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Recognizing a Need for New Jersey Legislative Change: Ensuring the Provision of Comprehensive School-Based Physical Therapy Intervention as Commander Under the Individuals With Disabilities Education Act is an Important Step in the Mitigation of a Public Health Concern

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RECOGNIZING A NEED FOR NEW JERSEY LEGISLATIVE CHANGE: ENSURING THE PROVISION OF COMPREHENSIVE SCHOOL-BASED PHYSICAL THERAPY INTERVENTION AS COMMANDED UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT IS AN IMPORTANT STEP IN THE MITIGATION OF A PUBLIC HEALTH CONCERN

I. INTRODUCTION

Childhood physical disability is a pervasive concern, affecting the quality of life of the disabled child, her family, and society.[1] Childhood physical disability alters every dimension of child development and leads to multi-faceted implications persisting into adulthood. It stretches the financial, programmatic, and emotional abilities of families; and it distends already strained societal resources.[2] As such, childhood physical disability is a serious public health concern, and maximizing the function, independence, and development of these children is critical to addressing this concern.

Due to physical therapists' unique focus on motor development – and their extensive training in mitigating the effects of disability on motor development[3] – physical therapy ("PT") intervention has the potential to play a critical role in mitigating this public health concern. For many children with physical disabilities, PT evaluation and treatment is essential to maximizing

[1] *See generally* P.K. Richardson, *The School as Social Context: Social Interaction Patterns of Children with Physical Disabilities*, 53 AM. J. OCCUPATIONAL THERAPY 296, 296-97 (2002).
[2] *See generally* Mary Law et al., *Environmental factors affecting the occupations of children with physical disabilities*, J. OCCUPATIONAL SCIENCE, Nov. 1999, at 102, 102.
[3] *See generally* Linda J. Michaud & The Committee on Children with Disabilities, *Prescribing Therapy Services for Children with Motor Disabilities*, 113 PEDIATRICS 1136, 1136 (2004); Diana Goldstein et al., *Enhancing Participation for Children with Disabilities: Application of the ICF Enablement Framework to Pediatric Physical Therapist Practice*, PEDIATRIC PHYSICAL THERAPY, July 2004, at 114, 115; Richardson, *supra* note 1, at 303.

function and meaningful participation across their lifespans.[4] For many of these children, however, access to PT intervention is limited.[5] This limited access has multiple causes, but the result is the same: many of the most vulnerable physically impaired children are accessing fragmented PT intervention, at best.[6]

The inadequate access to PT intervention endures in the public-school setting. Under the Individuals with Disabilities Education Act ("IDEA"), the federal legislation guiding special education in public schools, Congress mandates PT intervention as part of a child's individualized special education plan in certain circumstances.[7] Unfortunately, neither Congress nor the New Jersey ("NJ") legislature provides usable guidance on the provision of these services.[8] In fact, determining a student's qualification and need for school-based PT has been flogged the "most controversial and poorly understood aspect of [the] IDEA."[9] Because of this lack of clear statutory command, many of these children are denied adequate or comprehensive PT services in NJ's public schools as well, despite their universal access to the service and the federal government's universal requirement to offer it.[10]

Notwithstanding the current inadequacies, schools do provide an essential venue for provision of PT services for children with physical disabilities. They provide universal access to

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[4] *See* Goldstein, *supra* note 3, at 115.
[5] *See generally* M. Drainoni et al., *Cross-Disability Experiences of Barriers to Health-Care Access Consumer Perspectives*, J. OF DISABILITY POL'Y STUD., 2006, at 101, 101.
[6] *See generally* Janet Currie & Robert Kahn, *Children with Disabilities: Introducing the Issue*, FUTURE CHILD., Spring 2012, at 3, 7.
[7] *See* U.S.C. § 1400 et. seq. (Under the Act, public schools in receipt of federal funding are required to provide physical therapy services as part of a comprehensive, individualized special education plan if it is necessary for the child to benefit from his or her special education.)
[8] Carlo Vialu & Maura Doyle, *Determining Need for School-Based Physical Therapy Under IDEA: Commonalities Across Practice Guidelines*, 29 PEDIATRIC PHYSICAL THERAPY, 350, 350 (2017); See 20 U.S.C. § 1400 et. seq.; N.J. Admin.Code § 6A:14 et seq. (N.J. Special Education Statute); N.J. Admin.Code § 13:39 et seq. (N.J. Physical Therapy Licensing Act).
[9] Vialu, *supra* note 8, at 350.
[10] American Academy of Pediatrics, Council on Children with Disabilities, *Provision of Educationally Related Services for Children and Adolescents with Chronic Diseases and Disabling Conditions*, 119 PEDIATRICS 1218, 1221 (2007).

