**Everybody has the Right to Be Here: Perspectives of Inclusive Related Service Practitioners**

Related service providers are central team members in providing the most effective educational services to students with disabilities in seamless and inclusive ways (Tonennies, Bauman, & Huntenburg, 2002; Gillon, 2000; Feeney, Riddle, & Benedict, 2000; Giangreco, 1995). Since the passage of the Individuals with Disabilities Education Improvement Act (IDEIA) in 2004, related services are a necessary component of an Individualized Education Program (IEP) as a type of therapy that “may be required to assist a child with a disability to benefit from special education” within the least restrictive environment (LRE) (20 U.S.C. 1401§300.320[a][1]).

Related service providers have many roles, especially given the heightened use of response to intervention (RTI). These roles include screening, prevention, and intervention for at-risk students (Giangreco, 2010). Furthermore, their roles can be implemented through a variety of service delivery models (e.g., consultation, classroom-based or team teaching, community-based, pull-out, self-contained, resource room [Schraeder, 2013]). Given the IDEIA definition of related services and the LRE provision (34 C.F.R. Sec. 300.114) service delivery models vary in schools across the country, as these concepts are interpreted differently.

IDEIA contains a mandate that requires educational placements to be in the LRE. This is the educational setting that allows students with disabilities to receive instruction and services, to the maximum extent appropriate, which are contained in their IEP in the same setting as students without disabilities. Removal of students with disabilities is justifiable only “if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily” (34 CFR 300.114 (ii). Researchers have noted that the conceptions of “least restrictive” is contextual and a local decision (Kozleski, Artiles, Fletcher, & Engelbrecht, 2007). In this article, we explore related service delivery (specifically speech-language therapy, occupational therapy, and physical therapy) that is conducted within general education settings, through the combined use of consultative, inclusive, and classroom-based therapy models to learn about the experiences of providing inclusive services, and the barriers encountered within that service delivery model.

**Rationale for Inclusive Related Service Provision**

Grounded in the Roncker Portability Test, related services are deemed portable, meaning that they can be delivered in non-segregated, less restrictive setting, if it is feasible to do so (Roncker v. Walter, 700 F2nd. 1058 [6th Circuit 1983]; *cert. denied*, 464 U.S. 864, 104 S.Ct. 196, 78 L.Ed.2d. 171 (1983)). In essence this portability principle suggests educational services should be brought to the student, rather than bringing the student to the services. This study is grounded on this portability principle. Related service providers are crucial in ensuring access to general education, equipping students with the necessary supports and collaborating with educators who work in inclusive settings (Giangreco, Prelock, Reid, Dennis, & Edelman, 2000).

Schools are becoming more inclusive by providing academic, social, and therapy services for students with disabilities within general education contexts, with an emphasis on learning alongside peers (U.S. Department of Education, 2010). Seminal definitions of inclusion highlight the goal of “providing all children with an authentic sense of belonging” (Kunc, 1992) where “inequities in treatment and educational opportunity are brought to the forefront, thereby fostering attention to human rights, respect for difference and value of diversity” (Udvari-Solner, 1997). Research suggests that the impact of an inclusive model of service delivery, impacts the academic achievement of all students, not just students with disabilities (Burnstein, Sears, Wilcoxen, Cabello, & Spagna, 2004; McLeskey & Waldron, 2006; Morris, Chrispeels, & Burke, 2011).

Studies examined the effectiveness of classroom-based versus pull-out service delivery, finding that inclusive models in which the related service provider and educator co-teach is advantageous (McGinty & Justice, 2006; Throneburg, Calvert, Sturm, Paramboukas, & Paul, 2000). It is more effective in the areas of: a) efficient workload strategy (Toennies, Bauman, & Huntenburg, 2002); b) literacy and language development (Gormely & Ruhl, 2005); c) providing services in the LRE (Schraeder, 2013); and, d) implementing proactive, quality instruction and services within a responsiveness-to intervention program (Schradeder, 2013). Classroom based related service provision contributes to coordination of specialized education by professionals.

Related services have historically been employed through pull-out models that allow students with disabilities to receive intervention in individual or small group formats. Pull-out interventions are seen as non-inclusive because they involve removal from the general education academic and social context in order to receive intervention. The problem with pull-out related service delivery is that skills often do not generalize to natural contexts (Wilcox, Kouri, & Caswell, 1991), students with disabilities routinely miss important academic content (Cosier, 2010) and social interaction (TASH, 2009), and students do not have optimal peer models of age-appropriate language, communication, and behavior skills (TASH, 2009). Related service practitioners are increasingly being mandated or encouraged to provide services inclusively to students with disabilities (Farber & Klein, 1999; Villa, Thousand, Nevin, & Malgeri, 1996).

