor programmes involved are well learned and stored in the long-term memory. There is now spare attention which can be focused on opponents and tactics. To retain the new skill at this level, it must be constantly practiced to reinforce the motor programmes. Success is now 9 out of 10.

- **Summary**

DIFFERENT KINDS OF THINKING AND LEARNING: THE COGNITIVE DOMAIN Since the 1950's, researchers in cognitive theory and education have used Bloom's (1956) taxonomies of learning. In a number of landmark papers, Bloom and colleagues identified three learning domains: • the cognitive domain • the affective domain • the psychomotor domain The cognitive domain involves thinking of all sorts; it is discussed in some detail below. The affective domain includes feelings, emotions, attitudes, values, and motivations. Levels within the affective domain range from initial awareness to a commitment to values that guide behavior and decisions. The psychomotor domain of learning includes physical movement, coordination, motor-, and sensory-skills. The psychomotor domain is not considered further in this document. The other two domains, however, are involved in just about everything that follows. (Read on!). Although widely used by instructors for course design and student assessment, Bloom's

taxonomy does not include some of the new kinds of learning deemed important today (e.g., learning how to learn, communication and leadership skills, adaptability). Without question, the most widely used of Bloom's taxonomies is for the cognitive domain. Bloom divided this domain into six levels of understanding in a hierarchical sequence (Table 1). According to Bloom, the acquisition of facts (knowledge) marks only the beginning of understanding. The facts must be understood (comprehension) before they can be applied to new situations (application). Knowledge must be organized and patterns recognized (analysis) before it can be used to create new ideas (synthesis). Finally, to discriminate among competing models or evidence, the learner needs to be able to assess (evaluation) the relative merits and validity of information or ideas. Clearly, to attain the level of understanding that makes "evaluation" possible requires significant time and effort by the learner. Such a sophisticated level of understanding is not easily attained by simply reading a book or hearing a lecture. It requires active thought and reflection. Think about something in your own life in which you have attained a high level of understanding. Perhaps it is a hobby, a sport, or a skill. Try to write down examples of the different levels of understanding related to this proficiency that you have. How many hours did you spend dedicated to that task before you attained your current level of proficiency? Are you prepared to dedicate that much effort to leaning in college? Bloom and colleagues identified six levels within the cognitive domain. Subsequently, Anderson et al. (2001) pointed out that there are four categories of knowledge within the cognitive domain, each requiring different kinds of learning. They identified four principal kinds of knowledge: factual, conceptual, procedural, and metacognitive. Factual knowledge consists of isolated and discrete content elements. Conceptual knowledge is more complex and organized, including such things as knowledge of classifications, categories, principles, theories, models, and structures. Knowledge of "how to do something" such as techniques, methods and skills is termed procedural knowledge. Metacognitive knowledge is "knowledge about cognition and awareness of and knowledge about one's own cognition." Anderson et al. (2001) revised Bloom's taxonomy and showed that each of their four kinds of knowledge can be mapped across all six of Bloom's levels of understanding. So, there are 24 distinct combinations of knowledge type and level of understanding. In Learning to Think: Disciplinary Perspectives, Donald points out that different disciplines involve different and specific kinds of thinking and information. This, according to Donald explains why students gravitate toward one field or another. It is also the single most important predictor for success in a given field. Wow, our concepts of learning and understanding have already gotten a lot more complicated, and we're not finished yet!

Krathwohl et al. (1964) wrote the seminal book describing what Bloom and others called the affective domain. The affective domain includes all things that limit or enhance learning in addition to basic thinking. The affective domain describes learning objectives that emphasize a feeling, an emotion, or a degree of acceptance or rejection. Affective characteristics vary from simply paying attention, to complex qualities of character and conscience. The affective domain involves many things that at first seem unconnected, but Krathwohl et al. (1964) arranged them in a hierarchical order (Figure 1) related to an individual's level of commitment to learning. The Science Education Resource Center website has a good summary of the affective domain (http://serc.carleton.edu/NAGTWorkshops/affective/intro.html). The key idea is this: receiving information is the first and easiest part of learning. More important is that

FINK'S TAXONOMY OF SIGNIFICANT LEARNING In response to a need for a broader consideration of learning, Fink (2003) proposed a taxonomy of "significant learning" (Table 2) that involves aspects of both the cognitive and affective domains. This taxonomy was developed to emphasize that learning involves changes in the learner. Significant learning is characterized by "some kind of lasting change that is important in terms of the learner's life" (Fink 2003). Each of Fink's rather broad categories includes several related specific kinds of learning. However, unlike in Bloom's taxonomy, the categories in the Fink (2003) taxonomy are interactive rather than hierarchical. According to the Fink scheme, foundational knowledge includes knowledge and understanding of basic facts, ideas, and perspectives. Foundational knowledge also includes understanding the conceptual structure of factual knowledge within a subject, essential when applying factual knowledge in other areas. Foundational knowledge is also essential for other kinds of learning to be useful, hence the term foundational. In addition to being able to recall information and ideas, one also needs to be able to apply one's knowledge or skills to new situations; this is application. This category includes learning to engage in new kinds of thinking (critical, creative, practical) as well as certain skills (e.g., communication, playing an instrument). Critical thinking, discussed in more detail below, refers to the process of analyzing and evaluating, whereas creative thinking is the process of creating new ideas, designs, products, or forms of expression (Sternberg 1989; cited in Fink 2003). Practical learning occurs when foundational knowledge is applied to answering questions, solving problems, or making decisions. In the Fink taxonomy, the real intellectual power comes from integration, which involves being able to make connections between specific ideas, people, or different realms of life. This includes interdisciplinary learning, learning communities,

and connecting academic work with other areas of life. The human dimension of learning describes the type of learning that occurs when a student learns something important about himself or

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

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Points for Clarification

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- References / Further Readings

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Unit 2: Principles of Teaching

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

TEACHING PRINCIPLES

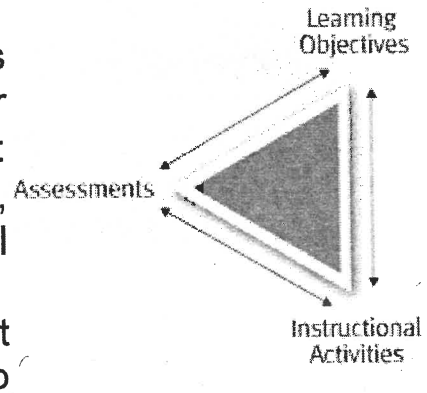
Teaching is a complex, multifaceted activity, often requiring us as instructors to juggle multiple tasks and goals simultaneously and flexibly. The following small but powerful set of principles can make teaching both more effective and more efficient, by helping us create the conditions that support student learning and minimize the need for revising materials, content, and policies. While implementing these principles requires a commitment in time and effort, it often saves time and energy later on.

1. Effective teaching involves acquiring relevant knowledge about students and using that knowledge to inform our course design and classroom teaching.

When we teach, we do not just teach the content, we teach students the content. A variety of student characteristics can

affect learning. For example, students' cultural and generational backgrounds influence how they see the world; disciplinary backgrounds lead students to approach problems in different ways; and students' prior knowledge (both accurate and inaccurate aspects) shapes new learning. Although we cannot adequately measure all of these characteristics, gathering the most relevant information as early as possible in course planning and continuing to do so during the semester can (a) inform course design (e.g., decisions about objectives, pacing, examples, format), (b) help explain student difficulties (e.g., identification of common misconceptions), and (c) guide instructional adaptations (e.g., recognition of the need for additional practice).

2. Effective teaching involves aligning the three major components of instruction: learning objectives, assessments, and instructional activities.



Taking the time to do this upfront saves time in the end and leads to a better course. Teaching is more effective and student learning is enhanced when (a) we, as instructors, articulate a clear set of learning objectives (i.e., the knowledge and skills that we expect students to demonstrate by the end of a course); (b) the instructional activities (e.g., case studies, labs, discussions, readings) support these learning objectives by providing goal-oriented practice; and (c) the assessments (e.g., tests, papers, problem sets, performances) provide opportunities for students to demonstrate and practice the knowledge and skills

articulated in the objectives, and for instructors to offer targeted feedback that can guide further learning.

3. Effective teaching involves articulating explicit expectations regarding learning objectives and policies.

There is amazing variation in what is expected of students across American classrooms and even within a given discipline. For example, what constitutes evidence may differ greatly across courses; what is permissible collaboration in one course could be considered cheating in another. As a result, students' expectations may not match ours. Thus, being clear about our expectations and communicating them explicitly helps students learn more and perform better. Articulating our learning objectives (i.e., the knowledge and skills that we expect students to demonstrate by the end of a course) gives students a clear target to aim for and enables them to monitor their progress along the way. Similarly, being explicit about course policies (e.g., on class participation, laptop use, and late assignment) in the syllabus and in class allows us to resolve differences early and tends to reduce conflicts and tensions that may arise. Altogether, being explicit leads to a more productive learning environment for all students. More information on how clear learning objectives supports students' learning. *(pdf)*

4. Effective teaching involves prioritizing the knowledge and skills we choose to focus on.

Coverage is the enemy: Don't try to do too much in a single course. Too many topics work against student learning, so it is necessary for us to make decisions – sometimes difficult ones – about what we will and will not include in a course. This involves (a) recognizing the parameters of the course (e.g., class size, students' backgrounds and experiences, course position in the curriculum sequence, number of course units), (b) setting our priorities for student learning,

and (c) determining a set of objectives that can be reasonably accomplished.

5. Effective teaching involves recognizing and overcoming our expert blind spots.

We are not our students! As experts, we tend to access and apply knowledge automatically and unconsciously (e.g., make connections, draw on relevant bodies of knowledge, and choose appropriate strategies) and so we often skip or combine critical steps when we teach. Students, on the other hand, don't yet have sufficient background and experience to make these leaps and can become confused, draw incorrect conclusions, or fail to develop important skills. They need instructors to break tasks into component steps, explain connections explicitly, and model processes in detail. Though it is difficult for experts to do this, we need to identify and explicitly communicate to students the knowledge and skills we take for granted, so that students can see expert thinking in action and practice applying it themselves.

6. Effective teaching involves adopting appropriate teaching roles to support our learning goals.

Even though students are ultimately responsible for their own learning, the roles we assume as instructors are critical in guiding students' thinking and behavior. We can take on a variety of roles in our teaching (e.g., synthesizer, moderator, challenger, commentator). These roles should be chosen in service of the learning objectives and in support of the instructional activities. For example, if the objective is for students to be able to analyze arguments from a case or written text, the most productive instructor role might be to frame, guide and moderate a discussion. If the objective is to help students learn to defend their positions or creative choices as they present their work, our role might be to challenge them to explain their decisions and consider

alternative perspectives. Such roles may be constant or variable across the semester depending on the learning objectives.

7. Effective teaching involves progressively refining our courses based on reflection and feedback.

Teaching requires adapting. We need to continually reflect on our teaching and be ready to make changes when appropriate (e.g., something is not working, we want to try something new, the student population has changed, or there are emerging issues in our fields). Knowing what and how to change requires us to examine relevant information on our own teaching effectiveness. Much of this information already exists (e.g., student work, previous semesters' course evaluations, dynamics of class participation), or we may need to seek additional feedback with help from the university teaching center (e.g., interpreting early course evaluations, conducting focus groups, designing pre- and posttests). Based on such data, we might modify the learning objectives, content, structure, or format of a course, or otherwise adjust our teaching. Small, purposeful changes driven by feedback and our priorities are most likely to be manageable and effective.

- **Objectives**

There has been an increasing focus over the past 10 years in Victoria and elsewhere on how students learn, and the implications of this for pedagogy. The Middle Years Research And Development (MYRAD) project research showed that different teaching approaches often result in substantial differences in both the ways students approach their learning and in the quality of that learning. The Quality Schools Project and the Schools for Innovations and Excellence initiative have both provided opportunities for teachers to collaboratively reflect on practice in ways that would improve learning. Indications from schools involved however, are that it can be difficult to find a fruitful way to structure reflection on practice because

learning and teaching are complex, multifaceted and highly interconnected activities. The Principles were developed to provide a structure to help teachers find a focus for their professional learning. They have evolved from similar sets of principles (or components as they were then referred to) developed as the basis for the Science in Schools (SIS) and the Middle Years Pedagogy Research and Development Project (MYPRAD). The Principles of Learning and Teaching P-12 are however applicable across all key learning areas and all stages of learning. 1 It is clear from research that there is no single 'right' or 'best' way to teach and it is important to recognise that the Principles are not an attempt to mandate a single 'one size fits all' approach. However, there is an increasing recognition of the importance of classrooms that can be characterised as 'learning communities'. In these classrooms, there is an emphasis on building rich meanings for ideas rather than completing tasks. Students in these classrooms are intellectually engaged, and they feel a sense of collaborative partnership with their peers and their teachers. Classrooms like these are extremely rewarding places to teach and learn in.

WHAT ARE THE PRINCIPLES? The Principles comprise six statements about the quality learning and teaching practices required for building effective learning communities. Each of these statements is accompanied by a subset of components that describe the teacher's role in relation to each statement Whilst they have been developed through extensive consultation they are not, of course, incontestable. They are designed to be interpreted and interrogated against particular learning contexts and in this way to stimulate reflection and conversations about pedagogy that will provide starting points for practitioner research. Meanings of the Principles will be constructed differently by different groups of teachers as they connect them to specific examples of classroom practice. The Principles are not standards or curriculum statements. They do however provide an effective basis for discussions about pedagogy amongst teachers who are jointly responsible both for delivering the curriculum and ensuring that their students reach the standards expected. The Principles focus on what teachers should do but they also flow from core beliefs about learning (eg 'All children can learn').

WHAT IS PEDAGOGY? Pedagogy involves much more than its most obvious component, the tasks that teachers set. It includes the ways in which teachers interact with students; that is how they question and respond to questions, use students' ideas and respond to students' diverse backgrounds and interests. It includes the social and intellectual climate that teachers seek to create and the types of learning that they set out to

promote. It also includes the decisions they make about framing the content around a series of tasks to be completed or as key ideas and skills that are revisited and built on. Teachers also need to think about how they link and sequence activities and how and what they assess. Professional learning teams will have rich and productive conversations and plan more effectively when they consciously address the many aspects of pedagogy described above.

HOW WILL THE PRINCIPLES HELP TEACHERS TO EXPLORE THEIR PEDAGOGY? One of the challenges faced by professional learning teams in conducting these conversations about pedagogy is that much of it is tacit. A teacher may share an innovative activity s/he has designed, but may not include subtle changes in some teacher behaviours that are crucial to its success. This means that when other teachers try it things may not be as successful. The thinking that informs teachers' actions and decision making is complex. Making this thinking explicit to oneself and other teachers in a range of ways can be very helpful to the development and sharing of practice. There is a growing recognition in the research literature of both the importance and the richness of the different types of knowledge generated by skilled teachers and of the difficulty of articulating and documenting such knowledge. 2 The Principles provide a scaffold for teachers to assist them in making explicit both the obvious and the more tacit aspects of their practices. They offer a stimulus for discussion and the sharing of experiences in ways oriented more toward articulating, sharing and documenting all aspects of pedagogy rather than just 'good activities'.

- **Definitions**

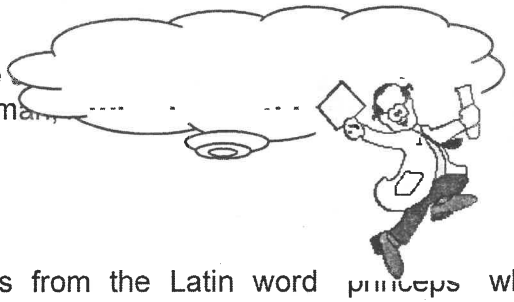
  The Code of Ethics for Teachers and School Officials, Article IV, Section 1 states: "All school official and teachers should feel teaching is among the noblest professions. They should manifest genuine enthusiasm and pride in their calling".

  The unparalleled nobility of the teaching profession was expounded by Garcia (1997) in his book Focus on Teaching. He claimed that from it springs all other professions, trades and vocations. From teaching born successful leaders of the nations, great scientists of the world, powerful politicians, lawyers, engineers, doctors, technicians, businessman, and the like.

  Looking at the social context on the definition of teaching, it is a social process, which takes place only when it brings out effective

and meaningful learning. According to William Kelly, " learning is the ultimate purpose of teaching and the true essence of it's success".

Teaching is also a **science** **art**(Eisner,1983 and Silberman,



The word principle comes from the Latin word principeps which means the beginning and the end of all things. On the other hand, the Greeks used the term not only to express the origin of things but also to express the fundamental laws, and to put out the ultimate objectives.

According to Webster's dictionary, principles are comprehensive laws or doctrines from which other are derived or on which others are founded. Hopkins stated the definition of principles as: rules for guiding the ship of education so that it will reach the port designated by the philosophy of education; it is a compass by which the path of education is directed.
The above definitions clearly support that principles are general truth or guiding norm by which a process (teaching) is carried on. These are psychological laws of learning, important educational theories, governing laws or rules of facts and generally accepted tenets.

- **Summary**

Teachers may begin with questions that act as prompts for inquiry and research. For example, How can we formally encourage students to link ideas in their learning? What tasks will enable them to do this effectively? How do we get them to do this independently? The questions should be quite specific and provide a clear impetus for innovation but not be so narrow as to be limiting. This type of questioning can sustain professional conversations and learning over a long period of time. New understandings follow, rather than precede, new practice. Outside ideas can be valuable at all points of the cycle, but only when teachers adapt them by developing new variations appropriate to their own contexts. This means that the knowledge developed is personal to each teacher's practice. However, the kinds of knowledge that can be generated by teachers in this endeavour do deserve to be shared. The Principles provide a basis for teachers to

articulate knowledge about learning and teaching in ways that can transcend subject and year level boundaries.

Teachers cannot be expected to create a vigorous community of learners among students if they have no parallel community to nourish themselves. Group support and stimulation is critical for professional learning. An effective professional learning team provides time and space for the cycle of reflective practice; it promotes the social construction of new knowledge as existing ideas are shared and new ones emerge from within the group. It also stimulates and supports innovation and risk taking. Meetings and professional conversations matter. However, discussions where good ideas are shared without an explicit and agreed purpose generally wind down before any clear goals have been established. There is often little response possible beyond 'That was a good idea'. In contrast, when a group has developed shared purposes, the successful experience or idea can be questioned (in an affirming way) against how and why it met one of these purposes such as students taking responsibility for their learning (Component 2.1). The Principles provide a starting point for identifying and clarifying shared goals and purposes as well as providing a scaffold for later reflection.

Most experienced teachers will get through their teaching week without crisis. The student learning agenda is not about resolving crises. It is about teachers identifying and sharing areas of apparently successful practice where they would like to do better. The Principles, together with an associated component mapping process that forms part of the structured PoLT program provide a framework and process that helps teachers do this. Questioning of practice cannot be forced. It flows from teachers being willing to inquire into their practice. The following reflection raises questions about two aspects of practice that offered new challenges to the teachers concerned. Asking good questions and higher order thinking are intertwined. We need to value the questions students ask and encourage it in our assessment. [we should] value, questions not answers. (I&E Cluster Meeting) These teachers realised that they needed to be seen to be genuinely valuing (and using) students' questions. This inevitably leads to classrooms that are more fluid, responsive and hence unpredictable and raises interesting challenges for their practice. They went further and set out to see if and how they could value question asking in their assessment. The teachers challenged their existing practice, but did so in a way that provided them with an opportunity to achieve further affirming progress as they developed and shared ways of meeting this new challenge.

Whilst concerns for student achievement and therefore accountability measures in crucial areas such as literacy and numeracy will always prevail, there are important outcomes of effective pedagogy that cannot be

measured by standardised testing. The Principles offer a basis for personal and group reflection designed to generate improvements in pedagogy. These improvements should in turn improve student learning outcomes in a range of ways, only some of which can be directly measured. It will be up to the individual teacher and/or the school rather to determine the evidence for effectiveness of any changes and make appropriate judgements leading to further action. The PoLT program incorporates mapping processes that will provide starting points for an action research cycle that is illustrated in Figure 1. However, the nature of action research means that initial goals will develop and change as teachers share and reflect on experiences. Teaching is a multifaceted and highly interconnected process: an initial focus on one aspect of pedagogy usually leads to reflection on many other aspects. The Principles can support teachers to embark on a journey of evolving practice.

The Component Mapping process The Component Mapping process is an essential part of the PoLT program. It serves a number of purposes: • to establish the Principles of Learning and Teaching at the centre of the PoLT initiative • to provide the basis from which teachers monitor their own practice • to support the development of the school action plan. The Component Map has been constructed to make the intention and language as clear and unambiguous as possible. Representing such a complex enterprise as teaching is no easy task, but the Component Map provides useful insights into its major elements. Establishing and maintaining reliable data on teacher classroom practice is important for supporting and demonstrating the success of school improvement initiatives. For this reason, and to support the reflective process, the PoLT Coordinator should ensure that the profile for each teacher is a true representation of their practice. Component Mapping teacher questionnaire Each individual teacher should complete the questionnaire prior to a discussion with the PoLT Coordinator. The aim of the questionnaire is to help establish the language of the Principles in preparation for the Component Mapping, and to help teachers determine which aspects of their practice they might work on during the implementation of the initiative. The teacher should circle the number (5, 4, 3, 2 or 1) which they feel represents their current practice on each aspect, and asterisk the number that represents where they would like to be in three years time. Note: '5' is not necessarily seen as a 'correct answer', since teachers of different levels and schools, with different perspectives, may well decide that 3 is their preferred position, depending on the class, topic or other factors. Under each component the teacher should note, in summary form, their strengths, and aspects they would like to work on during the project. The Component Mapping discussion The

Component Mapping discussion is intended to build a picture of each teacher's practice. The PoLT Coordinator will arrange a 45-minute discussion with each teacher. The teacher will bring the completed questionnaire to the discussion and the coordinator and teacher will together complete the PoLT Component Map to identify the position on each component that best describes the teacher's practice. The discussion provides an opportunity to acknowledge and affirm teachers' expertise and professionalism as well as encourage teachers to elaborate on or extend their practice. It also provides an opportunity to discuss pedagogical beliefs, and to question whether particular components and their descriptors are evident in the teacher's particular context. It is NOT a discussion in which the coordinator sits in judgment. The profiles of individual teachers will not be publicly identified, as each discussion is entirely confidential. The aggregated data from the Component Mapping should enable the PoLT Coordinator to build up a picture of what is happening across the school, identify the staff expertise and knowledge they can draw on and pinpoint areas of general need. Advice for the PoLT Coordinator Prior to the discussion the PoLT Coordinator should ensure that the Map is a realistic measure of each teacher's practice. The coordinator should: • be familiar with the Map descriptors beforehand so they understand what the graduations are focusing on • emphasise to teachers tha he number circled is an agreed position, but that they will need to clarify whether the descriptions are being reasonably interpreted. The language needs to be clarified so there is a shared understanding of what is being represented • remove, as far as possible, any suggestion that this is a judgmental exercise and emphasise that it is not expected that teachers be at the left end of the scale on each component or even more than a couple of components. It is quite conceivable that in some situations, on some components, a lower position (3 or even 2) is the place to be to best support learning. It depends somewhat on the classroom context and school ethos. Position 5 thus represents an 'ideal' about which teachers need to make their own judgment, as to whether it is appropriate for themselves. This discussion, held either with individuals or with the group in considering the combined data, will be informative and productive • be particularly careful when teachers are citing instances of practice that they are not putting themselves in an unrealistically high category based on a strategy being used on one occasion, or a low category because they are unrealistic about how

If we expect students to put forth sustained effort over time, we need to use assessments that students find fair; and that parents, community, and employers find credible. Fair evaluations are ones that students can prepare for: therefore, tests, exams and classroom assessments--as well as the curriculum--must be aligned to the standards. Fair assessment also means

grading against absolute standards rather than on a curve, so students can clearly see the results of their learning efforts. Assessments that meet these criteria provide parents, colleges, and employers with credible evaluations of what individual students know and can do. 1. Exams and tests are referenced to standards and designed to be studied for. The exams and tests are valid when students directly prepare to take them. 2. Exams, tests, and classwork are graded against absolute standards, not on a curve. 3. A reporting system exists that makes it clear to students and their parents how they are progressing toward expected standards. 4. Assessments validly test the full range of adopted standards. 5. Curriculum and assessments are aligned. 6. "Public accountability" assessment instruments and "instructional assessments" are aligned.