PT intervention; they offer efficient funding for that intervention; they offer ideal programmatic structuring for the services; and they provide the optimal team collaboration for intervention decisions.

This paper asserts three things: (1) under a comprehensive reading of the IDEA and judicial interpretation, federal law mandates provision of comprehensive physical therapy services in the public schools for qualifying students; (2) provision of these services in schools is essential to addressing the public health concern; and (3) NJ's public schools are failing to offer the PT services required under the IDEA. As a result, NJ is failing to properly mitigate this public health concern. This paper implores the NJ legislature to mitigate this concern by proscribing comprehensive PT services in the schools for qualifying students, as is demanded under the IDEA.

This paper will start by discussing childhood physical disability, the resulting public health concern, the importance of PT in addressing that concern, and the difficulties faced in accessing that intervention. This paper will then describe why public schools are an essential venue for providing PT services to these children, and it will contrast that to their failure to do so. Next, this paper will review the IDEA, and it will show why a strict reading of the IDEA, and related judicial interpretation, command provision of comprehensive school-based PT services. Last, this paper will urge NJ to clearly legislate comprehensive PT intervention in public schools, as required under the IDEA, to ensure compliance and mitigate related public health concerns.

II. SCHOOL-BASED PT INTERVENTION IS ESSENTIAL TO MITGATING PUBLIC HEALTH CONCERNS RELATED TO CHILDHOOD PHYSICAL DISABILITY

A. Childhood Physical Disability is a Public Health Concern

A typically developing child thrusts him or herself into almost constant interactions with the environment, attaining a variety of perceptual motor experiences, throughout the day: one child

drags his hand on the wall as he walks down the hallway; another skips and twirls on her way to the bus; a third plays pat-a-cake at recess with a peer. For typically developing children, these interactions drive the child's development. These seemingly innocuous movement experiences foster the child's growth in all developmental domains including cognition, socio-emotional development, and communication.[11] Unfortunately, when a child has a physical disability, opportunities for typical movement and interaction are restricted.[12] Childhood physical disability is characterized by the presence of motor impairments that result in a child's limited or lack of ability to perform an activity in the manner (or within the range) considered normal.[13] Since a child's movement experiences impact the progression of skills in all developmental domains, the consequences of childhood physical disability reach into all important spheres of the child's – and later the adult's – life.[14] Childhood physical disability impairs social development, leading to a variety of social deficits including "limited participation in … play, …, poor social skills, lack of drive, and decreased concentration."[15] The deprivation caused by the lack of environmental engagement can result in secondary social, emotional, and psychological disabilities including isolation, poor self-esteem, poor social adjustment and unemployment.[16] All of these deficits will persist to some degree into adulthood, and they often have devastating impacts on the economic

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[11] *See* Jamie M. Holoway et al., *Relationships between gross motor skills and social function in young boys with autism spectrum disorder*, PEDIATRIC PHYSICAL THERAPY, July 2018, at 184, 195.
[12] Donna Goodwin & Jane E. Watkinson, *Inclusive Physical Education From the Perspective of Students with Physical Disabilities*, ADAPTED PHYSICAL ACTIVITY Q., Apr. 2000, at 144, 152 (citing the United Nations definition of disability as cited in Shogan, D., *The social construction of disability: The impact of statistics and technology*, 15 ADAPTED PHYSICAL THERAPY Q. 269, 273 (1998)).
[13] *Id.*, at 273.
[14] *See* Mary Law et al., *Environmental factors affecting the occupations of children with physical disabilities*, J. OCCUPATIONAL SCIENCE, Nov. 1999, at 102, 102.
[15] Richardson, *supra* note 1, at 296.
[16] Richardson, *supra* note 1, at 297.