**Method**

As a result of more schools providing inclusive support services, collaboration being essential, and many related service providers being encouraged to provide classroom based therapy, this study explores the perspectives professionals working in inclusive, classroom-based settings, as it is not present in the literature. We add to research by examining both the conceptualization (the discourse of their experiences) and the operationalization (the enactment of inclusive services) of related service provision. We approached this study with an orientation that in order to maximize academic achievement, all students should have continuous, uninterrupted access to general education (Cosier, 2010; Rea, Mclaughlin, & Walther-Thomas, 2002; Westling & Fox, 2009; Cole, Waldron, & Majd, 2004; Downing, Spencer, & Cavallaro, 2004).

In this study, we qualitatively examined perspectives of 15 related service practitioners who conduct inclusive related service provision at elementary, middle and high school levels. We focused on three research questions. How do therapists who provide classroom-based therapy: (a) describe their experiences; (b) enact their work within inclusive schools; and, (c) discuss the barriers they encountered throughout their classroom-based service provision work? We used these responses to identify common themes in the experiences and practices of participants.

**Research Design**

We employed a qualitative multi-case study methodology and analyzed the data using analytic induction in order to understand the experiences of related service providers working in inclusive contexts. Our goal was to “gather descriptive data in the subjects’ own words so that the researchers can develop insights on how subjects interpret some piece of the world” (Bogdan & Biklen, 2007, p. 103). We collected stories of a range of similar individuals (Bogdan & Biklen, 2007) who engage in inclusive related service provision.

**Participants.**To gather a purposeful sample (Bogdan & Biklen, 2007, p. 73), eligibility criteria were set prior to recruitment. We interviewed related service practitioners who fit the following criteria, they: 1) provided classroom-based services, 2) represented different types of related services, 3) served the range of federal disability categories, and 4) represented various school settings (e.g., rural, urban, and suburban). We asked principals to nominate related service providers who conducted services in inclusive classrooms at least 50% of their workday. Twenty-one nominations were sent letters via email explaining the purpose of the study. Of these related service provider nominees, 15 expressed interest and met the eligibility criteria. Of the fifteen, four identifed as physical therapists, five as occupational therapists, and six as speech-language pathologists. These participants provided services to preschool to high school students with disabilities, were all white, served pre-kindergarten to grade 12, worked across rural, urban, and suburban districts, and were from two states. See Table 1 for participant demographics.

**Procedures.** Interviews ranged from 42 to 155 minutes, with an average of 71 minutes. Interviews were recorded and transcribed verbatim. An interview guide was used to gather information about their workday, collaboration, design and implementation of therapy services, and stories that reflected moments of success and challenge (see Table 2 for the interview guide). The use of a semi-structured interview guide as a tool ensured that a range of topics were discussed yet provided flexibility for participants to shape the content and have the freedom to respond openly (Bogdan & Biklen, 2007). The interviewers altered the types of prompts and probing questions in order to elicit explanations, details, or examples of practice.

**Data analysis.**After interviews were transcribed, cases were analyzed through an analytic inductive approach (Bogdan & Biklen, 2007, p. 70). Studying multiple cases allowed for understanding the work that inclusive-oriented related service providers performed across different sites, providing rich descriptions and examples regarding emerging themes. We created a tabular format of data and a three-level codebook with codes, categories, and emerging themes during ongoing data analysis stages (La Pelle, 2004). The researchers independently coded each line of the transcribed interviews, met frequently to discuss new codes, categories, and discussed developing themes, and revised and modified these themes. The methodological framework that guided our data analysis was the analytic induction method, as we developed understanding about the ways in which therapists can conduct inclusive related service provision.

**Results**

Analysis of related service provider’s responses yielded three primary themes that influence provision of therapy services within inclusive schools. We named the themes: a) “We is greater than I”: Collaboration; b) “Tinkering toward all classroom-based therapy”: Flexible service delivery; and c) “Balancing is really tricky”: Logistical barriers. These themes were further separated into categories that emerged as crucial elements and subthemes. See Figure 1 for a concept map that visually depicts the findings.