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

- References / Further Readings

Unit 3: Multi-sensory Approaches – Montessori Methods, VAKT Method, Orton - Gillingham Method, Augmentative and Alternative Communication

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

• Introduction

At the most basic level, our brains perceive stimuli through the five senses—seeing, hearing, touching, tasting, and smelling. Some people's sensory perception is stronger in one area than another, and most of us learn best when information and ideas are presented in a multisensory fashion. Novice teachers are often advised to let the wisdom of Confucius guide their planning: "I hear and I forget. I see and I remember. I do and I understand." When a student is involved in an activity, all the senses are engaged.

Multisensory teaching is effective for all students. In general, it means presenting all information to students via three sensory modalities: visual, auditory, and tactile. Visual presentation techniques include graphic organizers for structuring writing and pictures for reinforcing instruction; auditory presentation techniques include conducting thorough discussions and reading aloud; tactile presentation techniques include manipulating blocks and creating paragraphs about objects students can hold in their hands. Overall, implementing a multisensory approach to teaching is not difficult; in fact, many teachers use such an approach. It is important,

however, to be aware of the three sensory modes and to plan to integrate them every day.

- **Objectives**

Learning often relies on a child's sight to look at text and pictures and to read information. It also relies on a child's hearing to listen to what the teacher is saying.

Multisensory teaching isn't just limited to reading and listening. Instead, it tries to use all of the senses. Every lesson won't use all of a child's senses (taste, smell, touch, sight, hearing and movement). But in most multisensory lessons, students engage with the material in more than one way.

For example, let's say your child's class is studying apples. Your child might have the chance to visually examine, touch, smell and taste apples—instead of just reading and listening to his teacher speak about how they grow. Then he might hold a halved apple and count the number of seeds inside, one by one.

That's multisensory teaching. It conveys information through things like touch and movement—called tactile and kinesthetic elements—as well as sight and hearing.

What subjects is multisensory instruction used for?

Many programs designed to help struggling readers include a multisensory approach (in addition to other components). Orton–Gillingham pioneered this approach. Programs like these very deliberately use sight, sound, movement and touch to help kids connect language to words.

For example, one of the techniques the Wilson Reading System uses is a "sound-tapping" system. Students tap out each sound of a word with their fingers and thumbs to help them break the words down.

The Barton Reading Program materials include color-coded letter tiles that help students connect sounds to letters.

But multisensory instruction is used to teach other subjects, too. Some grade school math programs use manipulatives (small objects like interlocking cubes or shape blocks) to help kids do math.

Science labs, in which kids perform experiments, write down the steps and report their findings, are multisensory learning experiences.

Even songs and chants that teach things like the days of the week or the names of the states are examples of multisensory learning.

Who can benefit from multisensory instruction?

All kids can benefit from multisensory lessons, including kids who don't have learning and attention issues. If a student learns something using more than one sense, the information is more likely to stay with him.

But multisensory learning can be particularly helpful for kids with learning and attention issues. For example, these kids may have trouble with visual or auditory processing. That can make it hard for them to learn information through only reading or listening.

Using multiple senses gives these (and other) kids more ways to connect with what they're learning. This type of hands-on learning can make it easier for students to:

- Collect information
- Make connections between new information and what they already know
- Understand and work through problems
- Use nonverbal problem-solving skills

Multisensory instruction helps kids tap into their learning strengths to make connections and form memories. And it allows them to use a wider range of ways to show what they've learned.

Multisensory teaching takes into account that different kids learn in different ways. It helps meet the varying needs of all kids—not just those with learning and attention issues. And by providing multiple ways to learn, it gives every kid in the class a chance to succeed.

- **Definitions**

What is meant by multisensory teaching? Multisensory teaching is simultaneously visual, auditory, and kinesthetic-tactile to enhance memory and learning. Links are consistently made between the visual (what we see), auditory (what we hear), and kinesthetic-tactile (what we feel) pathways in learning to read and spell. Margaret Byrd Rawson, a former President of The Orton Dyslexia Society (the precursor to The International Dyslexia Association), said it well: "Dyslexic students need a different approach to

learning language from that employed in most classrooms. They need to be taught, slowly and thoroughly, the basic elements of their language -- the sounds and the letters which represent them -- and how to put these together and take them apart. They have to have lots of practice in having their writing hands, eyes, ears, and voices working together for the conscious organization and retention of their learning." Teachers who use this approach teach children to link the sounds of the letters with the written symbol. Children also link the sound and symbol with how it feels to form the letter or letters. As students learn a new letter or pattern (such as s or th), they carefully trace, copy, and write the letter(s) while saying the corresponding sound. The sound may be made by the teacher and the letter name(s) given by the student. Students then read and spell words, phrases, and sentences using these patterns. Teachers and their students rely on all three pathways for learning rather than focusing on a "sight-word" or memory method, a "tracing method," or a "phonetic method" alone.

When and where was multisensory teaching introduced for children with dyslexia? Dr. Samuel Torrey Orton and his colleagues began using multisensory techniques in the mid- 1920's at the mobile mental health clinic he directed in Iowa. Orton was influenced by the kinesthetic method described by Grace Fernald and Helen Keller. He suggested that kinesthetictactile reinforcement of visual and auditory associations could correct the tendency of reversing letters and transposing the sequence of letters while reading and writing. Students who reverse b and d are taught to use consistent, different strokes in forming each letter. For example, students make the vertical line before drawing the circle in printing the letter b; they form the circle before drawing the vertical line in printing the letter d. Anna Gillingham and Bessie Stillman based their original 1936 teaching manual for the "alphabetic method" on Dr. Orton's theories. They combined multisensory techniques with teaching the structure of written English, including the sounds (phonemes), meaning units (morphemes such as prefixes, suffixes, and roots) and common spelling rules. The phrase "Orton-Gillingham approach" refers to the structured, sequential, multisensory techniques established by Dr. Orton and Ms. Gillingham and their colleagues.

Children with dyslexia often exhibit weaknesses in auditory and/or visual processing. They may have weak phonemic awareness, meaning they are unaware of the role sounds play in words. They have difficulty rhyming words, blending sounds to make words, or segmenting words into sounds. They may also have difficulty acquiring a sight vocabulary. That is, dyslexic children do not learn the sight words expected in the primary grades. In general, they do not pick up the alphabetic code or system. When taught by a multisensory approach, children have the advantage of learning

alphabetic patterns and words by utilizing all three pathways. Orton suggested that teaching the "fundamentals of phonic association with letter forms both visually presented and reproduced in writing, until the correct associations were built up" would benefit students of all ages.

- **Summary**

Multi-Sensory approaches teach reading and writing (including spelling) through using Auditory (hearing), Visual (sight) and Kinesthetic (movement/touch) pathways. This gives multiple pathways for the information to reach the brain. It is diagnostic as it involves constant testing and reflection on the knowledge of the student. It is systematic and seeks to unite the components of written language. Thus it treats sound-symbol knowledge, oral language (grammar and pronunciation), written language conventions and handwriting in an organised and integrated fashion.

Teaching and learning in this way is an exciting journey of discovery. It is a fast paced and creative process where learning is fun since each small step is mastered and the learner is aware of what they have gained. Everyone now can call themself a success. Confidence is built through growing mastery of written language. The students can see themselves as successful learners and this helps each individual learner gain independence and a great "can do" attitude.

"Dyslexic students need a different approach to learning language from that employed in most classrooms. They need to be taught, slowly and thoroughly, the basic elements of their language—the sounds and the letters which represent them—and how to put these together and take them apart. They have to have lots of practice in having their writing hands, eyes, ears, and voices working together for conscious organization and retention of their learning."
(Quoted in International Dyslexia Association Fact Sheet on Multi-Sensory Structured Language Teaching)

How is learning styles theory related to multisensory approaches to teaching? In learning styles theory, the educator looks at the individual student and identifies the student's preferred styles or intelligences to learn. The educator uses a learning styles inventory to assess which learning styles and intelligences lead the student to succeed and which don't. The teacher then tries to design learning activities that integrate the student's learning styles.

Learning styles theorists have identified another form of learning styles to be reading styles. "Reading styles has been defined by Carbo (1980b, 1982) as an individual's learning style when he or she reads, and can include environmental, emotional, sociological, physiological, and psychological stimuli" (Sudzina, 1993, p. 2). According to Carbo (1996), the different reading styles are visual, auditory, tactile, kinesthetic, global, and analytic. Carbo explains:

Our individual reading styles predispose us to learn easily by using a particular reading technique. The problem is that different reading methods and materials demand different strengths of the learner. If a student has the strengths, a match occurs, and he or she learns to read easily and enjoy. If, however, there is a mismatch between the students and the approach, the instruction itself will hinder the youngster's learning to read (p. 9). When using the reading styles method, a Reading Styles Inventory is used to produce "a profile describing a child's strengths and the best way of teaching that child to read" (Carbo, p. 9). Learning activities are then designed to meet the different students' individual reading style preferences so that they will have success when learning to read.

What is a multisensory approach? A multisensory approach, "also known as VAKT (visual-auditory-kinesthetictactile) implies that students learn best when information is presented in different modalities (Mercer & Mercer, 1993)" (Murphy, 1997, p. 1). The belief is that students learn a new concept best when it is taught using the four modalities. A multisensory approach is one that integrates sensory activities. The students see, hear, and touch. "Activities such as tracing, hearing, writing, and seeing represent the four modalities" (Murphy, p. 1). For example, to teach spelling Graham and Freeman (1986) use a strategy that incorporates the four modalities (Murphy). Students say the word, write the word, check the word, trace the word, write the word from memory and check, and then repeat the entire process (Murphy). In essence, a multisensory approach incorporates the learning styles for visual, auditory, kinesthetic, and tactile learners. This approach doesn't single out a specific learning style for a specific student. A multisensory approach is an eclectic approach that teaches all children regardless of their preferred learning style (Murphy, p. 19). Ideally, all four learning styles should be addressed equally. Still, "Blau and Loveless (1982) suggest that we emphasize the visual component of VAKT too much" (Murphy, p. 15).

How have educational programs that use learning styles theory and multisensog approaches been effective in improving student achievement? Wilson Elementary Some educational programs have effectively adopted learning styles theory and multisensory approaches. Wilson Elementary

School is one example (Stone, 1992). Wilson Elementary, under the direction of Pete Stone, adopted a school wide program that is learning styles driven. After working to meet the students' individual learning style, the school saw "dramatic increases in standardized test scores (from the 20th and 30th percentiles to the 50th, 60th, and even the 70th percentiles in math and science)" (Stone, p.35). In addition there were fewer discipline problems because students were motivated and felt their needs were being met. Stone reflects, "Discipline was unbelievably good, and we could see significant improvements not only in students' achievement, but in their attitudes toward learning" (p. 36). Teachers at Wilson have worked to create a learning environment sensitive to the student's needs. The program now takes into consideration whether the student is global or analytic, and addresses "mobility, perceptual strengths, environmental preferences, and sociological groupings" (Stone, 1992, p. 35). In the Wilson program, students are given a
Learning Styles Inventory to assess their learning strength and weaknesses (Stone). The school staff works as a group to meet the needs of all the learners by grouping "students according to tactile/kinesthetic or auditory strengths" (Stone, p. 36). Teachers then design learning activities that integrate the preferred styles of the students. Additionally, the teachers have revised curriculum to integrate the preferred learning styles. Furthermore, the staff "redesigned every classroom to respond to individual students' needs for sound, light, seating, and mobility" (Stone, p. 35). In addition, teachers play soft background music, provide low light and informal seating, and even permit juice and raw vegetables in their classrooms (Stone). Even the instructional schedule has been adjusted "to permit as many children as possible to be taught at their best time of day" (Stone, p. 35).
Carbo (1996) provides examples of programs that have successfully used the Reading Styles model to improve students' reading. In Texas, Margil Elementary moved from 61st place to 9th place academically among the 65 elementary schools in the district. Rural schools in the poverty area of Bledsoe County, Tennessee, increased their stanine scores from 3 in reading to state and national averages (Snyder, 1994, as cited in Carbo). "In Tucson's Canyon del Oro High School, 33 special education students made average gains of nearly 2 years (or 12 NCEs) in reading comprehension in just four months" (Queiruga, 1992, as cited in Carbo, p. 8). In explaining the successes of these programs, Carbo (1996) explains that "At all of the schools, teachers based their styles of reading instruction on each student's

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

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Points for Discussion

Points for Clarification

- References / Further Readings

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Unit 4: Teaching Strategies – Task Analysis, Chaining, Shaping, Modelling, Prompting, Fading and Reinforcement, Role Play, Play Way method

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

Research shows that teacher integration of literacy-related instructional strategies facilitates student learning across all content areas. With the use of content-specific information, it is through the literacy skills of reading, writing, listening, speaking, viewing and presenting that students acquire and retain content knowledge and content-specific abilities. A variety of literacy-related instructional strategies that assist content-area learning are included in this section. The provided instructional strategies are designed for use by all content area teachers, as well as English language arts teachers, remedial reading and language arts teachers, literacy specialists and literacy coaches. They are designed for implementation by those teaching Grades 4-12. The instructional strategies presented are not reliant on extra texts, supplies or funding. The instructional strategies provided in this section are not exhaustive, they are only representative of innumerable effective strategies a teacher may choose to use. Variety is key. The instructional strategies are grouped by support for: comprehension, vocabulary, fluency and spelling; within those categories they are randomly presented. The classroom teacher must determine the most effective instructional strategy for her/his students.

The provided instructional strategies should be used with diverse fictional and nonfiction texts; should be used before, during and after reading; should be used as pre- and post-assessments, and should be used with students independently, in pairs, in small groups and as a whole class. A varied approach is crucial to meeting the needs of all learners. The instructional strategies presented must be introduced with explicit instruction and teacher modeling, and then continued with scaffolding and coaching from the teacher as students apply them to a range of texts. The instructional strategies must be implemented appropriately and with a specific purpose. It is critical teachers embed the strategies into the content they are already using that is aligned with state standards, district curriculum, school mission, and grade-level goals.

These techniques have multiple benefits: the instructor can easily and quickly assess if students have really mastered the material (and plan to dedicate more time to it, if necessary), and the process of measuring student understanding in many cases is also practice for the material—often students do not actually learn the material until asked to make use of it in assessments such as these. Finally, the very nature of these assessments drives interactivity and brings several benefits. Students are revived from their passivity of merely listening to a lecture and instead become attentive and engaged, two prerequisites for effective learning. These techniques are often perceived as "fun", yet they are frequently more effective than lectures at enabling student learning. Not all techniques listed here will have universal appeal, with factors such as your teaching style and personality influencing which choices may be right for you.

Strategic teaching is a way of making decisions about a course, an individual class, or even an entire curriculum, beginning with an analysis of key variables in the teaching situation. These variables include the characteristics of the learners, the learning objectives, and the instructional preferences of the teacher. Once these variables have been analyzed, informed decisions can be made about course content, structure, methods of assessment, and other key components.
The process of planning a course is not an easy one. (Although 'the course' is the unit of analysis being discussed, the process of creating an instructional strategy works equally well for an individual class or an entire curriculum.)

As an instructor, you need to make decisions about what topics to include and which to leave out; the order in which those topics will be presented; which pedagogical methods to use (e.g., lecture, discussion, hands-on

experiments); appropriate means of assessing the students; materials and technology to employ; how to get feedback; etc.

More often than not those decisions are made based upon what other faculty have done when they taught the class, or perhaps on what your instructor did when you took the same or a similar course. But those models may or may not accomplish the overarching goal of teaching: to help students master a set of key ideas and skills related to your discipline.

- **Objectives**

The Cornerstones Lesson Guide suggests instructional practices that will help students benefit the most from a Cornerstones teaching unit. This supplement explains the terms used in the Guide. • Read Aloud/Think Aloud: Make Your Thinking Visible • Comprehension Questions • Shared Reading and Guided Reading • Story Grammar • Writing • Build Word Knowledge • Teach Words Conceptually • Classroom Visual Aids The Cornerstones Lesson Guide recommends daily reading aloud, shared and/or guided reading, and independent reading. The purpose of read-aloud is to foster enjoyment of a story and comprehension on several levels. Shared reading and guided reading are ways that the teacher can give students practice and feedback as they learn decoding and comprehension strategies. At the other end of the reading continuum, students apply all that they know about reading when they read independently. The ideal combination of these approaches depends on the difficulty of the reading material and the reading skills of the students.

When you read aloud or present a video of the story, stop to model comprehension strategies for your students. Let them see what effective readers do inside their heads. For example, when the fox says, "Look at that beautiful bird!" you may be thinking, Who is the fox talking to? Is the crow beautiful? Why would the fox say that? Does the crow believe it? Would you? etc. These questions show the students how you reflect on the story, words, pictures, or language. They show how you begin to make predictions about what will happen next. When reading to young children, you may want to do such a think-aloud strategy during each reading. Each time choose a different section to open up for discussion, following the same order that concepts are presented in the Lesson Guide. It is best to think aloud during

reading (rather than when you have finished reading) at the actual point in the story that raises questions in your head.

Comprehension Questions Implicit in the think-aloud process is the use of questions. Ask the children openended questions that start with Why and How, as well as Who, What, Where, and Did/Do/Does. Encourage the children to ask their own questions, using a variety of question forms. There are three broad types of questions, and students should be exposed to all types: 2 1) The answer is explicit in the text. You ask, "What did the crow have in her beak?" The text says, "The crow had a piece of cheese in her beak." 2) The answer is implicit in the text and requires critical thinking. You ask, "Why did the crow drop the cheese?" The children need to think about what happened just before she dropped the cheese and what caused her to open her mouth. 3) The answer is not in the text but is in our experience. You ask, "How did the crow feel about losing her cheese?" The word "unfortunately" provides a clue. Also, maybe the children have lost something or had to give something up because they were tricked. They can remember how they felt or imagine how they would feel in such a situation. Shared Reading and Guided Reading You are aware of what the students know and you can use this information as you read aloud. In shared reading, you invite them to apply their skills, setting them up for success. Stop at particular points in the text and ask someone to help you read. Emphasis here is on the print so point to what you are reading. Stop reading and encourage children to read independently where you know they can be successful. Also, encourage students to volunteer to participate in the reading. When students come to a word they know, they can say or sign it aloud. Then you pick up with reading aloud until you come to another section of text which the students or one student can read independently. In guided reading, the student takes the lead, reading as best he or she can until coming to an unknown word. The teacher encourages the student to decode the word, looking at spelling patterns, using structural analysis (attending to a prefix or suffix, for example) or employing other strategies. Story Grammar A Cornerstones unit is designed so that teachers and students study one aspect of story grammar in depth each day; for example, characters, setting, problem, solution, outcome. Knowing the common structure that most stories follow can help students remember the details of a story. Typically, the story takes place at a point in time and in a certain location (the setting), there are characters, a problem and response, a resolution and sometimes a moral. One graphical organizer that you can use to good effect is a five-pointed star (see Graphical Organizer Section). Writing Writing facilitates the development of reading and reading facilitates the development of writing. The Cornerstones Lesson Guide recommends

that children write every day and suggests writing activities involving individual words, sentences, and longer pieces, according to the children's skills. When children write, they engage with words and ideas and explore new meanings— they communicate. With pencil in hand, children can ponder an idea, change their mind, and devote time to expressing themselves clearly. Writing is a tangible way for a 3 child to demonstrate to teachers and peers what he or she knows. For children who are not fluent with English, it is also a critical window by which the teacher can glimpse gaps in knowledge or understanding. It is important for you, the teacher, to model what you do when you write. Use shared and guided writing (which follow the same principles as shared and guided reading) and independent writing. Give children feedback on their writing. Feedback sessions should be interactive so that children learn to evaluate their own writing and put themselves in the shoes of their readers. Don't overwhelm children; focus on some low-level skills, such as spelling, punctuation and grammar, as well as some high-level skills, such as organization, expressive language and clarity of ideas. Give them a chance to improve their skills, and let them know when their written work has gotten better.

- **Definitions**

Teaching strategies refer to methods used to help students learn the desired course contents and be able to develop achievable goals in the future. **Teaching strategies** identify the different available learning methods to enable them to develop the right **strategy** to deal with the target group identified.

- **Summary**

Accelerated or individualized math: a system of having students work at different levels individually in one classroom. They progress by passing tests for each unit and move at their own pace. Acting out a story: Having the students act out a part of a story. Using physical movement to demonstrate and improve comprehension of the story. Could also be used on a smaller scale with puppets, etc. but includes physical movement of some sort. Adjusted speech: teacher changes speech patterns to increase student comprehension. Includes facing the students, paraphrasing often,

clearly indicating most important ideas, limiting asides, etc. Book on tape: Using books on tape to enhance reading development in some way. Having students use the tapes to go over the story after partner reading, to make sure they have not missed a vocabulary word, etc. Chunking and questioning aloud: The process of reading a story aloud to a group of students and stopping after certain blocks of text to ask the students specific questions about their comprehension of the story and some key features of the text. Collecting anonymous student generated questions: During, or at the end of a lesson, have students write any questions that they might have on a card. Collect the cards and answer the questions without identifying a student. Students might be more willing to ask questions they have anonymously, instead of in front of their peers. Combine kinesthetic and phonemic awareness: Associating different movements with phonemes in order to anchor sounds during practice drills in order to build phonemic awareness and remembering of sounds by the students.

Cooperative learning: a range of team based learning approaches where students work together to complete a task. Cross-disciplinary teaching on themes: Teaching similar vocabulary and themes in different classes (ex: Doing a reading on wolves in reading class while doing a unit on wolves in biology class). Curriculum based math probes: having students solve 2-3 sheets of problems in a set amount of time assessing the same skill. Teacher counts the number of correctly written digits, finds the median correct digits per minute and then determines whether the student is at frustration, instructional, or mastery level. Curriculum based oral reading probe: having students read aloud three basal reader passages for 1 minute. Teacher marks the place where the student stops and then asks comprehension questions and continues to give probes until students reach frustration level as defined by reading rate and median score. Daily re-looping of previously learned material: A process of always bringing in previously learned material to build on each day so that students have a base knowledge to start with and so that learned structures are constantly reinforced. Decodable text: Using readings that contain only words the students can decode and build on that. Decoding is the ability to translate a word from print to speech, usually by employing knowledge of sound-symbol correspondences; also, the act of deciphering a new word by sounding it out. Directly teach vocabulary through short time segments: Teach vocabulary directly through listening, speaking, reading, and writing each used in short blocks of time. Students are exposed to vocabulary in different ways and movement of activities helps hold attention. Ecological approach: involves all aspects of a child's life, including classroom, family, neighborhood, and community, in teaching the child useful life and educational skills. Explicit timing: timing math seatwork in 30-minute trials

that are used to help students become more automatic in math facts and more proficient in solving problems. Teacher compares correct problem per minute rate. Used to recycle materials and concepts. Explicit teaching of text structure: Teaching the parts of different types of text and making sure students understand the text structure before reading. This would include basics such as text in English is read from left to right, and also more sophisticated structures such as the structure of a fairy tale. Explicit vocabulary building through random recurrent assessments: Using brief assessments to help students build basic subject-specific vocabulary and also gauge student retention of subject-specific vocabulary.
Fluency building: Helping students build fluency in frequently occurring words through short assessments and exercises that give increased exposure to high-frequency words. Graphic organizers: visual displays to organize information into things like trees, flowcharts, webs, etc. They help students to consolidate information into meaningful whole and they are used to improve comprehension of stories, organization of writing, and understanding of difficult concepts in word problems. Hands-on, active participation: Designing activities so that students are actively involved in the project or experiment. Hands-on participation is as important as verbal participation in the activity. Individual conferencing: Listening to a student read, talking about a book, reading every other paragraph, one-on-one during independent reading time. Time to bond with a student. Opportunity to record informal assessments about a student's progress in reading. Journal of the senses: Having students write down in an informal way (possibly even a form to fill in) what they imagine the characters in a story would see, smell, hear, taste, and feel at a certain point in the story. K-W-L: know, want to know, learned, routine. A form of self-monitoring where students are taught to list what they know already about a subject, what they want to know, and later what they learned. Literature circles/book club/small group guided discussion: Students discuss portions of books in a small group. Sometimes roles are assigned for group interaction. Students at varying levels are able to share different points about the book. Mnemonics: Association techniques used to help students remember some aspect of reading. Ex: Associating a list of irregular verbs with each of the letters in a familiar name. Model-lead-test strategy instruction (MLT): 3 stage process for teaching students to independently use learning strategies: 1) teacher models correct use of strategy; 2) teacher leads students to practice correct use; 3) teacher tests' students' independent use of it. Once students attain a score of 80% correct on two consecutive tests, instruction on the strategy stops. Modeling/teacher demonstration: Teacher demonstrates how to do a lab or experiment before having the students try it on their own.