success and overall health of these children – as adults – lending them to a lifetime of less productive citizenry that may prove costly to society.[17]

Today, the estimated eighteen percent of children and adolescents in the United States who are living with a disability[18] are living longer lives than ever before.[19] Consequently, it is more important than ever for these children to enter adult health care systems, communities, and workforces as prepared as possible for self-sufficient, appropriate, and meaningful participation.[20] As they strive for independence, these children progressing into adulthood may seek PT services in an attempt to "improv[e] their ability to participate in meaningful community and life activities."[21] Unfortunately, physical therapists in adult settings often have less experience and less expertise in the treatment of these childhood onset physical disabilities.[22] Age-related issues secondary to childhood physical disability may compound already existing limitations and dependence of these adults, adding complexity to their care and treatment and diminishing their ability to meaningfully contribute to society.[23]

In addition to the direct effects of disability on each child throughout his lifespan, families and society also confront compounding indirect costs as a result of childhood physical disability.[24] As families decide how best to cope with a child's disability, they face stress in navigating the health-care and insurance systems; impasses to finding knowledgeable providers; obstacles to accessing specialists; paperwork requirements for obtaining approvals for rehabilitation services;

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[17] *See Id.*; H. Rep. No. 332, 94th Cong. at 11 (1975).
[18] Nancy A. Murphy & Paul S. Carbone, *Promoting the Participation of Children with Disabilities in Sports, Recreation, and Physical Activities*, 121 PEDIATRICS 1057, 1057 (2008).
[19] Margo N. Orlin et al., *The Continuum of Care for Individuals with Lifelong Disabilities: Role of the Physical Therapist*, 94 PHYSICAL THERAPY 1043, 1044 (2014).
[20] *C.f. id.* at 1045, 1049.
[21] *Id.* at 1044.
[22] *Id.*
[23] *Id.*
[24] Currie, *supra* note 6 at 8.

and hardships in coordinating care.[25] These programmatic familial burdens, coupled with the child's increased physical and emotional needs, significantly impact the entire family's time and money.[26] The parents usually spend more time caring for the child – and the child's needs – and away from work.[27] This often leads to secondary familial effects including lost productivity; under- or unemployment; and decreased economic performance.[28] Eventually, the ripple effects of these familial costs translate into societal costs including lower tax revenues; increased spending for social programs; and costs associated with a child's decreased future economic performance.[29]

For all of these reasons, childhood physical disability is an important public health concern. Maximizing the functional ability and self-sufficiency of these children – and consequently minimizing the secondary, lifelong social, emotional, and psychological consequences stemming from their disability – is critical to mitigating this concern.

B. Comprehensive PT Intervention is an Effective Tool for Mitigating the Public Health Concerns Resulting from Childhood Physical Disability

The public health concerns resulting from childhood physical disability can be mitigated by increasing these children's opportunities for guided movement, environmental interaction, and perceptual motor experiences. These opportunities for development will help maximize their independence and establish a strong foundation for the emerging adults they will become. Physical therapy intervention is essential to this mitigation.

Physical therapy practice is defined as the "identification of physical impairment [or] movement related functional limitations … [resulting from] … disability."[30] The vision of the

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[25] Drainoni, *supra* note 5, at 104.
[26] James M. Perrin, *Health Services Research for Children with Disabilities*, 80 MILBANK Q., 303, 307 (2002).
[27] *Id.*
[28] Currie, *supra* note 6 at 8.
[29] *Id.*
[30] N.J.C.A. § 13:39A-2.1.