**“We is greater than I”: The Necessity of Collaboration**

Participants revealed collaboration facilitated their ability to provide inclusive related service provision and develop teacher’s capacity to support students’ varying needs. Categories that emerged within this theme included consultant role, differentiated conception of responsibilities, and a shared focus and interdependence.

 **Consultant role***.* Many of the related service providers assumed leadership roles intended to support other school personnel through consultation. The aim was to increasingly develop teachers’ skills to seamlessly provide supports, accommodations, and modifications that linked to therapy needs for students. Thirteen participants articulated that consultation occurred through asking questions, problem solving, listening, celebrating successes, and providing new ideas.

Terry explained this consultation method of questioning:

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

Nicole revealed her method of consultation saying, “There’s an element of coaching on my part to ask the questions…it’s about how can we support all the learners as well as *this* learner.”

 Related service providers also considered problem solving. Moe shared about problem solving when a team became frustrated with a student’s use of a communication device.

I said this little guy is very impulsive and wants to push buttons. Let’s step back, think about what we can do…helping guide the teachers through, okay let’s let him create a content page and we pull it down to have more discussion…Otherwise, he gets too obsessed about the buttons on the device.

Moe provided a solution to maintain the level of communication support the student needed, but gave the team a solution for managing his impulsively with the device. Moe continued describing situations in which she provided prompt solutions when teams were stagnant with ideas.

 Most related service providers saw themselves as a leader on a problem solving team in a way that positioned them to facilitate the solution process. Nicole said, “I’m not looked at as the person who has all the answers. It’s more the person who can help guide them to their own thinking and their own success.” This facilitative role positioned related service providers as having expertise, and supporting colleagues. As Kendra said, “It’s about problem solving, getting resources, and giving support for teachers so that they’re not completely overwhelmed.”

 Therapists also described the consultative role of listening. Nicole explained, “I *really* listen to concerns and coach through the difficulties…Teachers say this is what just happened, so I open up that communication and listen deeply.” In reflecting on this professional development role, Kelsey said, “So far it’s had the effect that I wanted, which was that the teacher will call me or will stop me in the hall to ask me or tell me about students' challenges and successes!” Celebrating successes was a key theme. Cora said:

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

Consultation also happens through providing innovative ideas.

Impact what is happening for kids who need therapy supports throughout the day…talk about transitional movements. It provides gross motor development and body movement. Do a 20 second stomping or jumping transition…Perfect for a sensory diet during the day.

Kendra also describes a leadership role. She explains that even though teachers do not have constant support in the classroom, she mediates this by providing support strategies. “Teachers don’t have that support all the time. Then I give them three things to try…Here’s three examples or modifications that I just have based on this child’s …da, da, da. Do you think any of these would work?” Kendra provided numerous examples of support strategies she offered to teachers to support specific student needs.

Participants are cognizant about presenting ideas. Bernice describes being astute to collaboration with colleagues:

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

Participants often described this balance between respecting the ideas implemented by others, yet providing innovative suggestions to further support students. Another way that participants provided professional development to colleagues was to assume a coaching role by starting with a positive piece of current practice before providing additional recommendations. Several participants noted that this kept the interactions with others positive, and empowered colleagues. Nicole sees herself as a mentor:

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

The participant’s words reflected a desire to empower colleagues, while promoting an interdependent environment designed to have a proactive approach to serving students’ needs.

**Differentiated conception of responsibilities**. Several participants revealed that their educational team collaborates effectively as a result of the distinct roles that therapists have as compared to the general and special educators. Bernice shared an experience that demonstrated how her expertise of having a medical background, contributes to the educational team.

We recently had a situation where the child’s body appeared very asymmetric and had changed quickly. I asked the family to have the necessary x-rays and therapeutic consultation and realized that in our asking for that, we had actually frightened the classroom team into thinking that what they were doing, how they were carrying the child had actually caused the problem, but when in fact it was actually a result of neurological condition that preexisted. To help the team understand that this was part of the cerebral palsy, not a result of what they were or were not doing was key. It’s important to have people on the team that can work through those medical issues that impact the education sphere…Really it is a vital connection between teachers, therapists, families, and the medical side of some kids’ care. We’re in a unique situation to make this connection.

Related service providers have discipline specific expertise that is vital in the support strategies they suggest. Cora describes being able to offer disability specific advice to a physical education teacher.