Monitoring of progress through group and individual achievement awareness charts: Using charts to build awareness and motivation of progress for students. The emphasis here is on progress so even students working at different levels can chart significant gains. Native language support/instruction: providing auditory or written content input to students in their native language. Oral sharing on a related topic: Students share their written or prepared responses with the class so that students can share their answers to prompts with the class, but have had time to prepare them. Paraphrasing: Working on specific skills to orally retell or summarize what happened in a story. Partner reading: Having students work together in pairs to read a text to each other and discover the main ideas of the story. Peer tutoring: Having students working pairs with one student tutoring the other student on a particular concept. Picture word: Replacing key vocabulary words of a text with pictures and then adding the words back in, and also bringing in visuals of key vocabulary words in a text. Pictures to demonstrate steps: Using a series of pictures to demonstrate the steps in a project or experiment so that students get a visual image of what they need to do. Prediction: Having students predict what is going to happen in a story based on a title, headline, illustration, or initial sentence/paragraph. Pre-reading strategies: Giving overview of unit, previewing main ideas, connecting subject to the background knowledge of the students, etc. Pre-teach vocabulary: teaching key vocabulary words prior to working with the lesson or unit. Pre-teaching the organization of the text/unit organizers: Pointing out and getting students to discover the different parts of the text that can be used in learning: captions, headings, etc. Also familiarizing the students with the layout of the text, glossary, etc., beforehand. Problem solving instruction: explicit instruction in the steps to solving a mathematical or science problem including understanding the question, identifying relevant and irrelevant information, choosing a plan to solve the problem, solving it, and checking answers

Reciprocal peer tutoring (RPT) to improve math achievement: having students pair, choose a team goal to work toward, tutor each other on math problems, and then individually work a sheet of drill problems. Students get points for correct problems and work toward a goal. Recurrent, random vocabulary assessment: Recycling vocabulary words that have been discussed in class and randomly choosing words from this list to have random assessments on so as to reinforce the already "learned" vocabulary words. Reference skills: Teaching students how to use reference items, dictionary, glossary, etc. for a certain type of text (like science). Reinforcing math skills through games: Using games to follow-up a lesson in order to reinforce learned skills and use the skills in another context. Relate reading

to student's experiences: Having students talk about connections in the reading to their own experiences. Sharing in a large group or small group setting. Using group experiences to better understand reading. Repeated readings: the method of having students read passages orally three times in a row and each time try to achieve a faster speed and fewer disfluencies. If comprehension is being targeted, students answer some different comprehension questions after each reading or retell the story. Response cards: having students write brief answers to teacher questions on cards. Teacher asks a question and all students hold up cards. Teacher can scan answers of all students for understanding. Sometimes cards just have "yes" or "no" on them and can also be prepared by the teacher. Response journal: Students record in a journal what they learned that day or strategies they learned or questions they have. Students can share their ideas in the class, with partners, and with the teacher. Retelling: students verbally rehearse important story information by retelling a story to a partner, using an outline. The outline guides them to pick out important ideas and back them up with supporting information. Simplified text: Using science texts that have simplified language for ELL students. Student developed glossary: Students keep track of key content and concept words and define them in a log or series of worksheets that they keep with their text to refer to. Students generate word problems: Have students create word problems for a specific math skill. Through the construction of a problem the students learn what to look for when solving word problems they are assigned.

Summarize lesson: Have a summarizing activity as to what was learned in each lesson (Ex: having students summarize in their journals what was learned each day). Tactile, concrete experiences in math: Using three dimensional objects in math instruction such as geometrical shapes, coins, or blocks used to form various geometrical shapes. Tactile vocabulary development steps: Using three-dimensional or tactile objects to help in developing students' abilities to write words and letters. Ex: Writing letters in sand or tracing wood block letters. Teaching pre-, during-, and post- reading strategies: Teaching students reading strategies that they can use on their own when reading a text. Practicing these strategies in class as a group or in small groups. Teaching Greek and Latin prefixes and suffixes: Teaching prefixes and suffixes since students will encounter them often, especially in with science content vocabulary. Teaching main idea: Teaching students how to pick out the main idea of a paragraph or reading and explain why it is the main idea. Done as a class or in small groups to build consensus of what the main idea is. Think-alouds: using explicit explanations of the steps of problem solving through teacher modeling metacognitive thought. Ex: Reading a story aloud and stopping at points to think aloud about reading strategies/processes or, in math, demonstrating the thought process used in

problem solving. Use of diagrams to teach cause and effect: Using diagrams (ex: fishbone diagrams) to demonstrate the relationship of cause and effect. Use short segments to teach vocabulary: Teaching specific science vocabulary for a short period before a lesson through listening, seeing, reading, and writing. Using visuals: Bringing two or three dimensional visuals into the classroom to enhance teacher instruction in the content area. Visualization: Having the students draw a scene of a story, the plot, etc. to demonstrate student comprehension of the story or to have students organize ideas. May encourage students who have strong artistic talent, but emerging reading skills. Venn Diagram: Use of a Venn diagram (interconnected circles) to demonstrate how different subjects or topics overlap and how they are unique.

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

- References / Further Readings

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Unit 5: Development and Use of TLM for ID

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

How to use this Training Manual This training manual has been prepared for use by Basic Education trainers or teachers. The purpose of the manual is twofold: I to provide trainers and trainees with tools and guidelines for use in the provision of basic education I to enable trainers and trainees to choose, analyse, develop, use and evaluate their own TLMs. This manual can also be used by others directly or indirectly working in programmes aimed at improving the quality of basic education . The manual is arranged in five units. Each unit is subdivided into eight sections. To use this manual the trainer will first of all have to read all of it for clear understanding. The trainer should decide which of the proposed training materials are available and which ones he/she will have to prepare. The trainer must also decide which training method he/she will use and what preparations to make. The glossary or list of special temnnologies, and abbreviations, which have been used in this manual, are adequately explained in order to help the trainers and trainees to understand the manual. There is also a module test at the end of Unit 5. This is aimed at establishing how much knowledge the trainees have grasped from their training. The trainers are free to prepare additional questions to assess trainees' understanding of any other aspects covered in this manual. There is a list of accompanying fact sheets after Unit 5, which the trainer will refer to for more information or explanation on the use of teaching and learning materials. The purpose of providing this

information is to enable the trainer to prepare and present his/her lesson with less difficulties and to ensure that the lesson is relevant to the needs of the trainees. The references section provides additional sources of the material that the trainers/trainees can use in their lessons. It should be noted that the information given in this trianing manual is aimed at simply providing guidelines. Trainers are, therefore, free to think of and use as many innovative strategies as possible.

LIST OF TRAINING STRATEGIES USED IN THIS MANUAL The following are the suggested strategies that can be used in this training manual: I classroom presentation I lecture method I group work I pair work I individual work I role plays I brainstorming I class discussions/debates ABBREVIATIONS PAF: People's Action Forum TLMs: Teaching and Learning Materials VIPP: Visual Image UNESCO: United Nations Educational, Scientific and Cultural Organisation RCZ: Reformed Church in Zambia Development Programme

- **Objectives**

Why do We Use Materials/What are Materials for?

Language instruction has five important components--students, a teacher, materials, teaching methods, and evaluation. Why are materials important in language instruction? What do materials do in language instruction? Can we teach English without a textbook?

Allwright (1990) argues that materials should teach students to learn, that they should be resource books for ideas and activities for instruction/learning, and that they should give teachers rationales for what they do. From Allwright's point of view, textbooks are too inflexible to be used directly as instructional material. O'Neill (1990), in contrast, argues that materials may be suitable for students' needs, even if they are not designed specifically for them, that textbooks make it possible for students to review and prepare their lessons, that textbooks are efficient in terms of time and money, and that textbooks can and should allow for adaptation and improvization.

Allwright emphasizes that materials control learning and teaching. O'Neill emphasizes that they help learning and teaching. It is true that in many cases teachers and students rely heavily on textbooks, and textbooks determine the components and methods of learning, that is, they control the content, methods, and procedures of learning. Students learn what is presented in the textbook, and the way the textbook presents material is the

way students learn it. The educational philosophy of the textbook will influence the class and the learning process. Therefore, in many cases, materials are the center of instruction and one of the most important influences on what goes on in the classroom.

Theoretically, experienced teachers can teach English without a textbook. However, it is not easy to do it all the time, though they may do it sometimes. Many teachers do not have enough time to make supplementary materials, so they just follow the textbook. Textbooks therefore take on a very important role in language classes, and it is important to select a good textbook.

The Role of Materials in Relation to Other Elements

Since the end of 1970s, there has been a movement to make learners rather than teachers the center of language learning. According to this approach to teaching, learners are more important than teachers, materials, curriculum, methods, or evaluation. As a matter of fact, curriculum, materials, teaching methods, and evaluation should all be designed for learners and their needs. It is the teacher's responsibility to check to see whether all of the elements of the learning process are working well for learners and to adapt them if they are not.

In other words, learners should be the center of instruction and learning. The curriculum is a statement of the goals of learning, the methods of learning, etc. The role of teachers is to help learners to learn. Teachers have to follow the curriculum and provide, make, or choose materials. They may adapt, supplement, and elaborate on those materials and also monitor the progress and needs of the students and finally evaluate students.

Materials include textbooks, video and audio tapes, computer software, and visual aids. They influence the content and the procedures of learning. The choice of deductive vs inductive learning, the role of memorization, the use of creativity and problem solving, production vs. reception, and the order in which materials are presented are all influenced by the materials.

Technology, such as OHP, slides, video and audio tape recorders, video cameras, and computers, supports instruction/learning .

Evaluations (tests, etc.) can be used to assign grades, check learning, give feedback to students, and improve instruction by giving feedback to the teacher.

Though students should be the center of instruction, in many cases, teachers and students rely on materials, and the materials become the center of instruction. Since many teachers are busy and do not have the time or inclination to prepare extra materials, textbooks and other commercially produced materials are very important in language instruction. Therefore, it is important for teachers to know how to choose the best material for instruction, how to make supplementary materials for the class, and how to adapt materials.

What are Characteristics of Materials?

Littlejohn and Windeatt (1989) argue that materials have a hidden curriculum that includes attitudes toward knowledge, attitudes toward teaching and learning, attitudes toward the role and relationship of the teacher and student, and values and attitudes related to gender, society, etc. Materials have an underlying instructional philosophy, approach, method, and content, including both linguistic and cultural information. That is, choices made in writing textbooks are based on beliefs that the writers have about what language is and how it should be taught. Writers may use a certain approach, for example, the aural-oral approach, and they choose certain activities and select the linguistic and cultural information to be included.

Clarke (1989) argues that communicative methodology is important and that communicative methodology is based on authenticity, realism, context, and a focus on the learner. However, he argues that what constitutes these characteristics is not clearly defined, and that there are many aspects to each. He questions the extent to which these are these reflected in textbooks that are intended to be communicative.

In a study of English textbooks published in Japan in 1985, the textbooks were reviewed and problems were found with both the language and content of many of the textbooks (Kitao et al., 1995).

Language

English textbooks should have correct, natural, recent, and standard English. Since students' vocabulary is limited, the vocabulary in textbooks should be controlled or the textbooks should provide information to help students understand vocabulary that they may not be familiar with. For lower-level students, grammar should also be controlled. Many textbooks use narratives and essays. It would be useful to have a variety of literary

forms (for example, newspaper articles, poetry, or letters), so that students can learn to deal with different forms.

Information on Culture

The cultural information included in English textbooks should be correct and recent. It should not be biased and should reflect background cultures of English. It should include visual aids etc., to help students understand cultural information.

From Learners' Viewpoints

Content English textbooks should be useful, meaningful and interesting for students. While no single subject will be of interest to all students, materials should be chosen based, in part, on what students, in general, are likely to find interesting and motivating.

Difficulty. As a general rule, materials should be slightly higher in their level of difficulty than the students' current level of English proficiency. (Exceptions are usually made for extensive reading and extensive listening materials, which should be easy enough for students to process without much difficulty.) Materials at a slightly higher level of difficulty than the students' current level of English proficiency allow them to learn new grammatical structures and vocabulary.

Instructional issues. English textbooks should have clear instructional procedure and methods, that is, the teacher and students should be able to understand what is expected in each lesson and for each activity.

Textbooks should have support for learning. This can take the form of vocabulary lists, exercises which cover or expand on the content, visual aids, etc. Traditionally, language teaching materials in Japan are made up mostly of text, with few, if any, visual aids. However, with the development of technology, photos, visual materials and audio materials have become very important components of language teaching materials, and they are becoming easier to obtain. Teachers need to learn how to find them, and how to best exploit these characteristics.

Materials are getting more complicated, and instructional philosophy, approach, methods, and techniques are getting more important. Teachers need to be able to evaluate materials involving photos, videos, and computers now.

How Can We Learn About Materials?

There are various ways to get information about textbooks and other teaching materials. Many materials are published by publishers and developed and distributed by commercial companies. Thus, publishers are useful (if not entirely unbiased) sources of information and advice about what materials are available and what materials are appropriate for various purposes. Many publishers provide sample copies on request. Bookstores that carry textbooks are another possible source of information. Clerks at such bookstores may help you find the materials you want. In addition, publishers' displays at conferences are useful. They usually have the most recent materials, exhibitors are willing to help you and answer your questions, and in some cases, you will have opportunities to meet and talk with the authors. Colleagues and friends who are teachers are also good sources of recommendations of textbooks and advice about how to best use them. Finally, there is information from computer mailing lists and web pages on the Internet. Lists on language teaching often have discussions on materials, and you can ask questions and may get good feedback. Many publishers have www pages and e-mail addresses, so you can check with them and also ask questions about the materials.

How do We Get Materials?

In addition to publishers, there are many possible sources of materials. There is a lot of material available on the Internet. You can search for materials when you have free time, and store them for your future classes.

Many teachers go abroad during vacations these days, and they can collect materials in English-speaking countries. TV and radio are good sources. They provide a variety of materials. The information is current and the language is natural, but the content has to be chosen carefully. Newspapers, magazines, advertisements, and other types of printed material are very useful. Teachers can take photos, make video tapes or record audio tapes. If they make plans before they go overseas, they may be able to make good video or audio programs.

Even in your home country, you can browse the world wide web and search for useful materials for classes. There are lots of sources of materials and photos on www.

Concerns About Materials

The market of language teaching materials are fairly large, and many companies are competing. They produce new materials and promote them with many advertisements and through their salespeople. You need to be careful about what they tell you. You always need to examine their materials carefully from the point of view of what is appropriate for your students and the classes you are teaching.

Another concern about materials is that the copyright issue. Many teachers violate the copyright laws every day. We cannot copy any copyrighted materials. Of course, we cannot copy them and distribute them to our students in the class. We need the permission from the publisher to do so.

Summary and Conclusion

Though there are five elements in language instruction, and learners should be the center of instruction. However, materials often control the instruction, since teachers and learners tend to rely heavily on them. Materials that are appropriate for a particular class need to have an underlying instructional philosophy, approach, method and technique which suit the students and their needs. They should have correct, natural, current and standard English. Teachers need to look for good materials, both commercial and non-commercial, all the time. They also need to be aware of commercialism and copyright issues concerning materials.

AIM: The aim of this unit is to enable trainees to develop and analyse teaching and learning materials EXPECTED LEARNING OUTCOMES By the end of this unit, trainees should be able to: I differentiate between teaching and learning materials. I justify the purpose and importance of teaching and learning materials. I identify the different types of teaching and learning materials. I develop strategies of using teacl::ng and learning materials. I develop strategies for the effective use of teaching and learning materials. CONTENT SUMMARY 1. Definition of "Teaching " and "Learning" materials. 2. Purpose and importance of teaching and learning materials. 3. Types of teaching and learning materials. 4. Strategies of using teaching and learning materials. 5. Strategies for effective use of teaching and learning materials. PROPOSED TRAINING STRATEGIES The trainer can use any of the following strategies: I pair/group work I brainstorming I role plays I lectures I classroom presentations PROPOSED TRAINING MATERIALS The trainer can use any of the following materials: I Teaching

and learning materials manual I VIPP cards 0 Flip charts I Felt pens/markers I Exercise/note books I Activity sheets 0 Chalk/black boards
The term Teaching Learning Material (TLM) is used often and usually refers to some very specific, sophisticated equipment. There is a tendency to believe that it is quite important that a teacher uses TLM in the classroom. If it's not so, it may be understood that one is not using a child-centered and interactive pedagogy. So ultimately, what happens is that every lesson ends up being a demonstration even though that approach might not be appropriate for that particular lesson.

When we say teachers should use TLM, it's understood by default that it should also be prepared by teachers. This may not be the right thing to state or understand though I have seen teachers preparing and using their own TLMs. A couple of year ago, I was not any different. At the time, I believed that the job of the teacher was to ensure that all the TLMs were prepared by the teacher. This was based on the belief that since the teacher is an authority on the topic, he/she can prepare the best TLM. The teacher also kept the TLM safe so that he/she was able to use it again and again. This was the belief that I had started with. An incident in the classroom changed my perspective regarding teaching learning practices and the use of TLM.

While dealing with magnetism as a topic I used to work with the real permanent magnet to enable students to understand the basic magnetic properties of a magnet. Next, came the temporary magnet and here we had a very beautiful model of an electromagnet, which I liked to use a lot. It was the first time I had ever seen such a wonderful electrically adjustable electromagnet. It was made in Germany and was a beautiful piece and I enjoyed using it. A year went by this way and it was only I who was excited to use it. In my second year when I took it to the class I realized that that the students were passive. So the use of the TLM was not as effective as I'd expected it to be. I was unable to understand why such an interesting device could not attract and hold the attention of the students. Why was the response of the class not as I expected? Why did the possible questions not come up? I was unable to pin point the issue and the thought disturbed me a lot.

- **Definitions**

"Teaching materials" is a generic term used to describe the resources teachers use to deliver instruction. Teaching materials can support student learning and increase student success. Ideally, the teaching materials will be tailored to the content in which they're being used, to the students in

whose class they are being used, and the teacher. Teaching materials come in many shapes and sizes, but they all have in common the ability to support student learning.

- **Summary**

The students had now learned, through trial and error, that the power of the temporary magnet could be increased or decreased depending on the power. This idea could not have been communicated unless they were allowed to play and use the electromagnet to their satisfaction. They also discovered that the polarity of the magnet changed if we switched the terminals of the battery. Their finding excited them because it supported what they had proposed and hadn't been simply a means of proving the textbook right. This experience was an eye opener for me. It was my first experience with involving learners in the process of making of TLM.

Earlier, I used either ready-made TLMs or used to construct the TLM on my own. Until now, I hadn't realized that the process was hampering the learner's capability to analyze the things and was in face a great obstacle in the construction of their own knowledge as the students did not find the space to discover. I realized that when the learners were engaged in the process they discovered and understood many things on their own. This is what I would like to call the "creation of knowledge". Although all of their findings were written in the books which they could have referred to in the library, the feeling of creating and discovering something was far more fulfilling to them.

n the traditional classroom teaching there is hardly any scope for the children to interact with the teacher, teaching –learning materials and the teaching-learning environment. So Teaching becomes very monotonous and students have to mostly rely on rote learning.Most often classroom teaching is dominated by the Lecture Method of teacher. Except some essential aids like chalk, duster, blackboard, Teaching learning materials are hardly used in the classroom. When used it may not be context-specific. One of the major aim of NCERT [1](2005) is Designing, providing for, and enabling appropriate teaching-learning systems that could realise the identified goals. Learning has shifted from Response Strengthening to Knowledge Acquisition to Construction of Knowledge. In this contxt, The duty of the teacher is to provide appropriate environment where the child will constuct his knowledge by interacting with his physical and social environment.

In this context, there is a need to orient teachers and develop appropriate context specific teaching learning materials useful to enhance the quality of teaching-learning process.

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

- References / Further Readings

Bale, K. Producing Low Cost Visual Media, London, International Planned Parenthood Federation, 1980 Castle, E. B., Principles of Education for Teachers in Africa, Nairobi, Oxford University Press, 1973. Crone, C. D. and St John -Hunter, Carman, From the Field: Tested Participatory Activities for Trainers, New York, World Education, 1980 Emory University School of Medicine, Producing Low Cost AV's: A Workbook for Health Professionals and others Developing Their Own Educational Materials, Atlanta, Emory University School of Medicine Stanfield, N.F. A Handbook of Art Teaching in Tropical Schools, London, Evans Brothers

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Block 4: Intervention for Mal-adaptive Behaviour

Unit 1: Definition and types of Mal-adaptive behaviour

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

Adaptive behavior is a type of behavior that is used to adjust to another type of behavior or situation. This is often characterized as a kind of behavior that allows anindividual to change a nonconstructive or disruptive behavior to something more constructive. These behaviors are most often social or personal behaviors. For example a constant repetitive action could be re-focused on something that creates or builds something. In other words the behavior can be adapted to something else.

In contrast, maladaptive behavior is a type of behavior that is often used to reduce one's anxiety, but the result is dysfunctional and non-productive. For example, avoiding situations because you have unrealistic fears may initially reduce your anxiety, but it is non-productive in alleviating the actual problem in the long term. Maladaptive behavior is frequently used as an indicator of abnormality or mental dysfunction, since its assessment is relatively free from subjectivity. However, many behaviors considered moral can be apparently maladaptive, such as dissent orabstinence.

Adaptive behavior may be affected by mechanisms in the brain that lead to addiction. Regarding addiction as a disease provides opportunities for its treatment.[1]

Adaptive behavior reflects an individual's social and practical competence of daily skills to meet the demands of everyday living. Behavior patterns change throughout a person's development, across life settings and social constructs, changes in personal values, and the expectations of others. It is

important to assess adaptive behavior in order to determine how well an individual functions in daily life: vocationally, socially, educationally, etc.

- **Objectives**

The adaptive skills exhibited by a person with mental disability are critical factors in determining the support he/she requires for success in school, work, community, and home environments. Children with mental disabilities tend to have substantial deficits in adaptive behavior. These limitations can take many forms and tend to occur across domains of functioning. Limitations in self-care skills and social relationships, as well as behavioral excesses are common characteristics of individuals with mental disabilities. Individuals with mental disabilities who require extensive supports are often taught basic self care skills such as dressing, eating, and hygiene.[2] Direct instruction and environmental supports, such as added prompts and simplified routines are necessary to ensure that deficits in these adaptive areas do not come to seriously limit one's quality of life.[2]

- **Definitions**

Adaptive behavior includes the age-appropriate behaviors necessary for people to live independently and to function safely and appropriately in daily life. Adaptive behaviors include life skills such as grooming, dressing, safety, food handling, working, money management, cleaning, making friends, social skills, and the personal responsibilityexpected of their age and social group

- **Summary**

To determine a student's adaptive behavior capacities, professionals focus on the student's conceptual skills, social skills, and practical skills. To measure adaptive skills, professionals use adaptive behavior scales that have been normed on individuals with and without disabilities. Most adaptive behavior scales are completed by interviewing aparent, a teacher, or another individual who is familiar with the student's daily activities. Students may have a combination of strengths and needs in any or all of the areas regarding conceptual, social and practical skills.

Behavior scales help to measure possible impairments or delays in everyday life that are often related to a disability or illness. Measures of adaptive behavior must assess typical behavior rather than optimal performance. Adaptive behavior assessments are important for diagnosing intellectual disabilities.

The Vineland Scales-II is an instrument for supporting the diagnosis of intellectual and developmental disabilities. It not only aids in diagnosis but also provides valuable information for intervention plans and educational strategies. Additionally it helps determine eligibility for special programs and services. The scales of the Vineland II were organized within a four-domain structure: Communication, Daily Living, Socialization, and Motor Skills. In addition, Vineland-II offers an optional Maladaptive Behavior Index. It includes four forms: Survey Interview, Parent/Caregiver Rating, Teacher Rating, and Expanded Interview, which provide in-depth information and covers the full spectrum of adaptive behavior.