Pediatric American Physical Therapy Association comports with this definition: to "[o]ptimize movement for lifelong meaningful participation of all children."[31] Physical therapists are thoroughly trained in motor development and are uniquely situated to mitigate the effects of disabling conditions on development.[32] Physical therapy interventions can range broadly in their format. They can include altering or adapting the social and physical environment; providing consultation to families and other professionals; and providing direct intervention to children."[33] Regardless of the type of intervention, when children with physical disabilities have motor problems causing interference with their mobility, self-care, or communication, PT intervention can provide the child with amelioration, compensation, and adaptations for the impairments.[34] Physical therapists develop interventions to target motor impairments, such as muscle weakness; range of motion restrictions; and impairments in balance, coordination and motor planning,[35] in order to foster optimal movement, functional ability, and lifelong independence.[36] Physical therapy has become the intervention of choice for children with physical disabilities, especially where motor limitations are the primary factor interfering with other areas of development and participation.[37] Because pediatric physical therapists' core focus is physical development, physical therapy intervention offers a unique therapeutic opportunity to mitigate the effects of disabling conditions on development for children with physical disabilities.[38] As such, comprehensive PT

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[31] AMERICAN PHYSICAL THERAPY ASSOCIATION ACADEMY OF PEDIATRIC PHYSICAL THERAPY, https://pediatricapta.org/about-pediatric-physical-therapy/APTA-academy-pediatric-physical-therapy.cfm (last visited Dec. 29, 2020).
[32] Richardson, *supra* note 1, at 303.
[33] *Id.*
[34] Michaud, *supra* note 3, at 1136.
[35] *See id.*
[36] AMERICAN PHYSICAL THERAPY ASSOCIATION ACADEMY OF PEDIATRIC PHYSICAL THERAPY, *supra* note 31(last visited Dec. 29, 2020); *see* Lesley Wiart et al., *Parents' perspectives on occupational therapy and physical therapy goals for children with cerebral palsy*, DISABILITY & REHABILITATION, Jan. 2010, at 248, 248; Goldstein, *supra* note 4, at 115.
[37] Vialu, *supra* note 8, at 353.
[38] Richardson, *supra* note 1, at 303.

intervention is a critical means of mitigating the public health concerns arising from childhood physical disability.

C. Children with Physical Disabilities Face Issues Accessing Physical Therapy

Unfortunately, children with physical disabilities often face issues that limit their access to consistent and comprehensive PT intervention. Generally, Americans with disabilities are subject to healthcare access issues more pronounced than those faced by persons without disabilities, and the issues are often most pronounced for those who are the most severely disabled.[39] By one estimate, "nearly two of every five special needs children are either uninsured or inadequately insured,"[40] and many children with physical disabilities only have episodic health insurance coverage.[41]

Like most healthcare, PT intervention is not inexpensive,[42] and the large number of un- or underinsured children with physical disabilities often face delays in receiving adequate healthcare, fragmented healthcare service delivery, or unmet healthcare needs.[43] Sadly, poor and minority children – who are disproportionally affected by greater incidence and severity of childhood disability[44] – face the most pronounced healthcare access issues.[45] Their particularly high rates of disability, combined with their lack of adequate health care access, often puts these children in double jeopardy: they are both more likely to *have* a disability and more likely to *suffer* from it.[46]

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[39] Drainoni, *supra* note 5, at 101.
[40] Currie, *supra* note 6, at 9.
[41] *Id.* at 7.
[42] MD SAVE, https://www.mdsave.com/procedures/physical-therapy-visit/d787f9ce/new-jersey#:~:text=On%20MDsave%2C%20the%20cost%20of,shop%2C%20compare%20prices%20and%20save, (last visited Feb. 2, 2021) (Stating an average PT visit in New Jersey costs between fifty-five and eighty-five dollars.)
[43] *See* Currie, *supra* note 6, at 8-9 ("[C]oncluding, not surprisingly, that children with disabilities fare far better when they are insured.").
[44] Currie, *supra* note 6, at 11; Perrin, *supra* note 26, at 307 (stating that there is at least some evidence that poverty increases the incidence and severity of disability).
[45] Drainoni, *supra* note 5, at 101.
[46] Currie, *supra* note 6, at 11.