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

Cora later described how she gradually increased this student’s participation through implementation of several necessary modifications made in conjunction with the teacher.

Several related service providers describe the curriculum as the teacher’s expertise, and providing the therapy supports as their role. Referring to this curriculum component, Page said,

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

However, related service providers shared a sentiment that having some knowledge of grade-level curriculum was imperative, and that the one method to gain this information was to simply ask the teachers for quick summaries of units. This promoted successful inclusive related service delivery that was intrinsically linked to the curriculum.

Related service providers also articulated a sense of accountability that resulted from collaboration. Paulina explains the impact of inclusive delivery:

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

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

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

The collective expertise of each team member creates effective inclusive special education and related service delivery.

**Articulation of a shared focus and interdependence.**Related service providers shared that relationships were based on positive interactions because the focus centered on the child. Interdependence happened since the goal was to provide the best possible educational and therapy services to the child. Vanessa described this interdependence as the key to success: “I think with this model…everybody’s so involved in the kids’ development, and I don’t think it has anything to do with what I am doing solely as a therapist…It’s really because everybody is sharing goals.”

Joslyn also shared that this shared focus is imperative:

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

As the related service providers described their school settings, there was a tone of shared ownership with other adults. Mary described the sense of interdependence she felt in a classroom in which she conducted inclusive related services.

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

Mary’s view of collaborating demonstrates a strong value of connectedness and shared desire to provide effective supports. Many of the participants expressed importance of each role, yet sharing a proactive approach to meeting educational needs. As Francine described, “We is greater than I. It’s that simple. And, we have to work toward the same goal of supporting all students.”

**“Tinkering Toward All Classroom-based Therapy”: Service Delivery**

Related service providers stressed the importance of going towards inclusive services for a majority time, but they all stressed that flexible service delivery is an accurate representation of what really happens in their practice. The related service providers interviewed talked about why inclusive service provision is important, how to apply this foundation in practice in flexible ways, and strategies to meet goals from the child’s IEP in an inclusive manner.

**The importance of classroom-based therapy.**15 of the related service providers discussed the importance of providing inclusive related services. As Paulina said, “The basic philosophy is part of human potential and inclusion regardless of any diagnosis or testing results.” Elements of this underlying foundation linked to an inclusive schooling philosophy.

A classroom-based service delivery model allowed students with and without disabilities to have access to a shared academic learning and social context. Participants pointed toward the importance of social interaction. Bernice said, “I like this environment. I like that kids who would have placement in a self-contained classroom in a different school, have this freedom and environment in a typical classroom with peers.” This service delivery model allows all students to have access to general education contexts. Moe also discussed the social nature of inclusion.

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

An underlying element described by related service providers was that the climate embraces diversity, fosters a sense of social capacity to interact, and that socialization was important.

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

In addition to this social importance, related service providers discussed generalizability. Kelsey sums up the point of the importance of inclusive service delivery by saying, “One sure way to make sure you’re not working in a vacuum, is to do it inclusively and then you’re actually doing therapy sessions in the class. This promotes the best generalizability of therapy activities.”

Vanessa described the struggles she had in planning pull-out therapy sessions changed in her therapy session planning toward more classroom-based practice.

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

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

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

Paulina described providing services in the classroom allowed modeling amongst colleagues.

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

Page further describes providing supplemental support that is accommodating for all students.

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

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

**Practical application of inclusive related service provision.** 14 participants described their therapy sessions in relation to the instructional structure. As Kendra described, “An individual push-in session generally means I’m joining the child in whatever activity their classroom is participating in and looking to achieve their IEP goals through activity modification, through the use of adaptive strategies and therapeutic exercise.” Moe explains that her role varies depending on the instructional arrangement and teacher.

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

Later, Moe explains that this difference in role is because of common grade-level schedules. Bernice gives an example of a classroom where she is responsible for one center each week.

When we’re at our best teaming, co-teaching happens easily during push-in times. Therapists can push-in to lead an activity, targeted towards specific students. I might decide that Lucy and Pat are working on lower body strength. I have a learning center at 2:00 on Tuesdays. I’ll bring the learning activity and I’m always going to look to target that the skills of those two kids. All students will get a turn to practice.

Some therapists used sessions to observe, create, and implement student-specific supports that would allow them to better access the general education curriculum. Nicole explains her perspective of conducting inclusive related service provision:

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

Some therapists also described leading a whole-class lesson. Mary explained:

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

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

Vanessa gave an example of a classroom where there are four adults in the classroom.