AAIDD plans to release a new Diagnostic Adaptive Behavior Scale (DABS) in 2015 to provide an additional comprehensive standardized assessment of adaptive behavior. This scale emphasizes the importance of adaptive behavior in the diagnosis of intellectual disabilities because of its implications for special education services, home and community-based services, Social Security Administration benefits, and specific treatment within the criminal justice system

Most children with milder forms of mental disabilities learn how to take care of their basic needs, but they often require training in self-management skills to achieve the levels of performance necessary for eventual independent living. Making and sustaining friendships and personal relationships present significant challenges for many persons with mental disabilities. Limited cognitive processing skills, poor language development, and unusual or inappropriate behaviors can seriously impede interacting with others. Teaching students with mental disabilities appropriate social and interpersonal skills is one of the most important functions of special education. Students with mental disabilities more often exhibit behavior problems than children without disabilities.[2] Some of the behaviors observed by students with mental disabilities are difficulties accepting criticism, limited self-control, and bizarre and inappropriate behaviors. The greater the severity of the mental disabilities, generally the higher the incidence of behavioral problems.[2]

According to **practopoietic** theory,[3] creation of adaptive behavior involves special,*poietic* interactions among different levels of system organization. These interactions are described on the basis of cybernetic theory in particular, good regulator theorem. In practopoietic systems, lower levels of organization determine the properties of higher levels of organization, but not the other way around. This ensures that lower levels of organization

(e.g., genes) always possess cybernetically more general knowledge than the higher levels of organization—knowledge at a higher level being a special case of the knowledge at the lower level. At the highest level of organization lies the overt behavior. Cognitive operations lay in the middle parts of that hierarchy, above genes and below behavior. For behavior to be adaptive, at least three adaptive traverses are needed.

Maladaptive Behavior – types of behaviors that inhibit a persons ability to adjust to situations.
Maladaptive behaviors in students can appear in countless ways. Some categories and examples are explained below. This list is not exhaustive.
Stereotypical Behavior – repetitive movement, posture or utterance.
Examples:

- handplay
- rocking
- echolalia (repeating words or phrases)

Ritualistic Behavior – an attempt to regulate something concrete and controllable because the person cannot identify and control a problem – often manifests in compulsive behavioral.
Self-Injurious Behavior – any behavior that can cause damage to the individual.
Examples:

- head banging
- self biting
- scratching
- pica (consumption of inedible items)

Tantrums – a combination of two or more maladaptive behaviors.
Examples:

- screaming
- crying
- dropping to the ground

Aggression – an act of violence to another person or object.
Examples:

- hitting
- kicking
- biting
- slapping

- pinching
- grabbing
- pushing

Transition Difficulties – some students become easily upset when asked to transition to a new area or task.
Running/Darting – running out of the classroom, away from the area, or away from adults.
Compliance/Following Directions/Opposition – lack of cooperation with instructions/demands.
Verbally Inappropriate Behavior – disruptive to classroom, peers or individual learning/success.
Examples:

- name calling
- swearing
- screaming
- whining
- crying

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

- References / Further Readings

- R. Andrew Chambers (2008). Impulsivity, dual diagnosis, and the structure of motivated behavior in addiction. Behavioral and Brain Sciences, 31, pp 443-444 doi:10.1017/S0140525X08004792
- ^ Jump up to:[a b c d e] William Heward: *Exceptional Children* 2005
- **Jump up^** *Danko Nikolić (2014). "Practopoiesis: Or how life fosters a mind. arXiv:1402.5332 [q-bio.NC]." Retrieved 2014-06-06.*

Unit 2: Identification of Mal-adaptive behaviour

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

The early identification and intervention of maladaptive behaviors in preschool children as a precedent to the prevention of psychiatric disorders across the life span.

- **Objectives**

Maladaptive behaviors refer to types of behaviors that inhibit a person's ability to adjust to particular situations. Maladaptive behaviors are never good because they prevent people from adapting to the demands of life. Often used to reduce anxiety, maladaptive behaviors result in dysfunctional and non-productive outcomes. If you experience frequent panic (anxiety) attacks and have been diagnosed with panic disorder or another anxiety disorder, you may have inadvertently developed maladaptive patterns of behavior to cope with your situation.

Some common maladaptive behaviors are discussed below. They are classified here as "dysfunctional" because they tend to provide only short-term relief from anxiety. They are non-productive in alleviating the actual problem in the long run and may, in fact, serve as reinforcers of the underlying problem.

People with anxiety disorders, including panic disorder and agoraphobia, sometimes use alcohol or other substances as a means of coping with fear and anxiety. Some studies show that people with anxiety disorders are up to three times more likely to have an alcohol or other substance abusedisorder than those without an anxiety disorder. Abusing alcohol or other drugs to

control stress and anxiety is classified as a maladaptive behavior because it provides only temporary relief from anxiety and actually may create more long-term problems. Substance abuse does not fix the underlying problem and long-term alcohol or drug abuse can lead to tolerance, dependence, and for some, addiction.

Many challenges in life require ongoing action — both behaviorally and mentally. Sometimes we struggle and succeed. Sometimes we struggle and fail. When the latter occurs, we can try again, or we can withdraw from the conflict with a resigned acceptance of our situation. When it comes to panic disorder or other anxiety disorders, withdrawing is incompatible with recovery. It is a maladaptive behavior because it means we submit to the illness and become unable to meet the demands of life. In essence, withdrawing in this sense is like giving up. For many people, the recovery process from anxiety disorders is slow and filled with setbacks. Recovery is accomplished with diligence and a strong resolve *not* to accept the control that panic attacks and other anxiety-related symptoms have over our lives.

- **Definitions**

It's not unusual for people who have panic disorder, agoraphobia or another anxiety disorder to experience frustration because of their condition. Sometimes this frustration can develop into anger -- anger toward yourself, anger at your situation or anger toward others. This type of anger is rooted in anxiety.

Anger is a powerful feeling that is a normal part of the human experience. Everyone has felt angry at one time or another. Anger itself is not a bad thing. But, if you express your anger in unhealthy ways, it can become a problem. Plus, anger can intensify your anxiety and worsen your panic symptoms. Anger management programs can help you find more adaptive ways to deal with anxiety.

- **Summary**

Adaptive behavior is a type of behavior that is used to adjust to another type of behavior or situation. This is often characterized as a kind of behavior that allows anindividual to change a nonconstructive or disruptive behavior to something more constructive. These behaviors are most often social or personal behaviors. For example a constant repetitive action could be re-focused on something that creates or builds something. In other words the behavior can be adapted to something else.

In contrast, maladaptive behavior is a type of behavior that is often used to reduce one's anxiety, but the result is dysfunctional and non-productive. For example, avoiding situations because you have unrealistic fears may initially reduce your anxiety, but it is non-productive in alleviating the actual problem in the long term. Maladaptive behavior is frequently used as an indicator of abnormality or mental dysfunction, since its assessment is relatively free from subjectivity. However, many behaviors considered moral can be apparently maladaptive, such as dissent orabstinence.

Adaptive behavior may be affected by mechanisms in the brain that lead to addiction. Regarding addiction as a disease provides opportunities for its treatment.[1]

Adaptive behavior reflects an individual's social and practical competence of daily skills to meet the demands of everyday living. Behavior patterns change throughout a person's development, across life settings and social constructs, changes in personal values, and the expectations of others. It is important to assess adaptive behavior in order to determine how well an individual functions in daily life: vocationally, socially, educationally, etc.

Adaptive behavior includes the age-appropriate behaviors necessary for people to live independently and to function safely and appropriately in daily life. Adaptive behaviors include life skills such as grooming, dressing, safety, food handling, working, money management, cleaning, making friends, social skills, and the personal responsibilityexpected of their age and social group.[2]

To determine a student's adaptive behavior capacities, professionals focus on the student's conceptual skills, social skills, and practical skills. To measure adaptive skills, professionals use adaptive behavior scales that have been normed on individuals with and without disabilities. Most adaptive behavior scales are completed by interviewing aparent, a teacher, or another individual who is familiar with the student's daily activities. Students may have a combination of strengths and needs in any or all of the areas regarding conceptual, social and practical skills.

Behavior scales help to measure possible impairments or delays in everyday life that are often related to a disability or illness. Measures of adaptive behavior must assess typical behavior rather than optimal performance. Adaptive behavior assessments are important for diagnosing intellectual disabilities.

The Vineland Scales-II is an instrument for supporting the diagnosis of intellectual and developmental disabilities. It not only aids in diagnosis but also provides valuable information for intervention plans and educational

strategies. Additionally it helps determine eligibility for special programs and services. The scales of the Vineland II were organized within a four-domain structure: Communication, Daily Living, Socialization, and Motor Skills. In addition, Vineland-II offers an optional Maladaptive Behavior Index. It includes four forms: Survey Interview, Parent/Caregiver Rating, Teacher Rating, and Expanded Interview, which provide in-depth information and covers the full spectrum of adaptive behavior.

AAIDD plans to release a new Diagnostic Adaptive Behavior Scale (DABS) in 2015 to provide an additional comprehensive standardized assessment of adaptive behavior. This scale emphasizes the importance of adaptive behavior in the diagnosis of intellectual disabilities because of its implications for special education services, home and community-based services, Social Security Administration benefits, and specific treatment within the criminal justice system

Tendencies[edit]
The adaptive skills exhibited by a person with mental disability are critical factors in determining the support he/she requires for success in school, work, community, and home environments. Children with mental disabilities tend to have substantial deficits in adaptive behavior. These limitations can take many forms and tend to occur across domains of functioning. Limitations in self-care skills and social relationships, as well as behavioral excesses are common characteristics of individuals with mental disabilities. Individuals with mental disabilities who require extensive supports are often taught basic self care skills such as dressing, eating, and hygiene.[2] Direct instruction and environmental supports, such as added prompts and simplified routines are necessary to ensure that deficits in these adaptive areas do not come to seriously limit one's quality of life.[2]

Lifestyle[edit]
Most children with milder forms of mental disabilities learn how to take care of their basic needs, but they often require training in self-management skills to achieve the levels of performance necessary for eventual independent living. Making and sustaining friendships and personal relationships present significant challenges for many persons with mental disabilities. Limited cognitive processing skills, poor language development, and unusual or inappropriate behaviors can seriously impede interacting with others. Teaching students with mental disabilities appropriate social and interpersonal skills is one of the most important functions of special education. Students with mental disabilities more often exhibit behavior problems than children without disabilities.[2] Some of the behaviors observed by students with mental disabilities are difficulties accepting

criticism, limited self-control, and bizarre and inappropriate behaviors. The greater the severity of the mental disabilities, generally the higher the incidence of behavioral problems.[2]

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

- References / Further Readings

Unit 3: Functional Analysis and Behaviour Modification Techniques, Cognitive Behaviour Techniques (CBT)

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

Before we move on, let's look at the steps involved in behavior modification. We most always begin with a behavior that we want to increase (reinforce) or decrease (punish or extinguish). From there we determine a target behavior that we can hopefully reinforce to achieve or behavior modification goal. Having a well defined target behavior allows us to focus on the specific problem and learn what elicits the behavior (antecedent) and what maintains the behavior (consequence). Next we pay attention and document the occasions when the behavior occurs and make note of what happens right afterwards (consequences). This is important because we need to know what contingencies are in place that maintain the behavior. For example when a child has a tantrum, and the consequence is attention from grandma, then we would suspect that grandmother's attention might be reinforcing and therefore maintaining the tantrum behaviors. Next we need to determine what the antecedents in relation to the target behavior are. These are the circumstances that elicit or trigger the behavior. In the tantrum example, do the child only have tantrums in the presence of grandma? Or do they occur only in the presence of grandparents? Only in the presence of females? Etc? It is critical to take note of the circumstances in which the behaviors occur so we can use this information to conduct a functional assessment of behavior. Now that we have recorded the ABC's

during a period of baseline measurement (observation without intervention), we can conduct a functional assessment which will be described in detail within this chapter. Once we understand the ABC and how they are interrelated, we can attempt to devise new antecedents and consequences during an in intervention period while still recording the ABCs related to the target behavior of interest. After some period we can then evaluate how effective our intervention was.

- **Objectives**

Steps involved in the behavior modification process: Step 1: Describe the target behavior Step 2: Describe the consequences Step 3: Describe the antecedents Step 4: Examine the ABCs (Functional Assessment) Step 5: Devise new antecedents and consequences Step 6: Evaluate the outcome So far we have covered Steps 1, 2, and 3. This section covers step 4. By now you should be well underway in establishing a baseline of behavior by entering the ABCs into your behavioral diary. We can use the information in your behavioral diary to conduct a functional assessment of the behavior you are trying to modify. The functional assessment of behavior is designed to help you develop a hypothesis regarding the relationship between the ABCs of behavior. It is used to identify the environment (antecedents) in which the behaviors occur and how the outcomes of the behavior function to maintain it (consequences). Once a hypothesis is developed, it becomes the basis for future intervention to decrease the undesirable behavior and to increase desirable behaviors. Through functional assessment of behavior we can begin to investigate the behavior and what is reinforcing it so we can ultimately design an intervention to decrease the behavior if the behavior was undesirable. As discussed in earlier sections, behaviors can be organized by their topographies and functions. Some behaviors have a similar topography (form) but have different functions. Some students have used behavior modification to decrease the frequency of saying the f-word or dropping the "f-bomb". Sometimes when they say the f-word they mean it in different ways (functions) even though it sounds the same (topography). People might use it when they are scared (e.g., on a roller coaster ride), when they want to start a fight, when they are mad about the outcome of a test (e.g., received an "F"), or when they are startled, etc. We should add that there are also hand gestures that function similarly to the f-word (giving the finger). Iowans are generally polite and kind, however we have found that there is a higher likelihood of "getting the finger" when failing to yield or pull over to the fast lane on the freeway when another driver is attempting to merge. In the freeway example, how do you think 'giving the finger' functions for the motorist trying to merge? In other words what is reinforcing the motorist's finger pointing behavior? And why mostly in the context of

merging on the freeway? A good guess would be that the function of the finger was to get you to move over. However, if this was the case what other behaviors could the driver have done to achieve the same objective? Clearly there were other things such as slowing down or speeding up that the driver could do. They could have also signaled you to move over, if that is what they really wanted. Of all things why flash the finger? It is possible that it is used as an emotional response (perhaps aggressive, perhaps a tension release, or perhaps it is cultural). The point is that we can examine the functions to help develop a working hypothesis of why the behavior occurs in the first place. When a behavior occurs there is generally something reinforcing it. If we know what is reinforcing the behavior, we can change the contingencies and perhaps extinguish the behavior.

- **Definitions**

"People do not engage in self-injury [or] aggression...solely because they have...developmental disabilities. There is logic to their behaviour, and functional assessment is an attempt to understand that logic"
- O'Neill, Horner, Albin, Sprague, Storey, and Newton (1997, p. 8)

A Functional Behaviour Assessment (FBA) is not one single thing; it is a broad term used to describe a number of different methods that allow researchers and practitioners to identify the reason a specific behaviour is occurring (Cooper, Heron, & Heward, 2007).

These assessments are typically, but not exclusively, used to identify the causes of challenging behaviours such as self-injury, aggression towards others or destructive behaviours.

Although there are different methods for carrying out functional assessments, they all have the same goal: to identify the function of a challenging behaviour so an intervention can be put in place to reduce this behaviour and/or increase more adaptive behaviours.

- **Summary**

Eating is another behavior that basically has the same topography. Put food in mouth, chew, swallow, and repeat. However, we can all agree that eating has a variety of functions. Since eating has many functions, if an individual has a problem with over eating it will be beneficial to understand the

different circumstances in which the individual is eating. We can examine the circumstances and develop a working hypothesis of why/how the problem behavior is occurring and what is maintaining the behavior. Typically we may have more than one hypothesis. In this case we can make a list with the best hypothesis (the one that most likely will explain the behavior) at the top of the list. Starting at the top of the list, once we have a hypothesis of how the behavior is functioning and the circumstances in which it occurs, we can begin experimenting with behavioral interventions. We refer to it as experimenting because after all it is only a hypothesis of why the behavior is occurring in the first place. We will only know if we are correct when the intervention works. Just like a laboratory experiment, to test our hypothesis, we should have an existing baseline of the occurrence of the behavior prior to the intervention. The baseline is similar to a control group in many research experiments. The baseline is used to determine changes due to the experimentation. We should then implement the intervention and continue to record the behavior. If the intervention is designed to decrease the behavior, we should see a steady decline in the frequency of the target behavior following the intervention. If the intervention is to increase a behavior, we should see a steady increase in behavior. However, if the intervention does not change the frequency of the target behavior, then we either need to alter the intervention, or we have to go back and re-evaluate our hypothesis. In other words we need to 'go back to the drawing board' and test a new hypothesis. It is very seldom that we "hit" on the correct intervention the first time. The main thing is to keep trying and dial it in. This is why a good list of hypotheses is important to have. Regarding the eating example above, suppose the individual skips breakfast, eats a regular meal for lunch and diner, but snacks all night long until she goes to bed. What would be some hypotheses about why this pattern of behavior is occurring?

In the world of behavior analysis we are not always only trying to modify our own behavior, we are often asked to help modify the behavior of others as well. Therefore we need to know about the many ways of observing analyzing behaviors. The functional analysis of behavior can be either direct or indirect. Direct involves observing the behaviors while they occur. Indirect involves gathering information about the behaviors usually through 2nd party sources. Some assessments might involve a combination of both methods. Direct assessment: Involves the observation and recording of behaviors. The recording can be done by the individual, by others or electronically (video recording for example). The observations are made under naturally occurring conditions. Observations therefore involve noticing when the target behavior occurs, what happens as a result (consequence) and then looking back in time to determine what may have elicited or "set

the occasion" for the behavior (antecedent). This observation method would include writing the ABCs down in a behavioral diary. Once the ABCs are determined, the observer must keep an accurate recording to document the ABCs. It is best to record the ABCs as close to the event as possible so as not to forget that it occurred or not to omit important details that might otherwise be overlooked with the passage of time. Often times in a behavioral project such as the ones we may be doing for class, we get too busy to record the behavior as it occurs and try to reconstruct what happened later relying on memory. However memory is not perfect. As such, it is often necessary to have the recording device nearby/handy. Recording devices can range from low technology such as paper and pencil (keeping a small note pad handy) to a computerized system involving a handheld PDA. Indirect. Indirect assessment might involve the use of an interview process or a questionnaire. The assessment can include interviews with parents, teachers, care givers, and the individual undergoing the assessment for behavioral change with the goal of determining the intervention that will have the greatest likelihood of changing the individual's behavior. During the interview the ABCs are identified as well as the possible function of the behavior (i.e., what is the purpose of the behavior?). Indirect assessments are often necessary when the individual is unable to communicate (as in the case of severely autistic children), unwilling to communicate (as in defiant adolescents), or unable to "access" the larger picture (sometimes the people around us may have better insight into what our issues/problems are). One advantage of the indirect assessment is that outside observers may be less subjective. Once the assessment is conducted (regardless if the direct or indirect method was used), it is often helpful to continue to document the ABCs. Through documentation we might find that our target behavior is too broad. For example, suppose Michelle wanted to cut back on the amount of caffeine she was consuming. It seemed like a very specific target behavior (although it turned out that what she originally only had in her mind to stop drinking caffeinated soda – something more specific). After she began to document the caffeine she was consuming she noticed that many products contained caffeine such as tea, chocolate, ice cream, pain relievers, and cold relief medicine. She then decided to redefine her target behavior to caffeinated soda. So she concentrated on that. The documentation did several things for Michelle, a) it allowed her sufficient information to gather the ABCs related to her target behavior, b) it allowed her to graph a baseline of her behavior, c) it allowed her insight into her behavior, and d) it allowed her to redefine her target behavior to reflect her goals. It is not uncommon to continually change and redefine (tweak) the target behaviors and the contingencies throughout the behavior modification process. In fact it is desirable and is a sign of a

dynamic behavior modification program. In fact even if you are successful, you will want to make changes to your behavior modification process. For example, suppose you want to increase the number of "A's" you get on your exams. Suppose that you really like doughnuts and choose to reinforce yourself with a doughnut for every "A" you get on an exam. Earning a doughnut for every "A" is a continuous reinforcement. It is a very high rate of reinforcement. At base line, you note that you earn only 1 "A" on every 5 exams. Suppose you have 4 classes with an average of 4 exams each. This would amount to 3 or 4 doughnuts every semester. A diet can handle that many doughnuts for the most part. Now suppose that you devise a super killer intervention and you are earning on the average 10 "A's" per semester. That might be more doughnuts than your diet can afford. You might want to alter your reinforcement schedule to a doughnut for every other "A" you earned. Reducing the times you are reinforced involves making your reinforcement schedule leaner (reinforcing less often). We might refer to this as 'leaning out' the reinforcement schedule. Another option you could do would be to implement a random schedule which will be discussed in the next section. The main point is that the intervention is dynamic and is constantly under change. Another change you might want to make is to change the target behavior. You might find that getting "A's" in your psychology classes is easy and really no longer requires a doughnut for reinforcement to maintain the behavior. From a behavioral perspective we would say that it is under more natural contingencies such as feeling good about yourself for doing well (or praise from your friends and family, etc.). Suppose however that your grades in math are still not to the "A" level. You could redefine your target behavior more narrower from getting "A's" to getting "B's" or better in math. Thus, a dynamic behavioral intervention might involve changes in the target behavior, changes in the schedule of reinforcement, and changes in the reinforcer, among other things. As you can see behavior modification is a dynamic process that involves careful recording of the behavior, as well as the consequences and antecedents surrounding that behavior. It involves a functional analysis of the behavior to develop a list of possible reasons for the behavior that we can then frame in terms of several hypotheses. From this list hypotheses we can then systematically implement interventions to see if the behavior changes in relation to the baseline occurrence. If the intervention is not successful then you have to go back to your list try the next hypothesis. If the intervention is successful you may still have to back over it and change some of the contingencies such as leaning out the reinforcer to occur less often and to ultimately have the behavior occur naturally so the intervention can ultimately be dropped or end.

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

- References / Further Readings

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Unit 4: Management of Mal-adaptive behavior at Home and School, Parental Counselling - Individual, Group and Community

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

Defining, measuring, and modifying human behavior is a challenging endeavor, made more difficult in persons with developmental disabilities by varying degrees of cognitive impairment often accompanied by psychopathology. Developing and implementing effective and applicable interventions for the various maladaptive behaviors demonstrated by persons with developmental disabilities, often proves to be a daunting and intricate task. Several traditional approaches to managing maladaptive behavior compromise individual choice, dignity and autonomy. Treatment plans have often taken an outcome-driven approach to control behavior in lieu of person-centered planning aimed at developing behavior.

- **Objectives**

Contemporary trends in behavior analysis continue to emphasize an objective approach to measuring and modifying behavior, however several of the existing paradigms do not translate to in-vivo application and do not account for maladaptive behavior as symptom manifestation of psychopathology - thus rendering them inadequate. Treatment plans continue to focus on the extinction or management of behavior rather than functional development of individual behavior. Management of behavior implies a reactive approach whereas development of behavior implies a

proactive approach; the former has an acute and transitory impact on holistic development while the latter has a pervasive and longitudinal impact. Psychopharmacological treatment protocols for persons with developmental disabilities traditionally have been inadequately developed with poor outcomes primarily as a result of inadequacies in evaluation and an emphasis on termination of behavioral difficulty by way of sedation or polypharmacy with disregard to adverse events and individual choice and dignity.

Innovations in systematic assessment of behavior and subsequent behavior development planning provide for novel intervention protocol design that is practical in application, person-centered, respects individual dignity, and allows for personal growth and autonomy. Procedures such as making maladaptive behavior functionally adaptive, response modeling, and independent behavior development training, have demonstrated efficacy in developing individual behavior regardless of psychosocial factors and the additional presence of psychopathology. Innovative approaches to psychopharmacological treatment have yielded successful outcomes in the absence of adverse events, sedation, and polypharmacy via diagnostic-driven minimalist treatment strategies. It is by redefining our perspectives on treatment planning that successful outcomes can be achieved and celebrated without compromising individual choice, dignity and autonomy.