Significant numbers of these children face devastating obstructions to or delays in needed services,[47] and the inevitable fragmented nature of their care places a tremendous burden on the families struggling to fill in the gaps.[48] In this way, a child's disability can tend to further impoverish a family, compounding the access issues.[49]

While families' limited financial resources and access issues reduce the reality of consistent PT intervention for these children, other factors also contribute. Some parents inevitably admit to forgoing their child's therapeutic interventions, such as PT, in order "to enjoy family life, to have the time to meet other demands such as homework, or … [to] reserve[e] time for their children to play."[50] Other parents, perhaps not fully appreciating PT's long-range socio-emotional developmental benefits, view therapy as detracting from the ability of their child or siblings to develop social relationships and enjoy family time.[51]

In summary, families of children with physical disabilities face a multitude of barriers to accessing adequate and consistent comprehensive physical therapy for their children. These access issues, especially pervasive in poor and minority families, lead to a fragmented approach to health care, generally, and a fragmented approach to therapeutic PT services, specifically.[52] Unfortunately, lack of access to consistent and comprehensive PT intervention leaves many children with childhood physical disability falling short of their individual potential for independence and self-sufficiency.

D. <u>Schools are an Essential Venue for Physical Therapy Provision</u>

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[47] Drainoni, *supra* note 5, at 104 (stating significant obstructions or delays in health care are faced by an estimated twenty to thirty percent of children with disabilities).
[48] Currie, *supra* note 6, at 11.
[49] Perrin, *supra* note 26, at 307.
[50] Lesley Wiart et al., *Parents' perspectives on occupational therapy and physical therapy goals for children with cerebral palsy*, DISABILITY & REHABILITATION, Jan. 2010, at 248, 253.
[51] *Id.*
[52] Currie, *supra* note 6, at 11.

Schools are a child's natural learning environment, and by their nature and design, schools afford an optimal confluence of time, funding, and personnel for provision of PT services. Attendance in public schools and funding for special education programs are directed by local, state, and federal law. New Jersey mandates school attendance for all children between the ages of six and sixteen, for 5.5 to seven hours per day.[53] Most children spend more time in school than any other single environment outside of their home.[54] Auspiciously, through the IDEA, the federal government mandates an avenue for provision and funding of PT services in NJ's public schools (for qualified students).[55] Since children have universal access to public schools for a significant portion of their day, and the IDEA requires PT services be provided free to the families of qualifying children, schools provide an excellent venue for delivery of PT services. Coordination of school-based PT services for children with physical disabilities can help lighten programmatic, financial, and other barriers to therapeutic access, ensuring consistent PT intervention.[56]

Personnel and staffing coordination also make schools an optimal venue for provision of PT services to these children. Special education departments comprise a critical team of developmental and medical professionals dedicated to the growth of children. For children with physical disabilities, the gold standard for habilitative services encompasses a multi-disciplinary team.[57] While a family may depend on an oft ill-equipped pediatrician to evaluate their disabled child and to determine the need for physical therapy intervention,[58] schools employ (or contract) teams of physicians, therapists, educators, psychologists, social workers, and learning consultants,

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[53] N.J.S.A. 18A:38-28 - 31.
[54] N.J. DEP'T OF EDUC., A GUIDE TO YOUR CHILDREN'S SCHOOLS: A PARENT'S HANDBOOK TO NEW JERSEY SCHOOLS, https://nj.gov/education/bilingual/resources/ParentHandbook.pdf (last viewed Feb. 2, 2021) (reporting the average NJ student spends between 5.5 and seven hours each day in school).
[55] *See* 20 U.S.C. § 1400 et. seq.
[56] Perrin, *supra* note 26, at 310.
[57] Orlin, *supra* note 19, at 1044.
[58] Michaud, *supra* note 3, at 1136 (stating many pediatricians have limited formal education about therapeutic intervention or physical disabilities).

many of whom work together daily. Since children with physical disabilities benefit from the coordinated service of a multi-disciplinary approach to their care, the team inherent in the school setting – purposed with addressing the social, educational, psychological, and physical development of children – is the quintessential venue to link children to PT services.

Another reason why schools are an essential venue for provision of PT intervention relates to the importance of rendering PT evaluations and treatment within a child's natural environment.[59] Skill building in a child's natural environment – where adaptations in motor performance can be associated and integrated with accommodating changes in the child's world – provides the best opportunity for functional skill progression and carry-over.[60] Various motor control theories of motor learning corroborate and reinforce the importance of environmental context.[61]

In summary, because the school environment provides ample time, universal access to, and funding for ongoing and regular PT intervention; fosters that intervention in a multi-disciplinary approach; and delivers that intervention in the child's natural environment, public schools are the ideal venue for provision of PT services to children with physical disabilities.