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

The participants report diverse methods of implementation that demonstrate their flexibility to support students based on the teacher’s instructional structure.

**Meeting IEP goals inclusively***.* The related therapy practitioners described that knowledge of the larger IEP goals was crucial in planning their classroom-based therapy session. Terry explains that a clear focus about skills and educational goals aids decision making.

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

Terry describes the balance between body positioning that will lead to increased tone and strengthens and academic goals. She makes flexible instructional decisions based on the individual. Mary describes how therapy impacts academics.

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

Francine explains that the ways in which she has written IEP goals have changed now that she is doing classroom-based therapy.

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

Attending to educational goals by identifying which strategies would provide support throughout the school day was a common sentiment expressed by related service providers. As Cora succinctly said, “It’s easy to write goals based on what the expectations are for that grade-level.”

Even though related service providers described seamlessly meeting IEP goals within the classroom-based sessions, there were exceptions. Both speech-language pathologists and physical therapists provided examples of specific sessions that were not conducted within the course of the typical classroom schedule. Articulation was a specific area that speech-language pathologists felt lends itself to pull-out therapy sessions, but sometimes in targeted 5 minute sessions.

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

Based on her professional expertise as a speech-language pathologist, Vanessa believed that articulation support needed to occur one-on-one with a student. She simultaneously described a rich underlying philosophy of inclusion. To negotiate these two beliefs, she decided that she would spend five minutes of her therapy session doing targeted articulation support with individual students. She described that when making this decision, she consulted with other professionals in her school.

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

This example demonstrates that related service providers aimed to meet IEP goals in an inclusive setting. When there are exceptions based on specific skills that need targeted one-on-one attention, this happens in short bursts, often within the classroom context or at a table right inside the classroom so the student can return to the general education activity immediately. As Kendra explained, “We are tinkering toward all classroom-based therapy, but it’s flexible in nature.”

**“Balancing is Really Tricky”: Logistical Barriers**

15 related service providers elaborated on the complexities and realities of schooling. Resistance to change by teachers and administrators was one factor. Several explained scheduling conflicts that caused their practical application to change. Being flexible was also underlying orientation that each found as crucial. These logistical barriers provide evidence that the related service providers in this study work in typical schools across the country where barriers exist.

**Resistance to change.**Therapists need to balance the teacher’s willingness of change with the mission of providing classroom-based services. Nine participants discussed providing services in classrooms where the teacher was resistant to changing the ways that therapy had previously been delivered. Terry articulated what she perceived as the rationale for resistance.

It gets to the point that you felt like you weren’t really wanted in the classroom. They might not like me that much…Sometimes it’s their insecurities with teaching, the content, the lesson, the lack of planning. They don’t want you watching them. They don’t want you seeing how they handle a tough situation. Some are set in their ways…change is difficult.

Resistance stemmed from factors related to trust, confidence in decisions, and planning. Taken collectively, these individualized factors impact an educator’s ability to negotiate changing service delivery models.

Therapy practitioners also described that the administrative philosophy and vision for the school directly impacted others’ willingness or resistance to change. Cora explained that during an administrator hire, the school was unsure about how therapy services would be provided, leaving them with a feeling that their inclusive practices could be in jeopardy.

The district director tells us we’re to do push in therapy. That’s what we believe in. The new director just came. We are worried her vision won’t align. What’s her philosophy? Will pushing into classrooms be out the window? Will it be different? Who knows. Change is hard, especially when we have the best interests of students in mind.

Participants often described administrators as agents who impacted the type of therapy service delivery implemented. Mary explained that her administrator did not understand her role.

She insisted that if I’m pushing in I’m working on curriculum. I explained that’s not true. I’m not qualified to work on curriculum. Instead, I provide modifications and supports so students can better get that content from the curriculum. That’s a big difference.

Mary describes working with an administrator who was unclear about her role as a therapist who worked in a general education classroom. Later Mary stressed the importance of her administrator understanding that as a related service provider, her goal was to maintain a therapeutic focus (Ehren, 2000). She also described types of modifications recommended to support specific student’s IEP goals that seamlessly worked in conjunction with the curriculum. It was clear that Mary projected a therapeutic focus, yet shared in the responsibility of success for students.