- **Definitions**

Adaptive behavior includes the age-appropriate behaviors necessary for people to live independently and to function safely and appropriately in daily life. Adaptive behaviors include life skills such as grooming, dressing, safety, food handling, working, money management, cleaning, making friends, social skills, and the personal responsibilityexpected of their age and social group.[2]

Adaptive behavior is a type of behavior that is used to adjust to another type of behavior or situation. This is often characterized as a kind of behavior that allows anindividual to change a nonconstructive or disruptive behavior to something more constructive. These behaviors are most often social or personal behaviors. For example a constant repetitive action could be re-focused on something that creates or builds something. In other words the behavior can be adapted to something else.

In contrast, maladaptive behavior is a type of behavior that is often used to reduce one's anxiety, but the result is dysfunctional and non-productive. For example, avoiding situations because you have unrealistic fears may initially reduce your anxiety, but it is non-productive in alleviating the actual problem in the long term. Maladaptive behavior is frequently used as an indicator

of abnormality or mental dysfunction, since its assessment is relatively free from subjectivity. However, many behaviors considered moral can be apparently maladaptive, such as dissent orabstinence.

Adaptive behavior may be affected by mechanisms in the brain that lead to addiction. Regarding addiction as a disease provides opportunities for its treatment.[1]

Adaptive behavior reflects an individual's social and practical competence of daily skills to meet the demands of everyday living. Behavior patterns change throughout a person's development, across life settings and social constructs, changes in personal values, and the expectations of others. It is important to assess adaptive behavior in order to determine how well an individual functions in daily life: vocationally, socially, educationally, etc.

- **Summary**

Typically behaviour management plans attempt to change behaviour by manipulating the environmental consequences of selected behaviour. However, identifying the antecedent events that precede behaviour has also been demonstrated to be an important component of effective behaviour change programmes. The present case presentation attempts to demonstrate how antecedent procedures could be used to effectively manage behaviour problems in individuals with brain injury. Visual inspection of changes in the frequency of physical aggression and self-injurious behaviour of a child with brain injury provides preliminary data supporting the use of an intervention package of antecedent and consequence-based procedures. Clinical implications, limitations and possibilities for future research of antecedent control procedures are discussed.

Behavior Therapy is a treatment approach based on the application of findings from behavioral science research to help improve the quality of life for individuals, couples, families and systems in ways they would like to change. A major assumption is that although the past is significant, the **current environment is most important in affecting present behavior.** The focus in treatment is to improve self-control by expanding skills and abilities.

Maladaptive Behavior

Behavioral therapy can be a useful treatment tool in an array of mental illnesses and symptoms of mental illness that involve maladaptive behavior, such as:

- weight management
- substance abuse
- aggressive behavior
- anger management
- eating disorders
- phobias
- development disabilities
- anxiety disorders
- stress
- pain management
- sexual dysfunction
- children's social behaviors
- bipolar disorder

Organic Disorders

Behavioral therapy is also used to treat organic disorders such as incontinence and insomnia by changing the behaviors that might be contributing to these disorders. Behavioral therapy, or behavior modification, is based on the assumption that emotional problems, like any behavior, are learned responses to the environment and can be unlearned. Unlike psychodynamic therapies, it does not focus on uncovering or understanding the un-conscious motivations that may be behind the maladaptive behavior. In other words, behavioral therapists **don't try to find out why** their patients behave the way they do, they just **teach them to change** the behavior.

Coping With Life

As an adult, child or adolescent, your life may be hindered by unwanted or excessive emotions such as anxiety, depression, fear or anger. You may also feel burdened by worrisome or disturbing thoughts and unhelpful behaviors such as sleep difficulties, procrastination, anger outbursts and addictive or repetitive behaviors. You may just have difficulty coping with the stress of daily life. Learning or attention disorders may impede your success or the success of your child. Behavior Therapy can help you address these and other roadblocks to achieving success and happiness.

Treatment

Initial treatment sessions are typically spent explaining the basic tenets of behavioral therapy to the patient and establishing a positive working relationship between therapist and patient.

Behavioral therapy is a collaborative, action-oriented therapy, and as such, it empowers patients by giving them an active role in the treatment process. It also discourages overdependence on the therapist, a situation that may occur in other therapeutic relationships. Treatment is typically administered in an out-patient setting and is relatively short compared to other forms of psychotherapy.

Behavioral therapy techniques are sometimes combined with other psychological interventions such as medication. Treatment depends on the individual patient and the severity of symptoms surrounding the behavioral problem.

Embedding Maladaptive Behavior /Process in a Cultural and Emic View

- What do individuals perceive as the positive aspects of engaging in maladaptive behavior? Can similar behaviors be maladaptive for some while being adaptive for others given their personal circumstances or sub/cultural contexts? Can maladaptive consumption be adaptive given the potential consequences of engaging in other behavior or avoiding the behavior and reaping the repercussions?
- How do consumers negotiate and engage in potentially problematic behaviors without it becoming maladaptive? How do consumers engage in seemingly benign behaviors (shopping, eating, using technology, social drinking) without moving towards over-consumption? How do those with former maladaptive behaviors reframe or renegotiate the meaning, reward, rituals etc. of such behaviors to be more adaptive (and avoid relapse)?
- How do consumers interpret and describe maladaptive behaviors as well as outcomes such as over-consumption, harm, compulsiveness, etc? How does their recognition and the meaning they assign to such phenomena alter our view of maladaptive behavior and promotion of behavior change?
- What role(s) does marketing play in constructing product and cultural cues related to maladaptive consumption? What role(s) does societal and regulatory forces play in constructing cultural and market cues so that they result in a consumption being viewed as maladaptive? How might media and social media influence views of maladaptive behavior?

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

- References / Further Readings

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1. R. Andrew Chambers (2008). Impulsivity, dual diagnosis, and the structure of motivated behavior in addiction. Behavioral and Brain Sciences, 31, pp 443-444 doi:10.1017/S0140525X08004792
2. ^ Jump up to:[a b c d e] William Heward: *Exceptional Children* 2005
3. **Jump up^** *Danko Nikolić (2014). "Practopoiesis: Or how life fosters a mind. arXiv:1402.5332 [q-bio.NC].". Retrieved 2014-06-06.*

Unit 5: Ethical Issues in behaviour management and implications for Inclusion

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

• Introduction

Existing theoretical models of individual ethical decision making in organizations place little or no emphasis on characteristics of the ethical issue itself. This article (a) proposes an issue-contingent model containing a new set of variables called *moral intensity;* (b) using concepts, theory, and evidence derived largely from social psychology, argues that moral intensity influences every component of moral decision making and behavior; (c) offers four research propositions: and (d) discusses implications of the theory.

• Objectives

Is every child entitled to be educated in the same setting as his or her peers? Is segregated education automatically oppressive by its very nature? Is the diagnosis of behavioural disorders harmful to disabled people in general? Are so-called behavioural disorders just undesirable manifestations of human diversity? These questions are matters that call on us to take a normative stand about whether something is right or wrong, good or bad. In other words, besides being educational policy issues, they are ethical questions. In this chapter, the ethical issues I will explore relate to disability and childhood. I will begin by explaining what ethics and political philosophy are all about, and how they are relevant with regard to disability.

After that, I will discuss inclusive education and the diagnosis of behavioural disorders as ethical issues. My aim is not to offer exhaustive normative arguments that would show the moral superiority of certain viewpoints over others. Instead, I hope to offer conceptual tools and fresh points to consider, with the aim of helping professionals working in the field to question ethical norms that they may have considered self-evident.

- **Definitions**

In addressing Students with Special Education Needs in the following report the term Special/Inclusive Education is used and defined as "catering for students with special education needs in mainstream/ regular classrooms". The term was used for ease of communication with providers, and is reflective of the unit titles offered in this area. In the context of this report the definition of special needs is "having disability, learning difficulty or behaviour support need". Although some providers have included "gifted and talented students" and "indigenous students" in their definition of "students with special education needs", they are not the focus of this review. The term Classroom Management is used to address both general classroom management for all students and management/support specific to students who have behavioural issues. There is some overlap in the students captured under the definition of Special/Inclusive Education and Classroom Management which means students with behavioural issues are addressed in both areas. However behaviour management/support for students with behaviour problems is one component of many in Special/ Inclusive Education.

- **Summary**

Students with special educational needs National policies in relation to special education have been influenced by international policy documents such as the Salamanca Statement on Special Needs Education UNESCO (1994), the UN Convention on the Rights of the Child (UN) (1990) and the UN International Convention on the Rights of Persons with Disabilities (2006). Within a European context, the Council of Europe (CE) Political Declaration (2003) and Action Plan (2006) have been of high relevance in Ireland. Irish policy documents relating to special education have adopted the philosophy of the Special Education Review Committee (SERC) (Government of Ireland, 1993, p. 22) report in favouring "as much integration as is appropriate and feasible with as little segregation as is necessary". Since the Education Act 1998 (Government of Ireland, 1998) established the right to an appropriate education for all children there has been a large body of legislation which has influenced thinking, policies and

While philosophies of teaching and learning differ between universities/ colleges it is clear that providers, irrespective of their commitment to a particular approach, also include at least some minor elements of other pedagogical approaches. For purposes of this document these approaches are described as ranging from teacherdirected learning to student-directed learning approaches. This is evident to greater or lesser extents in both Special/Inclusive Education and Classroom Management. At the student-directed end of the continuum is the approach of the University of Sydney which adopts a student inquiry methodology for course delivery in both Special/ Inclusive Education and Classroom Management. Fundamental to this approach is the use of case studies for the exploration of different philosophies and pedagogical approaches, and the examination of how these are interpreted by teachers in a range of classroom contexts. The intent of this approach is to enable teacher education students to understand how teachers make decisions as they work with diverse students in classrooms. Ultimately teacher education students are encouraged to develop their own philosophy of teaching and learning, embedded in their approach to management. Charles Sturt University also operates at the more student-directed end of the continuum with an approach based on the theoretical underpinnings of "complexity and self-organisational theory, using key principles of embedded design, feedback and common scheme". The intent is to have teacher education students become self-organising, inclusive educators through the process of research, design, reflection and collaboration (see "Of special interest", Charles Sturt University). Towards the teacher-directed end of the continuum is the University of Technology, Sydney which is more prescriptive in its approach to Classroom Management, delivering selected content, based on the belief that teacher education students must be equipped with a well-defined, wellresearched set of practices to become effective teachers. University of NSW also adopts a more teacher-directed approach to Classroom Management centred on evidence-based practice. These universities are characteristic of all providers in that they include practices that range across the continuum from student-centred to teacher-centred. For example, the University of NSW also "has a focus on teacher education students taking responsibility for their learning". Many providers adopt what could be termed a "constructivist" approach. For example, Macquarie University, in its approach to Classroom Management, requires teacher education students to learn about several approaches and make their own judgements about the strengths and weaknesses of each. These are incorporated with their experiences to make their own unique approach. This involves both teacher-directed and student-directed learning. In general providers use a range of methodologies reflective of teacher-centred and

student-centred approaches, such as delivery of research-based lectures, case study analysis, development of personal philosophies, critical reflection, experiential learning etc.

Providers adopt a range of modes for the delivery of content in their Special/Inclusive Education and Classroom Management units. Some units are conducted primarily face to face, for example University of Wollongong and Avondale College. Other units are conducted entirely in distance mode, for example some units at Southern Cross University where teacher education students are presented with online lecture content, including PowerPoint presentations and recorded lectures, and are required to complete study guides and activities and attend online discussion forums. In some circumstances teacher education students are able to elect whether they will study face-to-face or by distance, for example University of New England where off-campus students receive edited versions of their lectures by podcast, and PowerPoint presentations online. In lieu of on-campus workshops online discussion forums are provided for distance students. In the case of University of New England, distance education is supported through the innovative "Future Campus" based at Parramatta and regional study centres. In other circumstances providers present their units in mixed/blended delivery mode combining both face-to-face and online learning, for example University of Western Sydney where this is seen not only as enhancing flexibility but as a model for best classroom practice. Macquarie University adopts a model of blended learning by presenting its unit in Special/Inclusive Education both to internal and external students via two recorded lectures each week (25 in total) published on their iLearn platform. On-campus students must attend a one-hour weekly face-to-face tutorial, and external students must attend a two-day compulsory oncampus school in lieu of the tutorials. Alphacrucis College students study primarily by distance with a mixed mode of delivery including online learning, a week of intensive oncampus workshops, community visits, school visits and professional experience. Morling College has a similar model with students required to be on campus for several days and then work through a study guide, directed reading, materials presented in audio format and case studies, along with keeping a journal.

Teaching approach and content Most programs have adopted a noncategorical approach to Special/ Inclusive Education, with some providers articulating this in their philosophical statements, that is the University of Newcastle and Charles Sturt University. This means that, in the main, children who have special education needs are not considered under disability labels. In some cases however, providers have found it

advantageous to consider groups of students by disability type for at least a few topics in their units. For example, the University of Wollongong includes categories of language and communication difficulties, intellectual impairment, physical impairment, learning difficulties/specific learning difficulties and Autism Spectrum Disorder. Implications of those disabilities and teaching and learning strategies are integrated throughout the categorical topics in addition to coverage in stand-alone topics, which include differentiation and managing the differentiated classroom. The University of New South Wales chooses to categorise students under the headings "high incidence disabilities", "mental health issues" and "low incidence disabilities", and to address learner characteristics and teaching strategies according to those categories, along with additional stand-alone topics. Charles Sturt University addresses types of disabilities in the classroom in one topic which includes Autism and twice exceptionality (i.e. being both gifted/talented and having a disability). At least six providers have also chosen to address Gifted and Talented Children in the Special/Inclusive Education unit (Avondale College, Conservatorium of Music, Morling College, Australian Catholic University, Alphacrucis College and University of Notre Dame). At least two providers address indigenous students (University of NSW, Alphacrucis College) in the core Special/Inclusive Education units. The University of New England does not use disability categories, preferring to focus on "using an instructional planning model", and also placing emphasis on support teams. The University of Sydney also does not use categories and focuses on a "teaching and learning cycle ... and quality learning". In some cases where treatment is entirely non-categorical, for example, Australian Catholic University and Avondale College, students are required to address a specific disability in their assessments. However, consistent among many providers is special attention paid to Autism Spectrum Disorder. Discussion with key personnel in universities/colleges revealed this was a reflection of feedback from in-school teachers and executive staff, who are themselves seeking further education to enhance their competence to teach an increasing number of children diagnosed with Autism. At least 10 of the providers include specific topics on Classroom/ Behaviour Management in core Special/Inclusive Education units (Avondale College, Wesley Institute, Morling College, Macquarie University, Australian College of Physical Education, University of Technology, Sydney, University of Western Sydney, University of Notre Dame, University of Sydney and Southern Cross University). In general, however, apart from legislation (which is featured as a topic in all courses), the focus of all units is on strategies for teachers to use in classrooms. These strategies generally address the identification and assessment of student needs and designing and implementing individual

programs. Curriculum-based assessment and differentiation feature in most courses, along with concepts of accommodation, adjustments, modification and adaptations. Working with families and support staff to assist teachers to cater for students with special needs is also addressed.

Globally as well as in Europe, there is a clear move towards inclusive practice and wide agreement on the key principles first encompassed in the Salamanca Statement (UNESCO, 1994). Since that time, these principles have been reinforced by many conventions, declarations and recommendations at European and global levels, including the UN Convention on the Rights of Persons with Disabilities (2006), which makes explicit reference to the importance of ensuring inclusive systems of education. The UNESCO Policy Guidelines on Inclusion in Education (2009) set out the following justifications for working towards inclusive practices and educating all children together: Educational justification. Inclusive schools have to develop ways of teaching that respond to individual differences and benefit all children. Social justification. Inclusive schools are able to change attitudes towards diversity and form the basis for a just, non-discriminatory society. Economic justification. It costs less to establish and maintain schools that educate all children together than to set up a complex system of different schools 'specialising' in different groups of children. The Agency Teacher Education for Inclusion project uses the following definition of inclusion, which is significantly broader than earlier definitions that have often focused on the dilemma between special education and 'integration' into mainstream school. The UNESCO (2008) definition states that inclusive education is: 'an ongoing process aimed at offering quality education for all while respecting diversity and the different needs and abilities, characteristics and learning expectations of the students and communities, eliminating all forms of discrimination' (p. 3). It is clear, then, that thinking has moved on beyond the narrow idea of inclusion as a means of understanding and overcoming a deficit and it is now widely accepted that it concerns issues of gender, ethnicity, class, social conditions, health and human rights encompassing universal involvement, access, participation and achievement (Ouane, 2008). Arnesen et al. (2009) notes that 'inclusion may be understood not just as adding on to existing structures, but as a process of transforming societies, communities and institutions such as schools to become diversity-sensitive' (p. 46). The authors make the point that the international commitment to human rights has led to a changing view and a reduced emphasis on an individual's 'disability' which has, in turn, led to its classification as 'socio-cultural'. This view is consistent with the disability studies perspective which recognises disability as 'another interesting way to be alive' (Smith et al., 2009) and sees individual support

as the norm for all learners. More specifically regarding teacher education, Ballard (2003) says that inclusive education is concerned with issues of social justice, which means that graduates entering the teaching profession should 'understand how they might create classrooms and schools that address issues of respect, fairness and equity. As part of this endeavour, they will need to understand the historical, socio-cultural and ideological contexts that create discriminatory and oppressive practices in education. The isolation and rejection of disabled students is but one area of injustice. Others include gender discrimination, poverty and racism' (p. 59). The ideology of inclusive education, as outlined above, is implemented in different ways across different contexts and varies with national policies and priorities which are in turn influenced by a whole range of social, cultural, historical and political issues. When considering policy and practice for inclusive education across countries, therefore, it is important to keep in mind that policy makers and practitioners are not always talking about the same thing (Watkins and D'Alessio, 2009). Mitchell (2005) states: 'Since there is no one model of inclusive education that suits every country's circumstances, caution must be exercised in exporting and importing a particular model. While countries can learn from others' experiences, it is important that they give due consideration to their own socialeconomic-political-cultural-historical singularities' (p. 19). Despite differences in national contexts, it has been possible to highlight the key principles of inclusive policies agreed upon by Agency member countries in the report Key Principles for Promoting Quality in Inclusive Education (2009). The inter-related and mutually supporting key principles, which summarise the Agency perspective, are as follows: – Widening participation to increase educational opportunity for all learners; – Education and training in inclusive education for all teachers; – Organisational culture and ethos that promotes inclusion; – Support structures organised so as to promote inclusion; – Flexible resourcing systems that promote inclusion; – Policies that promote inclusion; – Legislation that promotes inclusion.

Regarding teacher education to meet more diverse needs, the European Commission Communication Improving the Quality of Teacher Education (3/08/2007), calls for different policy measures on the level of member states in order to adapt the profession to meet the new challenges of the knowledge-based economy. It states: 'Changes in education and in society place new demands on the teaching profession, [...] classrooms now contain a more heterogeneous mix of young people from different backgrounds and with different levels of ability and disability. [...] These changes require teachers not only to acquire new knowledge and skills but also to develop them continuously' (p. 4). It states that teachers have a key role to play in preparing pupils to take their place in society and in the world

of work and points out that teachers in particular need the skills necessary to: – Identify the specific needs of each individual learner, and respond to them by deploying a wide range of teaching strategies; – Support the development of young people into fully autonomous lifelong learners; – Help young people to acquire the competences listed in the European Reference Framework of Key Competences; – Work in multicultural settings (including an understanding of the value of diversity, and respect for difference); – Work in close collaboration with colleagues, parents and the wider community. Further to this, in the Conclusions of the European Council on improving the quality of teacher education (15/11/2007), ministers responsible for education agreed amongst other things, that teachers should: – Possess pedagogical skills as well as specialist knowledge of their subjects; – Have access to effective early career support programmes at the start of their career; – Have sufficient incentives throughout their careers to review their learning needs and to acquire new knowledge, skills and competence; – Be able to teach key competences and to teach effectively in heterogeneous classes; – Engage in reflective practice and research; – Be autonomous learners in their own career-long professional development. The Communication from the Commission on improving competences for the 21st Century: An agenda for European cooperation in schools (03/07/2008) also highlights the need for initial teacher training to improve the balance between theory and practice and to present teaching as a problem-solving or research-in-action activity linked more to pupils' and students' learning and progress. The increasingly diverse mix of students in many schools and the need to pay more attention to the learning needs of individual pupils was noted in the European Parliament resolution on improving the quality of teacher education (23/09/2008) which stated that 'the challenges faced by the teaching profession are increasing as educational environments become more complex and heterogeneous' (p. 2).

- **Revision**

- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

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Points for Discussion

Points for Clarification

- References / Further Readings

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Block 5: Therapeutic Intervention

Unit 1: Occupational Therapy – Definition, Objective, Scope, Modalities and Intervention

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

Occupational Therapy is the branch of Medicine associated with Occupational Science and the optimisation of human health, functional performance and quality of life.
An OT performs Assessment of physical and cognitive function,ergonomics, posture & normal movement, specialist seating (wheelchairs & seating).

They Specialise in the following areas:
Stroke
Paediatrics
Neurology
Burns
General Medicine
Eldery Medicine
Surgery
Orthopedics
Psychiatry (PTSD-MoD, NHS,Emergency Services)
Rehabilitation Medicine
Oncology & Palliative Care
Hand Therapy
Pain Management
Ergonomics
Housing Adaptations
Private Practice/GP-NHS/Hospital-NHS/Schools and Clinics.

According to the *Merriam-Webster Dictionary*, occupational therapy is, "creative activity prescribed for its effect in promoting recovery or rehabilitation." I chose to research this career for many reasons. First, many occupational therapy patients are children, and I love to be with and work with kids. Second, I am passionate about helping people, and helping them medically has always been a keen interest of mine. Third, I have always had a heart for the physically and mentally challenged. Additionally, I have often been told that I would make a great therapist. After shadowing a pediatric occupational therapist, I know that occupational therapy is the career I want to pursue.

The United States Department of Labor explains that, "Occupational therapists treat patients with injuries, illnesses, or disabilities through the therapeutic use of everyday activities. They help these patients develop, recover, and improve the skills needed for daily living and working." Occupational therapists strive to make their clients as independent as possible. To do so, the therapist must assess the client's condition, interests, needs, and potential in order to establish a personalized treatment plan. Once the plan is made, the therapist, client, and client's family work together through varying types of exercises to achieve the set goals.

To be an occupational therapist, one must have specific education and training. First, most students are required to have a bachelor's degree in "biology, psychology, sociology or liberal arts" (Nau). Second, most master's degree programs require that the student has participated in a volunteer internship within the field of occupational therapy. Third, the student must have a master's or doctoral degree. In addition, to be an occupational therapist, one must pass the National Board of Certification in Occupational Therapy Exam. Once the student has passed the exam, they must get a license in order to practice. Then, they are equipped to find a job and start their career. While many colleges offer bachelor's degrees in biology, psychology, sociology, liberal arts, or health science, the only school in South Carolina that offers a master's degree in occupational therapy is the Medical University of South Carolina.

Many skills, hard and soft, are needed in order to be an occupational therapist. Hard skills, or technical skills, are learned in college and through other life experiences and are crucial for any medical career. Occupational therapists are required to know all of the core medical information and facts needed to do their jobs. In addition, they must also learn written communication skills, technology skills, cognitive skills, advanced verbal

communication skills, and intense motor skills. Written skills are needed to write and record information efficiently; many records are through computers so one must know how to use the provided technology. Therapists must be able to problem solve, analyze data, use computers, record and store data, and diagnose; those are all cognitive skills. Hard skills, such as these, are needed to be an OT.

In addition, "Soft skills are personal attributes that enhance an individual's interactions, job performance, and career prospects... soft skills are interpersonal and broadly applicable" (Rouse). Many soft skills, like adaption skills, interpersonal skills, stress management skills, observational skills, and the desire to help others, are needed to be an occupational therapist. New treatments are discovered regularly, so one must be able to adapt to new ways of treating patients. Interpersonal skills are all about communicating well; managing stress, while not easy, is crucial to the job. Pediatric occupational therapist, Lori Griffith, stated that one must have good "people skills" to be an effective OT. She also said that one must have a passion of "caring for others," and that "time management" is a must.