Kendra describes an administrator who initially framed the change in therapy service delivery as an experiment in which a number of factors would need to continually change based on individual circumstances, and explained to both teachers and therapists that with change, there must be a development period filled with both moments of success and failure.

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

Vanessa succinctly explained, “My principal and my special education director really want both special education teachers and therapists to be in the classroom. That is their message across the board. It is clear. We need to figure out how.”

**Working in complex schooling institutions**. Related service practitioners described that schedules are a barrier. An underlying value was working around these complexities while still managing to provide classroom-based services. Terry described grade-level schedules that mandate subjects are taught at certain times of the day.

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

Moe also talked about the schedule.

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

To cope with this scheduling issue, she negotiates with teachers to allow therapy sessions at different times so she can see students during different subjects, depending on target goals. Both Terry and Moe are creative in changing schedules to provide inclusive related service provision.

Many therapists also discussed not having face-to-face time with students they provide services for the entire time in the classroom. This is a change from the pull-out therapy provision where therapists literally sat with the students with disabilities. Francine articulated this point:

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

The change means that inclusive related service providers undertake support and consultation that is different from the direct side-by-side support model traditionally used. It also means that the related service provider plans with the classroom practices in mind.

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

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

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

Participants described having dilemmas with the schedule. Each described ways to work within the school schedule in order to meet their inclusive therapy goals. This highlights that therapists’ jobs are situated within complex social institutions. Given these realistic circumstances, they are driven to provide inclusive therapy services within complex school schedules.

***Thinking on your feet.***Participants continued to describe instances in which being flexible was a crucial factor in working in inclusive school settings. Moe described the following:

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

Many therapists also described having conversations with teachers about their role in the classroom. These talks included scheduling, curriculum and content, and how therapists could have a meaningful co-teaching role within the classroom. Some therapists described the pitfalls of the one teach, one assist in a side-by side support role (Causton, 2009). This assist role was filled by the therapists. Many described feeling like an assistant in a teacher’s classroom without a meaningful role, and articulated the importance of planning useful therapy roles and responsibilities. Paulina described this:

You need to be careful to not become a glorified teaching assistant. You need to be careful about the time of day that you’re pushing in and to make sure you have a useful therapy service delivery role. Obviously you have to pay specific attention to the student’s IEP goals. That is the key to our services. Make certain that it’s during time that you can meet those goals in addition to working within the classroom, with the curriculum, and the other kids. Being an assistant is not the best way to use the expertise of a therapist.

Paulina recognized that her role of being an assistant did not utilize her specialized knowledge.

Therapy practitioners described the balancing of being prepared for the inclusive therapy session and having a flexible oriented while working in classrooms. Some accommodations and therapy activities are pre-planned, and others happen during the midst of the classroom-therapy session. Participants also describe that effective sessions occur when meaningful roles are determined by the therapist and teacher. When the therapist is merely utilized as a “glorified teaching assistant” the sessions were ineffective to support inclusive ideals.

**Discussion**

**Limitations and Scope of Study**

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

**Understanding Elements that Facilitate or Inhibit Inclusive Related Service Provision**

 **Consultant role.** Participants described possessing discipline knowledge that contributed to teams’ understanding of students. Researchers caution the creation of an unproductive hierarchy based on expertise and recommend that everyone’s expertise is valued and recognized (Giangreco, Prelock, Reid, Dennis, & Edelman, 2000). Related service providers in our study echoed these findings when alluding to finding creative solutions for providing consultation advice and having explicitly defined areas of expertise in order to contribute a shared, collaborative, and proactive approach to supporting students. Participants shared roles varied from providing supports and modifications, to running stations, to team teaching to leading lessons.

 **Flexible service delivery.** Possessing a common underlying conception about the importance of classroom-based therapy provision was consistent across participants. Research suggests this foundation of a shared framework allows team members to have consistent beliefs, values, and assumptions about students, other professional roles, related service delivery, co-teaching, and accommodations and support strategies that contribute to collaboration and practical application (Giangreco, Prelock, Reid, Dennis, & Edelman, 2000). This shared foundation was prevalent in that the participants valued inclusive service delivery, believed that skills and IEP goals could be best generalized when they were supported within general education environments, thought that peer models and socialization were crucial, and that their discipline specific expertise could value all students within classrooms.