- **Objectives**

"All you have to do is know where you're going. The answers will come to you of their own accord." - Earl Nightingale. For the longest time I wasn't sure where I was going. I was beginning the last year of my undergrad and was apprehensive about what do to next. While chatting with a friend about my concerns she suggested occupational therapy and for some reason it immediately sparked my interest. I began a furious search of the role of an occupational therapist and discovered that is where I want to go and by obtaining a Master's in occupational therapy I will find the answers. What most intrigues me most about occupational therapy is the multitude of opportunities within the discipline. Occupational therapists have the chance to interact with people of all ages to help them find purpose in their lives and create environments for them to actively participate in society. Previously I was determined to work with children because of the joy that my previous experiences with them have brought me. Coaching figure skating, teaching swimming lessons, and running summer day camps has lead me yearning to continue to work with children. However, my recent experiences with a group of seniors at the Gorge Road Hospital and Burdett House, in combination with an adult development course at the University of Victoria, have changed my perspective of older adults. I have found that age does not matter, it all just depends on your attitude and your ability to form relationships with many different types of people. Another appealing aspect of occupational therapy is the opportunity to get

involved in the community and provide assistance to those trying to overcome a mental or physical obstacle in their life. Our society is fast paced and unwilling to help those that don't fit into our norms and to be able to aid someone to function on their own, or provide them with the support they require to do so, would be an exciting challenge for me. While running summer day camps I was approached by a parent of an Autistic boy who had seen the ad for FunSeekers and had wanted to join in on the fun. Naturally the parent was concerned that her son would have a difficult time fitting in with the rest of the children since he could be difficult to handle sometimes. I had never dealt with an Autistic child before but was willing to give him a chance. He certainly was a handful and at times, and made my day very stressful, but I quickly learned his pattern of behaviour and could easily predict when he was approaching a meltdown. Most of the time all I had to do was distract him with another activity or give him a chance to calm down and have a moment to himself. I also found that after this I could more readily see different behavioral patterns in the other children I worked with became adept at maintaining the happiness of the group. Reflecting back I realize I have been a mediator on many ocasions and have enjoyed making sure that everyone can participate despite any disabilities. According to the World Federation of Occupational Therapists, occupational therapy is a profession concerned with promoting health and well-being through occupation. From my understanding you must be able to assess the reasons for difficulty in and individuals, or groups, daily activities and how it affects their well-being. After initial assessment the therapist must then be able to search out an appropriate way to adjust their lifestyle or occupation that will promote their well-being. Difficulties can include both mental and physical illness. Throughout my undergraduate education I have taken courses such as anatomy, physiology, and biology that have expanded my knowledge of the physical body as well as psychology courses in development, neuroscience, and abnormal psychology, which have educated me on the mental body. I believe that because of this extensive background knowledge from many aspects of the body, along with my personal experiences with people of all ages, I would be extremely capable of providing a creative and adequately suited solution for those requiring assistance.

Recently I have taken up running and it has taught me the fine art of dedication. During the beginning of my post-secondary education I felt that if I could pass a course without studying what was the point in wasting my time studying just in order to get a better grade? I applied this same theory to running and signed up for the Royal Victoria Half Marathon. I figure that as long as I went on a couple longer runs right before the marathon I would be fine. I was wrong and definitely paid for it after the marathon. I came to

the realization that it is called a marathon for a reason and it requires lots of training. Sure I ran the half marathon but it was extremely challenging and at the finish line I was left feeling dissappointed with myself because I knew I could do better. From that day on I have been running every week in order to build my stamina in order to redeem myself in the Red Deer Marathon in May 2010. From this I also realized that I wasn't applying whole self to my education either and was disappointed. That passing a course isn't what matters or the grade that you get but rather the knowledge you gain. Similar to how running a marathon isn't about crossing the finish line but rather proving how dedicated you are to your passion and willing to push yourself as far, and as fast, as you can.
The combination of my newly found determination, the need for a challenge, a desire to learn, problem solving abilities, and past experiences are applicable to what I believe is the role of an occupational therapist. I hope to be the person that can rearrange someone life back to normal when their world has flipped upside down.

- **Definitions**

"Occupational therapy is the use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, poverty and cultural differences or the aging process, in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultations. Specific occupational therapy services include teaching daily living skills; developing perceptual motor skills and sensory integrative functioning; developing play skills and prevocational and leisure capacities; designing, fabricating or applying selecting orthotic and prosthetic devices or selective adaptive equipment; using specifically designed crafts and exercises to enhance functional performance; administering and interpreting tests such as manual muscle testing and range of motion; and adapting environments for the handicapped. These services are provided individually, in groups, or through social systems."

- **Summary**

Occupational therapy practitioners ask, "What matters to you?" not, "What's the matter with you?"
In its simplest terms, occupational therapists and occupational therapy assistants help people across the lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, helping people recovering from injury to regain skills, and providing supports

for older adults experiencing physical and cognitive changes. Occupational therapy services typically include:

- an individualized evaluation, during which the client/family and occupational therapist determine the person's goals,
- customized intervention to improve the person's ability to perform daily activities and reach the goals, and
- an outcomes evaluation to ensure that the goals are being met and/or make changes to the intervention plan.

Occupational therapy services may include comprehensive evaluations of the client's home and other environments (e.g., workplace, school), recommendations for adaptive equipment and training in its use, and guidance and education for family members and caregivers. Occupational therapy practitioners have a holistic perspective, in which the focus is on adapting the environment to fit the person, and the person is an integral part of the therapy team.

Occupational therapy (**OT**) is the use of assessment and treatment to develop, recover, or maintain the daily living and work skills of people with a physical, mental, or cognitive disorder. Occupational therapists also focus much of their work on identifying and eliminating environmental barriers to independence and participation in daily activities.[1] Occupational therapy is a client-centered practice that places emphasis on the progress towards the client's goals.[2] Occupational therapy interventions focus on adapting the environment, modifying the task, teaching the skill, and educating the client/family in order to increase participation in and performance of daily activities, particularly those that are meaningful to the client. Occupational therapists often work closely with professionals in physical therapy, speech therapy, nursing, social work, and the community.

The term "Occupational therapy" can often be confusing. It carries the misconception that the profession's focus is on vocational counseling and job training. The word occupation as defined in *Webster's Dictionary* is "an activity in which one engages." Occupational therapists promote skill development and independence in all daily activities. For an adult, this may mean looking at the areas of self-care, home-making, leisure, and work. The "occupations" of childhood may include playing in the park with friends, washing hands, going to the bathroom, cutting with scissors, drawing, etc[3]

The earliest evidence of using occupations as a method of therapy can be found in ancient times. In c. 100 BCE, Greek physician Asclepiades initiated humane treatment of patients with mental illness using therapeutic baths, massage, exercise, and music. Later, the Roman Celsus prescribed music, travel, conversation and exercise to his patients. However, by medieval

times the use of these strategies with people considered to be insane was rare, if not nonexistent.[4]

In 18th-century Europe, revolutionaries such as Philippe Pinel and Johann Christian Reil reformed the hospital system. Instead of the use of metal chains and restraints, their institutions utilized rigorous work and leisure activities in the late 18th century. This was the era of Moral Treatment, developed in Europe during the Age of Enlightenment, where the roots of occupational therapy lie.[5] Although it was thriving abroad, interest in the reform movement waxed and waned in the United States throughout the 19th century. It re-emerged in the early decades of the 20th century as Occupational Therapy.

The Arts and Crafts movement that flourished between 1860 and 1910 also impacted occupational therapy. In a recently industrialized society, the arts and crafts societies emerged against the monotony and lost autonomy of factory work .[6] Arts and crafts were utilized as a way of promoting learning through doing and provided an outlet for creative energy and a way of avoiding the boredom that was associated with long hospital stays, both for mental illness and for tuberculosis.

Occupational therapists continue to work in the field of mental health, many universities place a strong emphasis on training students in psycho-social occupational therapy.

The health profession of occupational therapy was conceived in the early 1910s as a reflection of the Progressive Era. Early professionals merged highly valued ideals, such as having a strong work ethic and the importance of crafting with one's own hands with scientific and medical principles.[4] The National Society for the Promotion of Occupational Therapy, now called the American Occupational Therapy Association(AOTA), was founded in 1917 and the profession of Occupational Therapy was officially named in 1920.

The emergence of occupational therapy challenged the views of mainstream scientific medicine. Instead of focusing on purely physical etiologies, occupational therapists argued that a complex combination of social, economic, and biological reasons cause dysfunction. Principles and techniques were borrowed from many disciplines—including but not limited to nursing, psychiatry, rehabilitation, self-help, orthopedics, and social work—to enrich the profession's scope. Between 1900 and 1930, the founders defined the realm of practice and developed supporting theories. By the early 1930s, AOTA had established educational guidelines and accreditation procedures [7]

World War I forced the new profession to clarify its role in the medical domain and to standardize training and practice. In addition to clarifying its public image, occupational therapy also established clinics, workshops, and training schools nationwide. Due to the overwhelming number of wartime injuries, "reconstruction aides" (an umbrella term for occupational therapy aides and physiotherapy aides, now known as physical therapists) were recruited by the Surgeon General. Between 1917 and 1920, nearly 148,000 wounded men were placed in hospitals upon their return to the states. This number does not account for those wounded abroad. The success of the reconstruction aides, largely made up of women trying to "do their bit" to help with the war effort, was a great accomplishment. Post-war, however, there was a struggle to keep people in the profession. Emphasis shifted from the altruistic war-time mentality to the financial, professional, and personal satisfaction that comes with being a therapist. To make the profession more appealing, practice was standardized, as was the curriculum. Entry and exit criteria were established, and the American Occupational Therapy Association advocated for steady employment, decent wages, and fair working conditions. Via these methods, occupational therapy sought and obtained medical legitimacy in the 1920s.[4]

Occupational therapy. Toy making in psychiatric hospital. World War 1 era.

The profession has continued to grow and expand its scope and settings of practice. Occupational science, the study of occupation, was created in 1989 as a tool for providing evidence-based research to support and advance the practice of occupational therapy, as well as offer a basic science to study topics surrounding "occupation".[8]

The philosophy of occupational therapy has changed over the history of the profession. The philosophy articulated by the founders owed much to the ideals ofromanticism,[9] pragmatism[10] and humanism which are collectively considered the fundamental ideologies of the past century.[11][12][13]

One of the most widely cited early papers about the philosophy of occupational therapy was presented by Adolf Meyer, a psychiatrist who had emigrated to the United States from Switzerland in the late 19th century and who was invited to present his views to a gathering of the new Occupational Therapy Society in 1922. At the time, Dr. Meyer was one of the leading psychiatrists in the United States and head of the new psychiatry department and Phipps Clinic at Johns Hopkins University in Baltimore, Maryland.[14][15]

William Rush Dunton, a supporter of the National Society for the Promotion of Occupational Therapy, now the American Occupational Therapy Association, sought to promote the ideas that occupation is a basic human need, and that occupation is therapeutic. From his statements came some of the basic assumptions of occupational therapy, which include:

- Occupation has a positive effect on health and well-being.
- Occupation creates structure and organizes time.
- Occupation brings meaning to life, culturally and personally.
- Occupations are individual. People value different occupations.[16]

These philosophies have been elaborated on over time in order to form the values that underpin the Codes of Ethics issued by each national association. However, the relevance of occupation to health and well-being remains the central theme. Influenced by criticism from medicine and the multitude of physical disabilities resulting from World War II, occupational therapy adopted a more reductionistic philosophy for a time. While this approach led to developments in technical knowledge about occupational performance, clinicians became increasingly disillusioned and re-considered these beliefs.[17][18] As a result, client centeredness and occupation have re-emerged as dominant themes in the profession.[19][20][21] Over the past century, the underlying philosophy of occupational therapy has evolved from being a diversion from illness, to treatment, to enablement through meaningful occupation.[16] This became evident through the development and widespread adoption of the Canadian Model of Occupational Performance.

The two most commonly mentioned values are that occupation is essential for health and the concept of holism. However, there have been some dissenting voices. Mocellin in particular advocated abandoning the notion of health through occupation as obsolete in the modern world and questioned the appropriateness of advocating holism when practice rarely supports it.[22][23][24] The values formulated by the American Occupational Therapy Association have also been critiqued as being therapist centred and not reflecting the modern reality of multicultural practice.[25][26]

Central to the philosophy of occupational therapy is the concept of occupational performance. In considering occupational performance the therapist must consider the many factors that comprise overall performance. This concept is made more tangible using models such as the person-environment-occupation model proposed by Law et al. (1996) and the Person-Environment-Occupation-Performance (PEOP) model developed at the same time by Christiansen and Baum in the United States.[27][28] This approach highlights the importance of satisfactions in one's occupations, broadening the aim of occupational therapy beyond the mere completion of tasks to the holistic achievement of personal well-being.

In recent times occupational therapy practitioners have challenged themselves to think more broadly about the potential scope of the profession, and expanded it to include working with groups experiencing occupational deprivation which stems from sources other than disability.[29] Examples of new and emerging practice areas would include therapists working with refugees,[30] children experiencing obesity,[31] and people experiencing homelessness.[32]

The expanded version of the Canadian model of occupational performance and engagement (CMOP-E) encourages occupational therapists to think beyond just occupational performance and address other modes of occupational interaction such as occupational deprivation, competence, and justice. The broader notion of occupational engagement encompasses all that we do to become occupied and is congruent with how occupational therapists address issues of occupational enablement today.[16]

- **Revision**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

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Points for Clarification

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Unit 2: Physiotherapy – Definition, Objective, Scope, Modalities and Intervention

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

WHAT IS PHYSIOTHERAPY?

Physiotherapy is a healthcare profession that assesses, diagnoses, treats, and works to prevent disease and disability through physical means. Physiotherapists are experts in movement and function who work in partnership with their patients, assisting them to overcome movement disorders, which may have been present from birth, acquired through accident or injury, or are the result of ageing or life-changing events

Physiotherapy can help recover from injury, reduce pain and stiffness, and increase mobility. A physiotherapist can also help you prevent further injury by listening to your needs and working with you to plan the most appropriate treatment for your condition, including setting goals and treatment outcomes.

What sort of treatment do physiotherapists use?

Physiotherapists are trained to assess your condition, diagnose the problem, and help you understand what's wrong. Your treatment plan will take into account your lifestyle, activities, and general health.

The following are common treatment methods physiotherapists may use:

- exercise programs to improve mobility and strengthen muscles
- joint manipulation and mobilisation to reduce pain and stiffness

- muscle re-education to improve control
- airway clearance techniques and breathing exercises
- soft tissue mobilisation (massage)
- acupuncture
- hydrotherapy
- assistance with use of aids, splints, crutches, walking sticks and wheelchairs.

- **Objectives**

Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice.

They maintain health for people of all ages, helping patients to manage pain and prevent disease.

The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible.

Physiotherapy is a science-based profession and takes a 'whole person' approach to health and wellbeing, which includes the patient's general lifestyle.

At the core is the patient's involvement in their own care, through education, awareness, empowerment and participation in their treatment.

You can benefit from physiotherapy at any time in your life. Physiotherapy helps with **back pain** or sudden injury, managing long-term medical condition such as **asthma**, and in preparing for childbirth or a **sporting event**.

- **Definitions**

Physiotherapists are health care providers who practice in a wide array of fields including orthopedics, sports, pediatrics, neuroscience, gerontology, cardiorespiratory and women's health. Physiotherapists provide preventative, diagnostic and therapeutic services aimed at restoring function and preventing disabilities from disease, trauma or injury. Physiotherapists have a strong understanding of disease, special needs, injury, the healing

process and how the body functions. Physiotherapists have the ability to distinguish what is abnormal in posture, balance, movement and function.

I have had the privilege of working as a certified Kinesiologist at Merivale Professional Physiotherapy Centre as a certified Kinesiologist and physiotherapist assistant for the last six months. I have learned a tremendous amount about the health care profession, physiotherapy and people. Physiotherapists have a career that allows you to be active, meet various people from many different ethnic backgrounds and help people to overcome there ailments and injuries. Physiotherapy is challenging, rewarding and fascinating.

I believe that it takes a special person to become a physiotherapist. Physiotherapists must be charismatic, confident, intelligent, creative, energetic and motivated. Physiotherapists need to exude confidence, show compassion, and truly care about the well being of their patients. Problem solving skills, social skills, professionalism, and common sense are qualities that should be found in physiotherapists. Physiotherapists should have strong communication and practical skills and should welcome challenges. A physiotherapist should possess the ability to educate and to work as a member of a team.

As my knowledge grows from my experiences at the physiotherapy center my desire to learn and become a physiotherapist grows as well. I want to become a physiotherapist because I enjoy working closely with people

Physical therapy or **physiotherapy**(often abbreviated to **PT**) is a physical medicine and rehabilitation specialty that remediates impairments and promotes mobility, function, and quality of life through examination, diagnosis, prognosis, and physical intervention (therapy using mechanical force and movements). It is carried out by **physical therapists** (known as **physiotherapists**in most countries).

In addition to clinical practice, other activities encompassed in the physical therapy profession include research, education, consultation, and administration. In many settings, physical therapy services may be provided alongside, or in conjunction with, othermedical services.

Physical therapy involves the illnesses, or injuries that limit their abilities to move and perform functional activities as well as they would like in their daily lives.[1] PTs use an individual's history and physical examination to arrive at a diagnosis and establish a management plan and, when necessary, incorporate the results of laboratory and imaging studies like X-rays, CT-scan, or MRI findings. Electrodiagnostic testing (e.g.,electromyograms and nerve conduction velocity testing) may also be of

assistance.[2]PT management commonly includes prescription of or assistance with specific exercises, manual therapy and manipulation, mechanical devices such as traction, education, physical agents which includes heat, cold, electricity, sound waves, radiation, rays, prescription of assistive devices, prostheses, orthoses and other interventions. In addition, PTs work with individuals to prevent the loss of mobility before it occurs by developing fitness and wellness-oriented programs for healthier and more active lifestyles, providing services to individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan. This includes providing therapeutic treatment in circumstances where movement and function are threatened by aging, injury, disease or environmental factors. Functional movement is central to what it means to be healthy.

Physical therapy is a professional career which has many specialties including sports,neurology, wound care, EMG, cardiopulmonary, geriatrics, orthopaedic and pediatrics.Neurological rehabilitation is in particular a rapidly emerging field. PTs practice in many settings, such as private-owned physical therapy clinics, outpatient clinics or offices, health and wellness clinics, rehabilitation hospitals facilities, skilled nursing facilities, extended care facilities, private homes, education and research centers,schools, hospices, industrial and this workplaces or other occupational environments,fitness centers and sports training facilities.[3]

Physical therapists also practise in the non-patient care roles such as health policy,[4][5][6][7] health insurance, health care administration and as health care executives.[8][9] Physical therapists are involved in the medical-legal field serving as experts, performing peer review and independent medical examinations.

Education qualifications vary greatly by country. The span of education ranges from some countries having little formal education to others having doctoral degrees and post doctoral residencies and fellowships.[11][12]

- **Summary**

The primary physical therapy practitioner is the Physical Therapist (PT) who is trained and licensed to examine, evaluate, diagnose and treat impairment, functional limitations and disabilities in patients or clients. Physical Therapist education curricula in the United States culminate in a Doctor of Physical Therapy (DPT) degree,[25] but many currently practising PTs hold a Master of Physical Therapy degree, and some still hold a Bachelor's degree. Currently the education programs for physical therapy

have changed. The Master of Physical Therapy and Master of Science in Physical Therapy degrees are no longer offered, and the entry-level degree is the Doctor of Physical Therapy degree, which typically takes 3 years.[26] PTs who hold a Masters or bachelors in PT are encouraged to get their DPT because APTA's goal is for all PT's to be on a doctoral level.[27][WCPT recommends physical therapist entry-level educational programs be based on university or university-level studies, of a minimum of four years, independently validated and accredited.[28] Curricula in the United States are accredited by the Commission on Accreditation in Physical Therapy Education(CAPTE). According to CAPTE, as of 2012 there are 25,660 students currently enrolled in 210 accredited PT programs in the United States.[29]

The physical therapist professional curriculum includes content in the clinical sciences (e.g., content about the cardiovascular, pulmonary, endocrine, metabolic, gastrointestinal, genitourinary, integumentary, musculoskeletal, and neuromuscular systems and the medical and surgical conditions frequently seen by physical therapists).

Curricula for the Physical Therapist professional degree include:

- Screening to determine when patients/clients need further examination or consultation by a physical therapist or referral to another health care professional.
- Examination: Examine patients/clients by obtaining a history from them and from other sources. Examine patients/clients by performing systems reviews. Examine patients/clients by selecting and administering culturally appropriate and age related tests and measures. Tests and measures include, but are not limited to, those that assess: a. Aerobic Capacity/Endurance, b. Anthropometric Characteristics, c. Arousal, Attention, and Cognition, d. Assistive and Adaptive Devices, e. Circulation (Arterial, Venous, Lymphatic), f. Cranial and Peripheral Nerve Integrity, g. Environmental, Home, and Work (Job/School/Play) Barriers, h. Ergonomics and Body Mechanics, i. Gait, Locomotion, and Balance, j. Integumentary Integrity, k. Joint Integrity and Mobility, l. Motor Function (Motor Control and Motor Learning), m. Muscle Performance (including Strength, Power, and Endurance), n. Neuromotor Development and Sensory Integration, o. Orthotic, Protective, and Supportive Devices, p. Pain, q. Posture, r. Prosthetic Requirements, s. Range of Motion (including Muscle Length), t. Reflex Integrity, u. Self-Care and Home Management (including activities of daily living [ADL] and instrumental activities of daily living [IADL]), v. Sensory Integrity, w. Ventilation and

Respiration/Gas Exchange, x. Work (Job/School/Play), Community, and Leisure Integration or Reintegration (including IADL)

- Evaluation: Evaluate data from the examination (history, systems review, and tests and measures) to make clinical judgments regarding patients/clients.
- Diagnosis: Determine a diagnosis that guides future patient/client management.
- Prognosis: Determine patient/client prognoses.
- Plan of Care: Collaborate with patients/clients, family members, payers, other professionals, and other individuals to determine a plan of care that is acceptable, realistic, culturally competent, and patient-centered.
- Intervention:Provide physical therapy interventions to achieve patient/client goals and outcomes. Interventions include: a. Therapeutic Exercise, b. Functional Training in Self-Care and Home Management, c. Functional Training in Work (Job/School/Play), Community, and Leisure Integration or Reintegration, d. Manual Therapy Techniques (including Mobilization/Manipulation Thrust and Nonthrust Techniques), e. Prescription, Application, and, as Appropriate, Fabrication of Devices and Equipment, f. Airway Clearance Techniques, g. Integumentary Repair and Protection Techniques, h. Electrotherapeutic Modalities,
- Provide effective culturally competent instruction to patients/clients and others to achieve goals and outcomes.
- Prevention, Health Promotion, Fitness, and Wellness: Provide culturally competent physical therapy services for prevention, health promotion, fitness, and wellness to individuals, groups, and communities. Apply principles of prevention to defined population groups.
- Students completing a Doctor of Physical Therapy program are also required to successfully complete clinical internships prior to graduation.

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

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Unit 3: Speech Therapy – Definition, Objective, Scope and Types of Speech, Language and Hearing Disorders and Intervention

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

This paper provides a guide to good practice in school-aged education as defined by speech pathologists in Australia. It is addressed to: • speech pathologists working in schools • other speech pathologists who provide services to school aged students • those employing or purchasing the services of speech pathologists to work in schools • consumer groups who access speech pathology services in schools. The paper can also be used to inform government authorities, members of the educational team, consumers and the public about the major role speech pathologists have to play in the education of school-aged children and adolescents. It outlines key recommendations for organising and structuring these services, highlighting issues and areas for further development. Speech pathologists throughout Australia are employed in various ways to assist schools in the delivery of appropriate programs to students. Between states and between organisations, there is significant variation in the work parameters and employment conditions of speech pathologists working in schools. This paper describes processes and issues relevant to most services provided in school settings by speech pathologists. Where information is not applicable across the board, specific mention will be made.

speech pathologists in schools may be employed by education authorities, community services, hospitals, other health services, non-government agencies, or may be in private practice. Private practitioners may be contracted by parents, schools or by the entities listed above. As such, there is variation in terms of defining the "client" of the speech pathology services in schools – be it the family, school, school cluster, education authority or other agency. The "client" influences the purpose and processes used to

structure the service. Ultimately however, students with special needs in communication and/or oro-motor functioning remain the focus for all speech pathology services delivered in schools. Some information in this paper may not apply to private practice services delivered in school-sites. The unique issues relevant to this group have been highlighted in section 9, "Special Consideration: The Private Speech Pathologist in Schools".
The concept of a "school" is becoming more diverse, with differences in the entry and exit ages of students (0-19years) and the nature of programs delivered in school-type educational facilities (Organisation for Economic Cooperation and Development, 2002). While there are a number of education facilities in which speech pathologists work (Scope of Practice, 2002), this paper refers to services provided for children and adolescents attending Australian preschool, preparatory classes, primary, secondary and special education facilities coordinated by government and non-government sectors. The age and type of students enrolled in these facilities and their eligibility for the speech pathology service will be based on local and state/territory policies and procedures.

"Students with special needs in communication" is a broad term that includes all students with needs in communication regardless of the cause or underlying diagnosis. It includes: • students who experience communication difficulties that arise from a wide range of extrinsic factors, such as limited opportunity to communicate, or a mismatch between the language, dialect, and/or communication styles used at home and at school. It includes issues with cultural and linguistic diversity (CLD) for children from Aboriginal and Torres Strait Island (ATSI) and non-English speaking backgrounds. • students with communication disabilities, which may result from speech, language, physical, intellectual, hearing, vision or multiple impairments. Communication disability is a disability in generating and sending messages, and/or receiving and understanding messages. Communication disabilities can be transient or permanent and range from mild to severe. The term "special needs in communication" may involve the following (see Appendix 1 for definitions): • articulation • phonology • comprehending language • processing and/or using language • voice • fluency • metalinguistics • pragmatics, social skills, behaviour • semantics • syntax • morphology • aspects of literacy, numeracy, problem-solving and general learning • communication modes. Students with severe communication difficulties may be non-verbal, have limited expressive language, or be unintelligible or very difficult to understand. Some students' special needs in communication will be apparent early in school life manifested as unclear speech or difficulties in understanding and using oral language. Other students' needs may become apparent later when literacy

development, general learning or social skills are affected. Based on empirical studies of Australian and other English-speaking school-aged populations, students with special needs in communication represent up to 14% of the school population (Blum & Rosenthal, 1992; Blum-Harasty & Rosenthal, 1992; Harasty & Reed, 1994). There may be regional differences, particularly considering issues of cultural and linguistic diversity associated with children from Aboriginal and Torres Strait Island (ATSI) and non-English speaking backgrounds (Australian Bureau of Statistics, 1999). Difficulties in communication may impact on a child's ability to participate in classroom activities, to interact with the teacher and with peers, to understand directions, to retain new information, to reason, to use their language for a variety of purposes in curriculum activities and to learn to read and write (Catts & Kamhi, 1999; Cazden, 1988; Dockrell & Lindsay, 1998; American SpeechLanguage Hearing Association, 2001; Stothard, Snowling, Bishop, Chipchase & Kaplan, 1998, Goswami, 2002).

- **Objectives**

The primary focus of the education team is to provide students of all ages in schools with appropriate curriculum programs to facilitate development and the achievement of educational outcomes. The education team may be comprised of parents/guardians, teachers, teacher-assistants and other paraprofessionals, administrators, special educators, guidance officers, school counsellors, psychologists, speech pathologists and other therapists, fellow students and the school community. An "educational outcome is the intended result of the learning-teaching process that can be observed and demonstrated. Outcomes are embedded in a range of incidental and planned contexts that relate to children's cognitive, emotional, social, communicative and problem solving capabilities. They describe essential learnings about what children know, can do, can learn about themselves and can learn about getting along with others" (Education Queensland, 2002). Education authorities have a responsibility to provide appropriate educational programs to all students enrolled in schools. As learning and other higher level cognitive functions are mostly mediated through oral and written language (Vygotsky, 1986), students with special needs in communication and/or oro-motor functioning may require assistance to access the school curriculum, participate in activities and achieve education outcomes. Functional language, communication and oro-motor skills are essential in all aspects of civic life, including health and wellbeing, education and training, family and social relationships, recreation, and work. It is well documented that difficulties in language, communication and oro-motor functioning have major implications for: • school success • self-esteem • independence • peer relations • literacy and numeracy development •

behaviour and problem solving • occupation • economic self-sufficiency (Communication Disability and Speech-Language Impairment, 1993; American Speech-Language Hearing Association, 2000; Leigh & Lamorey, 1996; Westby, 1997). Speech pathologists, as part of the education team, have expertise to offer in the management of children and adolescents with special needs in communication and/or oro-motor functioning. Evidence suggests that significant value is added to school programs when teaching professionals are able to collaborate with speech pathologists to implement appropriate educational provisions for students with special needs across the curriculum on a daily basis (Wright & Graham, 1997; ASHA, 2000; ASHA, 2001; Kerrin, 1996; Stothard et al, 1998; Goswami, 2002; Stainback & Stainback, 1998; Bradley, King-Sears & Tessier-switlick., 1997).

- **Definitions**

This position statement refers to people who are in hospital and who have critical care needs. Critical care refers to the level of care given to a group of people who are deemed to be critically ill. Many people who are critically ill have requirements for support for their neurological, medical, respiratory and digestive systems, all of which can impact on their ability to communicate and swallow independently. The classification system set up by Comprehensive Critical Care was revised by the Intensive Care Society in 2009 and provides a helpful framework as follows: Level 0 Requires hospitalisation Needs can be met through normal ward care Level 1 Patients recently discharged from a higher level of care Patients in need of additional monitoring/clinical interventions, clinical input or advice Patients requiring critical care outreach service support Level 2 Patients needing pre-operative optimisation Patients needing extended postoperative care Patients stepping down to Level 2 care from Level 3 Patients receiving single organ support Basic respiratory support [>50% FiO2] Basic cardiovascular support Renal, Neurological, Dermatological or Hepatic support singly Level 3 Patients receiving advanced respiratory support alone or a minimum of two organs supported Patients receiving advanced cardiovascular support

Speech pathologists working in schools provide services in metropolitan, regional and rural settings. In Australia, speech pathologists in schools may be employed by education authorities, community services, hospitals, other health services, non-government agencies, or may be in private practice. Private practitioners may be contracted by parents/guardians, schools or by the entities listed above. As such, speech pathology services in schools may vary depending on the location, setting, facilities, nature of the "client", the student needs, historical factors, available resources (including the provision of related support services), organisational context and system

priorities. Speech pathologists working in education environments may utilise a range of service delivery models including (for example): • consultancy and provision of resources/support materials • collaboration with members of the education team in the development of curriculum, appropriate assessments and individual education programs • whole-class screening and programming with teachers • co-delivery of curriculum activities in the classroom • home, individual and group programming (See sections 6.2 "Prioritisation"; 6.6 "Assessment"; 6.8 "Intervention" for further examples of service delivery options.) An individual speech pathologist may work concurrently within a number of different: • service delivery models • student populations • facilities.

- **Summary**

While the focus of critical care is on levels of care rather than location, some patients require care in specialist ICUs such as neuroscience, cardiothoracic or burns. Many of these patients will require speech and language therapy input due to specific conditions which increase their risk of swallowing and communication problems. Patients exhibit a range of aetiologies (neurogenic or structural, e.g. unilateral vocal fold palsy following thoracic surgery or inhalation burns to the larynx). These patients often have complex swallowing and communication difficulties of multiple aetiologies. More generally, critical care patients are at risk of swallowing and communication problems as a result of muscle weakness, prolonged intubation and procedures such as tracheostomy (NIHCE CG 83). Some patients may also have difficulty in swallowing and communication as a result of muscle weakness, prolonged intubation or procedures such as tracheostomy. The prevalence of swallowing dysfunction after extubation has been reported in between 20% and 83% of patients intubated for longer than 48 hours (Leder et al, 1998; Tolep et al, 1996; Skoretz et al, 2010; Heffner 2010, NIHCE CG 83). There are three main causes of communication and/or oropharyngeal swallowing disorders in critical care patients: Organic communication or oropharyngeal swallowing disorders, such as• those caused by stroke, major trauma, head injury, Guillian Barre syndrome, post-surgery to the oral cavity/pharynx or larynx, chronic obstructive pulmonary disorder (Martin-Harris-B 2001), Adult Respiratory Distress Syndrome (ARDS), spinal cord injury, tumours, etc. Concomitant communication or oropharyngeal swallowing disorders, such• as the effects of critical care neuropathy (due to disuse atrophy of striated muscle) or the effects of technologies to prolong life/enable clinical management of the illness such as mechanical ventilation, tracheostomy tubes, nasogastric tubes and naso-pharyngeal airways (Conlan and Kopec 2000; Pannunzio 1996). Psychogenic communication or oropharyngeal swallowing disorders,

such as those resulting from critical care psychosis, delirium or clinical depression. In addition, within the ICU environment an undervaluing of communication can occur due to the level of arousal and medications (Hemsley et al, 2001). Mechanically-ventilated people report high levels of frustration when communicating their needs (Patak et al, 2004).

Approximately 18.5% of hospitalised people require treatment in a critical care environment (Level 1-3) (North West London Critical Care network critical illness audit, 2003). Recent data presented at the 2011 UK Intensive Care Society Conference reported a current provision of 3,747 critical care beds across 156 ICUs with admissions increasing year on year. In 1996 there were 85,000 admissions rising to 120,000 in the year 2000, and 201,000 in 2009. Importantly, admission of 80+ year olds has doubled between 1996 and 2009, to 1,700. This is due to a combination of factors such as people living longer, improvements in healthcare technologies and raised expectations of survival. Tracheostomies are also increasingly commonplace. Recent work undertaken in the North West of England (McGrath, National Tracheostomy Safety Project 2013) extrapolating from HES statistics, has estimated approximately 15,000 percutaneous tracheostomies are managed in England's critical care units annually. The implications of this, along with the growing critical care population, are an increasing demand for speech and language therapy in order to meet swallowing and communication needs. The literature reports a high range (50-76%) of aspiration in the critical care population (Elpern et al, 1987; DeVita and Spierer-Rundback, 1990; Elpern et al 1994; Tolep et al, 1996; Leder, 2002; Gross et al, 2003; Toniolo and Soneghet, 2007; Barker et al, 2008; Hafner et al, 2008). The prevalence of swallowing dysfunction after extubation has been reported in between 20-83% of patients intubated for longer than 48 hours (Leder et al, 1998; Tolep et al, 1996). In particular, aspiration can frequently be seen in people requiring prolonged ventilation of three or more weeks (Elpern et al, 1994; Tolep et al, 1996; Leder, 2002). Long duration of mechanical ventilation was independently associated with postextubation dysphagia and the development of postextubation dysphagia has been independently associated with poor patient outcomes (Macht, 2011). There is a greater impact of aspiration in this vulnerable group, e.g. reduced mobility, reduced arousal, possible reduced awareness or cognitive impairment. However, there have been numerous difficulties in trying to establish the true prevalence and incidence of aspiration in the mechanically-ventilated population. The main reason for this is that aspiration is identified in different ways in different studies. Some studies employ bedside assessments (Elpern et al, 1987) and others use instrumental techniques (Leder, 2002; Gross et al, 2003). In the studies that have employed instrumental techniques it is reported that aspiration can be

"silent" or covert. This questions the veracity of those studies that have relied on overt aspiration detection; indeed, the true incidence of aspiration could be higher than is reported. The prevalence of communication difficulties in this population is reported to be between 16-24% (Thomas and Rodriguez, 2011). The inability to speak and the associated communication difficulties that result are a major source of stress for people who are or have been intubated (Menzel, 1998).

Many people who are critically ill have full decision-making capacity and should have access to the same level of services and choices offered to less critically-ill people in hospital. People who are critically ill have the right to maintain optimal use of their current communication and swallowing functions. Patients who do not have full decision-making capacity additionally have the right to have communication skills supported to optimise their capacity and the right to access 'Best Interest' processes in the informed absence of capacity.

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

References / Further Readings

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Unit 4: Yoga and Play therapy – Definition, Objective, Scope and Intervention

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

• Introduction

Art Therapy is a mental health profession in which clients, facilitated by the Art Therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem. (American Art Therapy Association)
Play Therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development. (Play Therapy Association)

Yoga Therapy uses yoga postures, breathing techniques, meditation and yogic philosophies to empower individuals towards improved health and well-being. (The International Association of Yoga Therapists)

• Objectives

Play is a child's natural form of communication. If we pay attention to how children are interacting with us, they are *always*communicating- in the form of play. Children do not need to be talking to be communicating with us. Children are excellent at communicating through play- but adults are not as excellent as noticing this natural form of communication and sometimes don't understand the significance play has. A child's "first" language, so to speak, is play. Their second language is their native verbal language. Even

when children are old enough to speak, communicate, and articulate their thoughts and feelings, their more natural more comfortable form of communication is still play. Play is intrinsic, inherently complete and universal.

Play is meaningful for a child in many ways. Children use play to work through issues they may be having. Children use play to try to understand different feelings they may be experiencing even if they do not understand why they are having such feelings. Often children do not have the verbal ability or cognitive understanding to communicate their thoughts and/or feelings with caring adults-thus play is imperative at helping children learn a secure sense of self, self worth, and coping skills, to name a few. Much research exists on the therapeutic value of play and how children are able to work through trauma, abuse, grief and loss, mental health concerns, behavioral concerns, developmental issues, general life stressors and much more. By utilizing play as a theoretical basis, Playing to Live! is able to harness a child's inner strength, build on resilience, and assist these children in further developing coping skills.

- **Definitions**

Yoga therapy (**Yoga** Chikitsa) is a modality for healing all parts of our being. Whether you are suffering from a serious condition, rehabilitating from a physical injury or surgery, or find yourself with mental and emotional imbalances, **Yoga Therapy** has much to offer you on your way back to vitality and wholeness.

Yoga therapy is a self-empowering process, where the care-seeker, with the help of the Yoga therapist, implements a personalized and evolving Yoga practice, that not only addresses the illness in a multi-dimensional manner, but also aims to alleviate his/her suffering in a progressive, non-invasive and complementary manner. Depending upon the nature of the illness, Yoga therapy can not only be preventative or curative, but also serve a means to manage the illness, or facilitate healing in the person at all levels.

TKV Desikachar & Kausthub Desikachar

Yoga therapy, derived from the Yoga tradition of Patanjali and the Ayurvedic system of health care refers to the adaptation and application of Yoga techniques and practices to help individuals facing health challenges at any level manage their condition, reduce symptoms, restore balance, increase vitality, and improve attitude.

Gary Kraftsow American Viniyoga Institute

Yoga therapy is that facet of the ancient science of Yoga that focuses on health and wellness at all levels of the person: physical, psychological, and spiritual. Yoga therapy focuses on the path of Yoga as a healing journey that brings balance to the body and mind through an experiential understanding of the primary intention of Yoga: awakening of Spirit, our essential nature.

Joseph LePage, M.A., Integrative Yoga Therapy (U.S.A.)

Yoga therapy adapts the practice of Yoga to the needs of people with specific or persistent health problems not usually addressed in a group class.

Larry Payne, Ph.D. Samata Yoga Center (U.S.A.)

Yoga therapy is the adaptation of yoga practices for people with health challenges. Yoga therapists prescribe specific regimens of postures, breathing exercises, and relaxation techniques to suit individual needs. Medical research shows that Yoga therapy is among the most effective complementary therapies for several common aliments. The challenges may be an illness, a temporary condition like pregnancy or childbirth, or a chronic condition associated with old age or infirmity.

Robin Monro, Ph.D. Yoga Biomedical Trust (England)

Yoga comprises a wide range of mind/body practices, from postural and breathing exercises to deep relaxation and meditation. Yoga therapy tailors these to the health needs of the individual. It helps to promote all-round positive health, as well as assisting particular medical conditions. The therapy is particularly appropriate for many chronic conditions that persist despite conventional medical treatment.

Marie Quail, Yoga Therapy and Training Center (Ireland)

The use of the techniques of Yoga to create, stimulate, and maintain an optimum state of physical, emotional, mental, and spiritual health.

Judith Hanson Lasater, Ph.D.

Yoga therapy consists of the application of yogic principles, methods, and techniques to specific human ailments. In its ideal application, Yoga therapy is preventive in nature, as is Yoga itself, but it is also restorative in many instances, palliative in others, and curative in many others.

Art Brownstein, M.D.

Yoga therapy may be defined as the application of yogic principles to a particular person with the objective of achieving a particular spiritual, psychological, or physiological goal. The means employed are comprised of intelligently conceived steps that include but are not limited to the components of Ashtanga Yoga, which includes the educational teachings of *yama*, *niyama*, *asana*, *pranayama*,*pratyahara*, *dharana*, *dhyana*, and *samadhi*. Also included are the application of meditation, textual study, spiritual or psychological counseling, chanting, imagery, prayer, and ritual to meet the needs of the individual. Yoga therapy respects individual differences in age, culture, religion, philosophy, occupation, and mental and physical health. The knowledgeable and competent yogin or yogini applies Yoga Therapy according to the period, the place, and the practitioner's age, strength, and activities.

Richard Miller, Ph.D.

Yoga therapy is of modern coinage and represents a first effort to integrate traditional yogic concepts and techniques with Western medical and psychological knowledge. Whereas traditional Yoga is primarily concerned with personal transcendence on the part of a "normal" or healthy individual, Yoga therapy aims at the holistic treatment of various kinds of psychological or somatic dysfunctions ranging from back problems to emotional distress. Both approaches, however, share an understanding of the human being as an integrated body-mind system, which can function optimally only when there is a state of dynamic balance.

Georg Feuerstein, Ph.D.

Yoga therapy is a holistic healing art. Rather than prescribe treatments, it invites presence and awareness. Using age-old yogic approaches to deeper

presence and awareness, we are able to know ourselves more fully. Out of that knowing, we are more easily moved to embrace the opportunity for change, growth, and enhanced well-being in body, feelings, thought, and spirit.

Michael Lee, Phoenix Rising Yoga Therapy

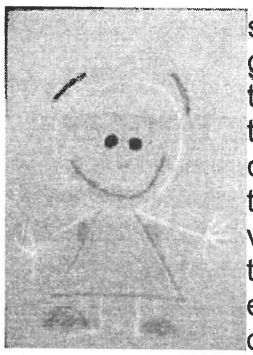
Yoga therapy is the application of Yoga to individuals to empower them to progress toward greater health and freedom from disease.

Ganesh Mohan, Svastha Yoga and Ayurveda

Play therapy refers to a method of psychotherapy with children in which a**therapist** uses a child's fantasies and the symbolic meanings of his or her **play** as a medium for understanding and communication with the child.

Play Therapy uses a variety of play and creative arts techniques (the 'Play Therapy Tool-Kit (TM)' to alleviate chronic, mild and moderate psychological and emotional conditions in children that are causing behavioural problems and/or are preventing children from realising their potential.

The Play Therapist works integratively using a wide range of play and creative arts techniques, mostly responding to the child's wishes. This distinguishes the Play Therapist from more specialised therapists (Art, Music, Drama etc).



This distinguishes the Play Therapist from more specialised therapists (Art, Music, Drama etc). The greater depth of skills and experience distinguishes a play therapist from those using therapeutic play skills. In order to become a Certified Play Therapist a minimum number of hours of supervised clinical work is required whilst in training. This varies according to country. These variations take into account the maturity of the play therapy profession, high in Canada and the USA , emergent in Europe and nascent in other countries. PTI does not want to discourage entrants to the profession where play therapy is not established because the training and practice hours are set too high. The minimum levels are set to ensure safe and effective practice.

- **Summary**

In recent years a growing number of noted mental health professionals have observed that play is as important to human happiness and well being as love and work (Schaefer, 1993). Some of the greatest thinkers of all time, including Aristotle and Plato, have reflected on why play is so fundamental in our lives. The following are some of the many benefits of play that have been described by play theorists.

Play is the child's language and ...

Play is a fun, enjoyable activity that elevates our spirits and brightens our outlook on life. It expands self-expression, self-knowledge, self-actualization and self-efficacy. Play relieves feelings of stress and boredom, connects us to people in a positive way, stimulates creative thinking and exploration, regulates our emotions, and boosts our ego (Landreth, 2002). In addition, play allows us to practice skills and roles needed for survival. Learning and development are best fostered through play (Russ, 2004).

WHAT IS PLAY THERAPY?

... toys are the child's words!

Initially developed in the turn of the 20th century, today play therapy refers to a large number of treatment methods, all applying the therapeutic benefits of play. Play therapy differs from regular play in that the therapist helps children to address and resolve their own problems. Play therapy builds on the natural way that children learn about themselves and their relationships in the world around them (Axline, 1947; Carmichael, 2006; Landreth, 2002). Through play therapy, children learn to communicate with others, express feelings, modify behavior, develop problem-solving skills, and learn a variety of ways of relating to others. Play provides a safe psychological distance from their problems and allows expression of thoughts and feelings appropriate to their development.

APT defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development."

HOW DOES PLAY THERAPY WORK?

Children are referred for play therapy to resolve their problems (Carmichael; 2006; Schaefer, 1993). Often, children have used up their own problem solving tools, and they misbehave, may act out at home, with friends, and at school (Landreth, 2002). Play therapy allows trained mental health

practitioners who specialize in play therapy, to assess and understand children's play. Further, play therapy is utilized to help children cope with difficult emotions and find solutions to problems (Moustakas, 1997; Reddy, Files-Hall, & Schaefer, 2005). By confronting problems in the clinical Play Therapy setting, children find healthier solutions. Play therapy allows children to change the way they think about, feel toward, and resolve their concerns (Kaugars & Russ, 2001). Even the most troubling problems can be confronted in play therapy and lasting resolutions can be discovered, rehearsed, mastered and adapted into lifelong strategies (Russ, 2004).

WHO BENEFITS FROM PLAY THERAPY?

Although everyone benefits, play therapy is especially appropriate for children ages 3 through 12 years old (Carmichael, 2006; Gil, 1991; Landreth, 2002; Schaefer, 1993). Teenagers and adults have also benefited from play techniques and recreational processes. To that end, use of play therapy with adults within mental health, agency, and other healthcare contexts is increasing (Pedro-Carroll & Reddy, 2005; Schaefer, 2003). In recent years, play therapy interventions have also been applied to infants and toddlers (Schaefer et. al., 2008).

HOW WILL PLAY THERAPY BENEFIT A CHILD?

Play therapy is implemented as a treatment of choice in mental health, school, agency, developmental, hospital, residential, and recreational settings, with clients of all ages (Carmichael, 2006; Reddy, Files-Hall, & Schaefer, 2005).

Play therapy treatment plans have been utilized as the primary intervention or as an adjunctive therapy for multiple *Mental Health Conditions and Concerns* (Gil & Drewes, 2004; Landreth, Sweeney, Ray, Homeyer, & Glover, 2005), e.g. anger management, grief and loss, divorce and family dissolution, and crisis and trauma, and for modification of *Behavioral Disorders* (Landreth, 2002), e.g. anxiety, depression, attention deficit hyperactivity (ADHD), autism or pervasive developmental, academic and social developmental, physical and learning disabilities, and conduct disorders (Bratton, Ray, & Rhine, 2005).

Research supports the effectiveness of play therapy with children experiencing a wide variety of social, emotional, behavioral, and learning problems, including: children whose problems are related to life stressors, such as divorce, death, relocation, hospitalization, chronic illness, assimilate stressful experiences, physical and sexual abuse, domestic violence, and

natural disasters (Reddy, Files-Hall, & Schaefer, 2005). Play therapy helps children:

- Become more responsible for behaviors and develop more successful strategies.
- Develop new and creative solutions to problems.
- Develop respect and acceptance of self and others.
- Learn to experience and express emotion.
- Cultivate empathy and respect for thoughts and feelings of others.
- Learn new social skills and relational skills with family.
- Develop self-efficacy and thus a better assuredness about their abilities.

Meta-analytic reviews of over 100 play therapy outcome studies (Bratton et. al., 2005; Leblanc & Ritchie, 2001) have found that the over-all treatment effect of play therapy ranges from moderate to high positive effects. Play therapy has proven equally effective across age, gender, and presenting problem. Additionally, positive treatment effects were found to be greatest when there was a parent actively involved in the child's treatment.

HOW LONG DOES PLAY THERAPY TAKE?

Each play therapy session varies in length but usually last about 30 to 50 minutes. Sessions are usually held weekly. Research suggests that it takes an average of 20 play therapy sessions to resolve the problems of the typical child referred for treatment. Of course, some children may improve much faster while more serious or ongoing problems may take longer to resolve (Carmichael, 2006; Landreth, 2002).