 **Logistical barriers.** Participants were forthcoming in explaining the numerous complexities and realities of schools that collectively diminish ease of implementation of inclusive therapy sessions. Resistance to change is well documented in research (Fullan, 2009). Another barrier was the difficulty of inclusive related service provision within existing institutional schedules. A third factor is the need to be flexible and unpredictable days. Logistical barriers highlight the importance of service delivery models that align with inclusive ideals being a whole-school structural decision. This is well documented in whole-school inclusive reform literature (Theoharis, Causton, & Tracy-Bronson, in press). When service delivery models are woven into the structural fabric of schools, there is a framework of inclusion and a common mission.

**Recommendations for Future Research**

The findings in this study provide a mere glimpse of the ways in which related service providers negotiate the complexities and realities of inclusive schooling environments. In-depth case studies would provide insights into the ways in which people with different professional roles promote generalizability of therapy skills. Second, qualitative interviews conducted with general educators and special educators who work on teams with an inclusive related service provider would allow for deeper understanding of the collaboration needed. The findings of the current study are encouraging in that they reveal the very realistic logistical barriers present in many schools across the country, yet the potential of related service practitioners who are interactive, collaborative, flexible, and proactive in delivering inclusive related service provision.

**Conclusion**

Based on the LRE clause of the IDEIA (2004) and the Roncker (1983) case stating that services should be brought to the student, now more than ever, is understanding the experiences of inclusive-based related services crucial. It is substantially important because students with disabilities are routinely missing classroom instructional time and wasting educational time transitioning to physically different spaces. Furthermore, research has shown that specialized therapy goals can be targeted by utilizing classroom-based therapy sessions (Ritzman, Sanger, & Coufal, 2006) and (Sekerak, Kirkpatrick, Nelson, & Propes, 2003). There is an ever-present shift for all service providers working toward educational goals and these are best remediated, practiced, and met within general educational settings. It is imperative that research expands the depth of knowledge available about inclusive related service provision. With proactive planning, collaboration, and a vision, inclusive related service provision allows us to ensure that “everyone has the right to be here.”

**References**

Bogdan, R.C., & Biklen, S. (2007). *Qualitative research for education: An introduction to theory and methods.* Needham Heights, MA: Allyn & Bacon.

Burstein, N., Sears, S., Wilcoxen, A., Cabello, B., & Spagna, M. (2004). Moving toward inclusive practices. *Remedial and Special Education, 25*, 104-116.

Cole, C.M., Waldron, N., & Majd, M. (2004). Academic programs of students with disabilities across inclusive and traditional settings. *Mental Retardation*, *42*(2), 136-144.

Downing, J.E., Spencer, S., & Cavallaro, C. (2004). The development of an inclusive charter elementary school: Lessons learned. *Research and Practice for Persons with Severe Disabilities*, *29*(1), 11-24.

Ehren, B.J. (2000). Maintaining a therapeutic focus and sharing responsibility for student success: Keys to in-classroom speech-language services. *Language, Speech, and Hearing Services in Schools, 31*, 219-229.

Farber, J., & Klein, E. (1999). Classroom-based assessment of a collaborative intervention program with kindergarten and first-grade students. *Language, Speech, and Hearing Services in Schools, 30*, 83-91.

Feeney, T., Riddle, L., & Benedict, L. (2000). *Giving urban children the language to succeed: A consultative-collaborative model.* Rochester, NY: Rochester Hearing and Speech Center.

Friend, M., & Bursuck, W.D. (2002). *Including students with special needs: A practical guide for classroom teachers* (3rd ed.). Needham Heights, MA: Allyn & Bacon.

Giangreco, M.F., Prelock, P., Reid, R., Dennis, R., & Edelman, S. (2000). Roles of related services personnel in inclusive schools. In R. Villa & J. Thousand, (Eds.), *Restructuring for caring and effective education: Piecing the puzzle together* (2nd ed.) (pp. 360-388). Baltimore: Paul H. Brookes.

Giangreco, M.F. (1995). Related services decision-making: A foundational component of effective education for students with disabilities. In E. McEwen (Ed.). Occupational and physical therapy in educational environments (pp. 47-67). Binghamton, NY: Haworth Press.

Gillon, G.T. (2000). The efficacy of phonological awareness intervention. *Language, Speech, and Hearing Services in Schools*, *31*, 126-141.

Gormley, S., & Ruhl, K. (2005). Shared storybook reading: Increasing vocabulary skills in an inclusive classroom setting. *Perspectives on School-Based Issues*, *6*(1), 11-13.

Idol, L. (2006). Toward inclusion of special education students in general education: A program evaluation of eight schools. *Remedial and Special Education, 27*, 77-94.

Kozleski, E.B., Artiles, A., Fletcher, T., & Engelbrecht, P. (2007). Understanding the dialectics of the local and the global in education for all: A comparative case study. *International Journal of Educational Policy, Research, & Practice: Reconceptualizing Childhood Studies*, *8*, 19-34.

La Pelle, N. (2004). Simplifying qualitative data analysis using general purpose software tools. *Field Methods, 16*(1), 85-108.

McLeskey, J., & Waldron, N. (2006). Comprehensive school reform and inclusive schools. *Theory Into Practice, 45,* 269-278.

Morris, M., Chrispeels, J., & Burke, P. (2003). Professional development that works: The power of two: Linking external with internal teachers’ professional development. *Phi Delta Kappan, 84*(10),748-767.

Rea, P., Mclaughlin, V., & Walther-Thomas, C. (2002). Outcomes for students with learning disabilities in inclusive and pullout programs. *Exceptional Children*, *68*(2), 203-223.

Report to Congress U.S. Department of Education. (2007). *Twenty-seventh annual report to congress on the implementation of the Individuals with Disabilities Education Act, 2005* (Vol. 1). Washington DC: Author.

Schraeder, T. (2013). *A guide to school services in speech-language pathology.* San Diego, CA:

 Plural Publishing.

Theoharis, G., Causton, J., & Tracy-Bronson, C.P. (in press). *Leading inclusive special education: Cases of school reform for students with disabilities.* Educational Administration Quarterly.

Villa, R.A., Thousand, J.S., Nevin, A.I., & Malgeri, C. (1996). Instilling collaboration for inclusive schooling as a way of doing business in public schools. *Remedial and Special Education, 17*, 169-181.

Westling, D. & Fox, L. (2009). *Teaching students with severe disabilities* (4th ed.). Upper Saddle River, New Jersey: Merrill Prentice Hall.

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| Table 1. Participant Demographics |
| Participant’s Name | Related Service Type | Years of Experience | Years of Experience with Inclusion | % of Time in I.C. |
| Terry  | PT | 16 years | 16 years | 70 % |
| Bernice  | OT | 25 | 25 | 80% |
| Mary  | PT | 4 years | 4 years | 90 % |
| Moe  | SLP | 10 years | 9 years | 80%  |
| Nicole  | SLP  | 21 years | 15 years | 85% |
| Francine  | SLP | 2 years | 2 years | 75%  |
| Kim  | OT | 13 years | 4 years | 80%  |
| Cora  | PT | 3.5 years | 3.5 years | 67%  |
| Kelsey  | OT | 30 | 26 | 50% |
| Mary  | SLP | 24 years | 5 | 50% |
| Kendra  | SLP | 9 years | 9 years |  90% |
| Vanessa | SLP | 30 years | 8 years | 80% |
| Paulina  | PT | 12 years | 10 years | 75% |
| Page  | OT | 23 Years | 23 years | 70% |
| Joslyn  | OT | 7 years | 6 years | 50% |

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

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| Table 2. Semi-Structured Interview Guide |
| **Interview Questions:** |
| 1. Describe your work in schools.
 |
| 1. Describe a time that you experienced satisfaction in your work and tell me about it.
 |
| 1. Help me understand how you came to be interested in providing therapy.
 |
| 1. Tell me about a time you were proud of the progress a student made. What do you feel you learned from this?
 |
| 1. Can you tell me about meeting or targeting specific therapy goals in a classroom setting? Give me an example of goals students have and tell me about meeting those goals.
 |
| 1. Talk about collaborating with others to make this therapy work.
 |
| 1. If you were giving new therapists advice about conducting inclusive therapy sessions, what advice would you give?
 |
| 1. What strategies or ideas can you give to other therapists?
 |
| 1. Can you tell me about a time when you had to take a strong stand about something?
 |
| 1. Tell me about a time when there has been change in therapy services and what that was like.
 |
| 1. Tell me about stories of barriers you’ve faced in your work.
 |
| 1. What kinds of staff conflicts, if any, have occurred here?
 |
| 1. Tell me about a time that frustrated you. What do you feel you learned from this?
 |
| 1. Is there anything else I should be asking you or something that may add to this interview that is important to you?
 |