HOW MAY MY FAMILY BE INVOLVED IN PLAY THERAPY?

Families play an important role in children's healing processes. The interaction between children's problems and their families is always complex. Sometimes children develop problems as a way of signaling that there is something wrong in the family. Other times the entire family becomes distressed because the child's problems are so disruptive. In all cases, children and families heal faster when they work together.

The play therapist will make some decisions about how and when to involve some or all members of the family in the play therapy. At a minimum, the therapist will want to communicate regularly with the child's caretakers to develop a plan for resolving problems as they are identified and to monitor the progress of the treatment. Other options might include involving a) the

parents or caretakers directly in the treatment by modifying how they interact with the child at home and b) the whole family in family play therapy (Guerney, 2000). Whatever the level of involvement of the family members, they typically play an important role in the child's healing (Carey & Schaefer, 1994; Gil & Drewes, 2004).

- **Revision**
- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

- References / Further Readings

The international yoga association
Play therapy international

Unit 5: Therapeutic intervention: Visual and Performing Arts (eg: Music, Drama, Dance movement, Sports, etc.)

- **Introduction**
- **Objectives**
- **Definitions**
- **Summary**
- **Revision**
- **Assignment/Activity**
- **Points For Discussion And Clarification**
- References / Further Readings

- **Introduction**

Art intervention is an interaction with a previously existing artwork, audience, venue/space or situation. It has the auspice of conceptual art and is commonly a form of performance art. It is associated with the Viennese Actionists, the Dada movement and Neo-Dadaists. It has also been made much use of by the Stuckists to affect perceptions of other artwork which they oppose, and as a protest against an existing intervention.

Intervention can also refer to art which enters a situation outside the art world in an attempt to change the existing conditions there. For example, intervention art may attempt to change economic or political situations, or may attempt to make people aware of a condition that they previously had no knowledge of. Since these goals mean that intervention art necessarily addresses and engages with the public, some artists call their work "public interventions".

Although intervention by its very nature carries an implication of subversion, it is now accepted as a legitimate form of art and is often carried out with the endorsement of those in positions of authority over the artwork, audience or venue/space to be intervened in. However, unendorsed (i.e. illicit) interventions are common and lead to debate as to the distinction between art and vandalism.[1] By definition it is a challenge, or at the very least a comment, related to the earlier work or the theme of that work, or to the expectations of a particular audience, and more likely to fulfil that function to

its full potential when it is unilateral, although in these instances, it is almost certain that it will be viewed by authorities as unwelcome, if not vandalism, and not art.

- **Objectives**

Illicit confronts the approved[edit]

Although the legal technicalities are straightforward, when an unauthorised intervention intervenes in an officially-sanctioned one, the moral issues may be far less straightforward, especially when the legal act meets with widespread public disapproval (even to the point of considering it vandalism), while the illicit reaction to it satisfies a public sense of justice.

Occupying private land as art without permission[edit]
In Wellington, New Zealand (Jan. 1978) Barry Thomas illegally occupied a central city site that had lain vacant for 2.5 years, becoming an 'eyesore site' in the local media. Thomas planted 180 cabbage seedlings in the shape of the word cabbage and called it 'Vacant lot of cabbages'. It was soon added to by many other creative interventions - this political/'site/event specific' work lasted 6 months and ended with a week-long festival to promote native forest restoration. The work encouraged large amounts of public participation and with the media became known as the 'Soap box art corner' "Post Duchamp we had to take the readymades and art back - out for real world walks" (Thomas) http://blog.tepapa.govt.nz/2012/11/02/vacant-lot-of-cabbages-documentation-enters-te-papas-archives/.

String up the perpetrator, 2003[edit]
In spring 2003, artist Cornelia Parker intervened in Auguste Rodin's sculpture *The Kiss*(1886) in Tate Britain by wrapping it in a mile of string.[14] This was a historical reference to Marcel Duchamp's use of the same length of string to create a web inside a gallery. Although the intervention had been endorsed by the gallery, many people felt it offensive to the original artwork and an act of vandalism rather than art. This reaction then prompted a further, unauthorised, intervention, in which Parker's string was cut by Stuckist Piers Butler, while couples stood around engaging in live kissing.[15]

Sticking it to Goya, 2003[edit]
In 2003, Jake and Dinos Chapman montaged clown and other "funny" faces onto a set of etchings of Goya's *The Disasters of War* (which they had purchased), thereby intervening in the original work. Aside from complaints on the grounds of bad taste, this act was described by some as "defacement", although the set was a late 1930s printing. Ostensibly as a

protest against this piece, Aaron Barschak (who later became famous for gate-crashing Prince William's 21st birthday party dressed as Osama bin Laden in a frock) threw a pot of red paint over Jake Chapman during a talk he was giving in May 2003.

The Chapmans then added monster heads to Goya's *Los Caprichos* etchings and exhibited them at the White Cube in 2005 under the title *Like a dog returns to its vomit.* Like other interventionists they asserted this was an improvement on the original: "You can't vandalise something by making it more expensive." However, Dinos pointed out one problem: "sometimes it is difficult to make the original Goya etchings any nastier; in one I found a witch sexually molesting a baby.".[16]

Throwing something at boxes, 2006[edit]

Interventionist with object at the Jonathan Meese performance at Tate Modern.

Another example at the Tate was an intervention inRachel Whiteread's *Embankment* installation in the Turbine Hall of Tate Modern on February 25, 2006. Whiteread's site-specific installation consisted of large piles of white plastic cubes, made by using a mould from cardboard boxes. Jonathan Meese, a German performance artist had staged a scheduled event in this environment, erecting props, and giving a wild monologue. During this, an object was thrown, or fell, from the walkway over the hall, landing with a bang. This was seen as intentional and considered by some people an art intervention, while others thought it was simply vandalism.[17] A month later, the Tate pronounced on this incident, "works get interfered with all the time and people often are unsure of the boundaries or social etiquette of Art and react accordingly, sometimes going beyond the pale." [18]

Outwitting the rules[edit]

A non-authorised and yet not illicit ploy is sometimes adopted, by carrying out purportedly "normal" behaviour, while finding loopholes in the regulations, pushing them to the limit and using them against the regulators.

Duchamp 1917[edit]

A seminal example of this approach took place in 1917 when Marcel Duchampsubmitted a urinal (laid on its back, signed by him "R.Mutt 1917", and titled *Fountain*) to the Society of Independent Artists exhibition. The Society had proclaimed their open-mindedness by stating they would accept all work submitted, only anticipating that conventional media (paintings) would be. Duchamp was a member of the Society's board, and interpreted the regulations at face-value. His entry was immediately rejected as "not being art", and he resigned from the board shortly after. The original *Fountain* was lost. Fifty years later, Duchamp commissioned reproductions, which were then highly sought by museums.[19]

In 1961, fellow Dadaist, Hans Richter, wrote to Duchamp:

> You threw a bottle rack and urinal in their faces as a challenge and now they admire them for their aesthetic beauty.

Duchamp wrote "Ok, ça va très bien" ("that's fine") in the margin beside it, and the quote is often erroneously attributed to him.

In a further piece of art intervention, in 1995, Brian Eno urinated in the reproduction of the Duchamp's Fountain in the Museum of Modern Art in New York City.

Stuckist clowns at the Tate, 2000–05[edit]

Main article: Stuckist demonstrations

The Stuckists have followed Duchamp's lead in exploiting regulations to their own advantage in yearly demonstrations outside the Turner Prize (2000–05) at Tate Britain. Prior to their first demonstration (dressed as clowns), they obtained written permission from the gallery that this form of dress was acceptable, and then walked round the Turner Prize wearing it.[20][21]

Stuckist artists dressed as clowns intervene at the Turner Prize, Tate Britain, in 2000

In 2002, when Martin Creed won with lights going on and off in an empty room, they flicked flashlights on and off outside, and in 2003 displayed a blow-up sex doll to parody Jake and Dinos Chapman's bronze (painted) sculpture modelled on one, by claiming they had the original.[22]Although barred from the prize ceremony, they have succeeded in infiltrating it psychologically to the extent that twice they have been mentioned by the guest of honour on live TV, just before the announcement of the winner.[23] They have also handed out manifestos to arriving guests at the Tate (and the Saatchi Gallery), thus getting their message carried into the events from which they were excluded.[24]

As the Stuckists condemn performance art as not real art, it raises the question as to whether their activities—which are carried out by artists and would therefore normally be classified as "art"—are still classified as "art", if they do not classify it that way themselves. On one occasion they were given an award for conceptual art by the proto-MU group nevertheless.

- **Definitions**

Intervention: The act of intervening, interfering or interceding with the intent of modifying the outcome. In medicine, an **intervention** is usually undertaken to help treat or cure a condition. For example, early**intervention** may help children with autism to speak.
The definition of therapeutic is having healing or curative powers for a disease or ailment.

Summary

- Artmaking can be one of the most meaningful activities in which a student with (and without)disabilities can be independently engaged. Many art educators have been minimally trained to work with a wide range of students with cognitive, physical, social or emotional challenges. These challenges can impede the students' ability to work with various media, art tools and techniques for personal exploration and completion of art tasks. Conversely, many special educators understand the challenges that their students face in the other academics, but may also lack training in the use of adaptive art strategies for their students' success in artmaking, either in the art class or in their own classrooms. This page is designed to help educators learn and implement adaptive art strategies for their students with disabilities.

- There are two fields of study that are helpful for the educator to consider when looking toward artmaking with their students with disabilities, art therapy and adaptive art. Both fields-in different ways-have the potential to assist students with various challenges to engage in art as a meaningful lifetime activity. According to the American Art Therapy Association (www.arttherapy.org) Art Therapy is a field that believes that art is healing and life enhancing for individuals and groups in various settings from private practice, hospitals, residential treatment centers to schools, as well as many other settings. Art Therapists are credentialed (registered and board certified) through the Art Therapy Credentials Board (ATCB) and may practice in schools in conjunction with IEP teams, and as School Art Therapists may hold teaching licensure depending upon the Department of Public Instruction (DPI) of the specific state. Art therapists in the schools work with students dealing with social, emotional, cognitive and physical challenges that affect their ability to engage with home, school and community. Increasingly, students of all ages are coming to school with issues related to family or personal crisis, as well as trauma that manifest with behaviors (unusual quietness, acting out, verbal or physical outbursts, etc.) that interfere with the student's ability to function in school. Oftentimes, students may not have the cognitive and verbal skills due to the issues to adequately be able to express themselves to persons who could support them. Educators, parents and guardians many times are the recipients of art images that may be considered unusual for particular students, and may seek out the support of other school staff such as school counselors or school psychologists to determine whether an image is an indication of issues to explore. Ideally, an art therapist or school art therapist should be consulted regarding the imagery due to the specialized training and subsequent therapy interventions to maximize the student's treatment. Many school art therapists specialize in working with specific student populations relating to emotional, social and cognitive issues.

- Adaptive Art is a field that focuses primarily on the students' access to artmaking that due to their challenges have difficulty using art to express themselves. Adaptive Art Specialists (see article below) are trained to adapt the*tools* that students need to paint, draw or sculpt. This may include retrofitting handles on paintbrushes, building up drawing tools for a wider grasp and seeking the most appropriate adapted scissors for a unique contractured hand grip. They are also trained to adapt the *media* for students who may not be able to use

traditional media due to oral issues and olfactory or other sensory sensitivity. Finally, the adaptive art specialist adapts the traditional art *techniques* to account for challenges in manipulating the specific tasks required for artmaking such as linoleum printing or silk screening. Many art and special educators are not aware of various adapted art tools, media and techniques that would increase their students' independence in artmaking. Too often, it is determined that students with physical challenges ONLY benefit from hand over hand intervention for the student to engage in artmaking. This encourages the student to rely on other persons for their artwork, and diminishes the desire to independently create, as the students no longer are given an opportunity to TRY by themselves.

- For students with physical challenges, adapted art tools may increase the ability to hold onto paintbrushes, drawing tools or scissors so that they can experience artmaking on their own. A tool as simple as a hand grip cut from a gallon milk carton with a marker or paintbrush pushed into the handle can create just the right angle for the student to make their own marks. Add a Connector Watercolor set (Faber Castell ™) that enhances color choice, and place on a wedge (Double Sided StoryBoard) for increased independent access. An Orbit ™ chewing gum container with adhesive backed foam cut into shapes assists a student with stamp printing a design they created.

- Students with sensory issues may need to have their materials adapted for the maximum engagement with the specific or exploratory art task. Students with visual impairments may gain a great deal of enjoyment from experiencing an art piece even AFTER it is created by choosing tactile materials to adhere to a poster paper- first, they choose the materials that are the most meaningful for them, glue them onto the mural with a strong glue, and then the final piece is hung accessible for the students to "see" well after the art is finished. Some students with sensory issues also use assistive technology supports such as visual strategies and voice output communication aids (VOCAs) to enhance their artmaking experience. Art and special educators need to be aware of these supports in the classrooms that should be included in the strategies for success in the art class for students with disabilities. Speech and Language Pathologists can help educators create communication opportunities for students that are specific to the needs of students in artmaking. Digitally assisted artmaking is another strategy to consider for students with other specific art making challenges.

- Techniques such as linoleum printing challenge all students, but students with spasticity or strength issues can benefit from the use of alternative cutting surfaces such as SoftCut™, pull type linoleum cutters instead of traditional push cutters, and lighter weight foam rollers instead of heavy brayers.

- All students with disabilities have the potential to express themselves through art. It is our responsibility to create the opportunities for our students to independently as possible access artmaking. Through adapting art tools, media and techniques, students will have these opportunities! Please contact Susan Loesl, Adaptive Art Specialist/Art Therapist at sloesl@att.net for further information regarding adaptive art, art therapy and assistive technology for students with disabilities. She is available for consultation and onsite workshops for educators.

- Below are links for art and special educators to explore adaptive art and art therapy for their students.

- American Art Therapy Association (www.arttherapy.org) is an organization of professionals dedicated to the belief that making art is healing and life enhancing.

- Miami-Dade County Public Schools (Florida) Clinical Art Therapy Program presents the school art therapy program for at-risk students and other students with exceptional needs. (http://arttherapy.dadeschools.net/)

Detroit MONA goes kaBOOM!, 2002[edit]

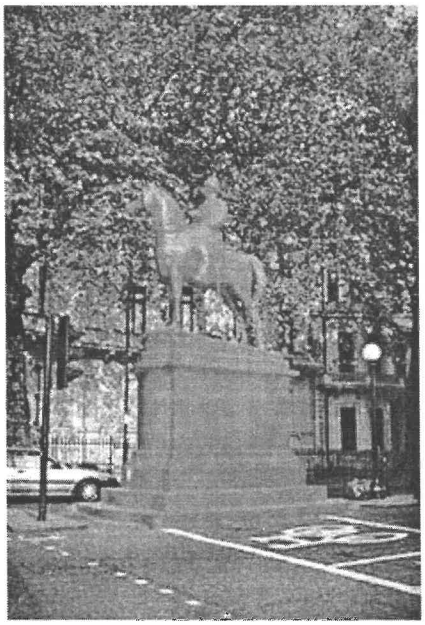
The extreme to which an authorised intervention can go and yet still meet with institutional approval was shown in 2002, when the Museum of New Art in Detroit staged a show *kaBoom!*, with the announcement, "Over the course of the exhibition, museum visitors will be invited to smash, drop, throw and slash artworks..."[2] The show was scheduled for two months, but by the end of the first night had been totally destroyed by visitors:

> "They even destroyed the pedestals and wall shelves," one museum staffer shrugged in disbelief. Fires were set in isolated galleries and a wrecking ball for one display had been removed from its chain and used instead as a bowling ball, taking out an installation as well as the corner of one wall. "In a twisted way, it was a wild success,"

MONA's director Jef Bourgeau says the morning after, on a surprisingly bright note as he wades through the carnage and debris.[3] This follows the precedent of the Dadaists. At one of their shows, visitors were invited to smash the exhibits with an axe.

Hanging Old Masters backwards, 2004[edit]

A more usual authorised art intervention in an institution is done with great care to make sure that no harm comes to the existing collection. In 2004, the Old Town House in Cape Town, South Africa, hung its Michaelis Collection of 17th century Dutch Old Master paintings facing the wall. The curator Andrew Lamprecht said this exhibition, titled *Flip*, "would force gallery goers to reconsider their preconceptions about the art and its legacy." Knowledge of intent is integral to such a process, as it would be perceived differently if it were announced in a conservation context, rather than as an art piece. However, in this instance there was some ambiguity about the purpose of the exercise as Lamprecht, although stating, "I'm asking questions about the history", also added a more standard "educative" comment, "the reverse of the paintings revealed a wealth of detail not normally on view to the public, ranging from old attempts to preserve the canvas to notes from different collectors over the years",[4] thus lessening the confrontational impact of his actions.



An equestrian statue of Lord Napier wrapped in red tape by Eleonora Aguiari in 2004.

Lord Napier in red tape, 2004[edit]

An authorised art intervention which required considerable effort to gain the requisite permission was the wrapping in red duct tape of the equestrian statue of Lord Napier of Magdala, situated on Queens Gate in West London. This was done by Eleonora Aguiari, aRoyal College of Art (RCA) student for her final show. When questioned as to whether she had considered a clandestine act, she replied, "No, not my style, I like to challenge the institutions." In order to do this she needed clearance letters from the RCA Rector, a professor, the Victoria and Albert Museumconservation department and the RCA conservation department, bronze tests, a scaffolding license, indemnity insurance, and permission from English Heritage (who own the statue), the City of Westminster, two Boroughs (Chelsea and Kensington, as their boundary bisects the length of the horse) and the present Lord Napier.

Then a layer of cling wrap and almost 80 rolls of red duct tape were applied by 4 people working for 4 days. Aguiari described it as "a Zen action up there in the middle of traffic, but alone with a beautiful statue. Every detail on the statue is perfect and slightly larger than normal," and said that "statuary that symbolizes military past, or imperialism should be covered to make the topics of the past visible." [5] Aguiari then received a phone call: "Saatchi wants to talk to you", but, on keeping the appointment, she found herself talking not to Charles Saatchi but to Michael Moszynski of the advertising firm, Saatchi & Saatchi, who thought her idea would be suitable for "a Tory advertising campaign", and wanted her to wrap an ambulance in red tape. She declined the offer.[6]

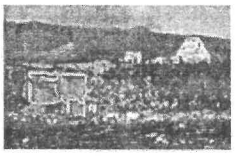
Despite her official clearance, the action caused controversy[7] through press coverage, including a Reuters press agency photo reproduced in the *Daily Times* ofPakistan.[8]

Illicit[edit]

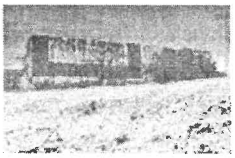
Some artists challenge the orthodoxy by not seeking, or perhaps not being able to obtain, permission, but carry out their intention anyway, contravening regulations—with official reactions of differing degrees of severity.

Concomitant, 1983[edit]

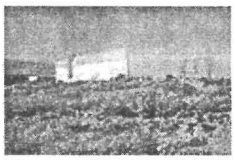
since 1983 Eberhard Bosslet is doing side-specific outdoor intervention: so-called "Re/formations and side effects"; at the Canary Islands;

- 

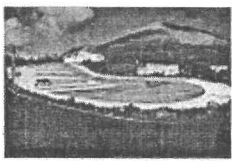
construction drawing - La Restinga II, El Hierro, 1983

- 

side effect VII, Guimar, Tenerife, 1990

- 

side effect X, Tajao, Tenerife, south side, 2006

- 

side effect X, Tias, Lanzarote, 2008

The black sheep, 1994[edit]

In 1994, Damien Hirst curated the show, *Some Went Mad, Some Ran Away*, at theSerpentine Gallery in London, where he exhibited *Away from the Flock* (a sheep in a tank). An artist poured black ink into it, and was subsequently prosecuted, at Hirst's wish. The artist's defence was that he thought Hirst would benefit from the publicity and one critic (Tony Parsons) said the artist's action proved that what Damien Hirst does is art. The exhibit was restored at a cost of £1000.

Two men jump naked into Tracey's bed, 1999[edit]

Main article: Yuan Chai and Jian Jun Xi

A notable case of an unauthorised intervention—which did no damage, yet was still liable for prosecution—occurred at 12.58 p.m. on October 25, 1999, when two artists, Yuan Chai and Jian Jun Xi, jumped on Tracey Emin's installation *My Bed*, in theTurner Prize at Tate Britain, wearing only underwear. They called their performance*Two Naked Men*

Jump Into Tracey's Bed. They were arrested for their action, but no charges were pressed. Chai had written, among other things, the words "ANTI STUCKISM" on his bare back. They said they were "improving" Emin's work, because they thought it had not gone far enough, and opposed the Stuckists, who are anti-performance art.[9]

Banksy, c.2000[edit]

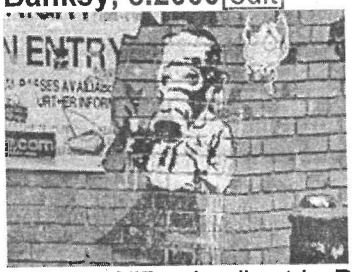


Photo of "Banksy" art in Brick Lane, East End. 2004.

Main article: Banksy

"Banksy" is the operating name of one of the best-known interventionists in the UK. He has carried out many graffiti stencillings, usually with a specific message or comment. He has also infiltrated his own artwork into museums, where they have remained for varying amounts of time before being removed. In May 2005, for example, he hung his own version of a primitive cave painting, showing a human hunting with a shopping trolley, in the British Museum. His work is now a desirable art commodity.

Lennie Lee, c.2005[edit]

In February 2005 Jewish artist, Lennie Lee, was censored for exhibiting a piece called "Judensau" (Jew pig) in Treptow Town Hall gallery, Berlin. The intervention was organized by the other artists working in the show who claimed (incorrectly) Lee was one of them. Lee's work was designed to put the institution in a difficult position. If they left it on the wall they would be accused of anti-semitism by their opponents. On the other hand, if they took the work down, they would be censoring the work of a Jewish artist dealing with antisemitic stereotypes.

The authorities were forced to take the piece down. The piece attracted considerable attention from the media. Lee offered to remove his "Judensau" on condition that a 14th-century sculpture of a "Judensau" was removed from the side of Martin Luther's church in Wittenberg.[10][11]

Taking a hammer to a urinal, 2006[edit]

On January 4, 2006, while on display in the Dada show in the Pompidou Centre in Paris, Marcel Duchamp's *Fountain* was attacked with a hammer by Pierre Pinoncelli, a 77-year-old French performance artist,

causing a slight chip. Pinoncelli, who was arrested, said the attack was a work of performance art that Marcel Duchamp himself would have appreciated.[12] This may be true, as on one occasion visitors to a Dada show were invited to smash up the exhibits with an axe. Previously in 1993, Pinoncelli urinated into the piece while it was on display in Nîmes, in southern France. Both of Pinoncelli's performances derive from neo-Dadaists' and Viennese Actionists'intervention or manoeuvre.

The *Fountain* attacked by Pinoncelli was actually number 5 of 8 recreated by Duchamp at a much later date, after the original one was lost. Another is on display in the Indiana University Art Museum, and there is one also in Tate Modern, where in 2000 it too was the target of a urination performance (unsuccessful according to the gallery) by Yuan Chai and Jian Jun Xi.

Pencils removed from Damien Hirst's Pharmacy, 2009[edit]
Artist Cartrain removed a packet of Faber Castell 1990 Mongol 482 series pencils from Damien Hirst's installation at his restaurant Pharmacy. This followed Hirst's action against Cartrain for using copies of Hirst's work. Cartrain stated:

> For the safe return of Damien Hirsts pencils I would like my artworks back that Dacs and Hirst took off me in November. Its not a large demand he can have his pencils back when I get my artwork back. Dacs are now not taking any notice of my emails and I have asked nicely more than five times to try and resolve this matter. Hirst has until the end of this month to resolve this or on 31st of July the pencils will be sharpened. He has been warned.[13]

- **Revision**

- **Assignment/Activity**

POINTS FOR DISCUSSIONS / CLARIFICATION

After going through the unit you may like to have further discussion on some points and clarification. Note down those points:-

Points for Discussion

Points for Clarification

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