E. NJ Public Schools Effectuate Public Health Concerns by Failing to Consistently Provide Comprehensive PT Intervention to Children with Physical Disabilities

School-based PT is a unique practice setting: it is governed by the IDEA, individual state PT practice acts, state special education law, and local education association ("LEA") authority.[62] While most school-based physical therapists admit to awareness of the general mandate of the

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[59] Goldstein, *supra* note 4, at 116.
[60] *Id.*; *Note, Education as Healthcare: Doctors, Teachers, and Lawyers Unite to Ensure Students with ASD Get the Related Services They Deserve Under the IDEA*, 16 J. HEALTH & BIOMED. L. 186, 190 (2020).
[61] Goldstein, *supra* note 4, at 116.
[62] AMERICAN ACADEMY OF PEDIATRIC PHYSICAL THERAPY, AMERICAN PHYSICAL THERAPY ASSOCIATION, SCHOOL-BASED PHYSICAL THERAPY: CONFLICTS BETWEEN INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) AND LEGAL REQUIREMENTS OF STATE PRACTICE ACTS AND REGULATIONS, 1 (2014).

IDEA, they look to statutory provisions – including state PT practice acts, special education law, and local statutes – to guide their compliant practice.[63] Many states, however, including NJ, and most local governments, offer no statutory framework for meeting the IDEA's requirements.[64] As a result, therapists tend to follow personally and commonly held beliefs about the IDEA's requirements, while immediately answering to and abiding by oft financially strapped LEAs. In the absence of clear state statutory guidance, these LEAs are left to self-interpret the IDEAs mandates. Since PT in the public schools is administered at no charge to qualifying children, most LEAs – when bound by no unequivocal mandate to the contrary – tend toward the immediate cost-savings of limiting PT services to the extent they feel is permissible.[65]

Consider fourteen-year-old Christopher Polk, who contracted encephalopathy during infancy.[66] Christopher was finally learning to stand independently and showed "some potential for ambulation."[67] Despite that identified potential for improved self-sufficiency, the NJ school district he attended replaced Christopher's direct, school-based PT intervention with a monthly consultative model.[68] In this model, Christopher's physical therapist merely trained his teacher how to integrate strategies into his classroom.[69] Another student, D.K., suffered from cerebral palsy, was wheelchair bound, and required adult care for all of his basic needs.[70] When he was eighteen-years-old, his parents had to fight for, *inter alia*, increased, continued PT intervention.[71] In another case, a school district allowed their own pediatrician to determine the amount of PT

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[63] *See generally id.*
[64] *See* N.J. Admin. Code § 6A:14 et seq.; N.J. Admin. Code § 6A:14-3.9.
[65] *See* Vialu, *supra* note 8, at 353; Jack Rodman et al., *A Nationwide Survey of Financing Health-Related Services for Special Education Students*, J. SCHOOL HEALTH, April 1999, at 133, 139 (citing Building the Legacy: IDEA 2004. Available at http://idea.ed.gov. Accessed July 19, 2013).
[66] *D.B. v. Ocean Twp. Bd. of Educ.*, 985 F. Supp. 457, 484 (D.N.J. 1997).
[67] *Id*.
[68] *Id*.
[69] *Id*.
[70] *B.K. v. Toms River Bd. of Educ.*, 998 F. Supp. 462, 464 (D.N.J. 1998).
[71] *Id.* at 465.

intervention required after mere consultation with the physical therapist.[72] The district's special education supervisor admitted a lack of district policy regarding the amount of PT afforded to special education students.[73] The pediatrician's recommendation totaled only ten PT sessions *per year* for this eleven-year-old child with autism.[74] This raised questions about the potential of intervention efficacy, especially considering children with autism often need frequent opportunities for practice to develop mastery of any skill.[75] Elsewhere in NJ, parents of B.S., a fifteen-year-old student with pervasive developmental delays, contested the school district's decrease of PT intervention to one time per month.[76] They claimed the decrease effectively "eliminated meaningful physical therapy" intervention for their child.[77] In yet another NJ district, seven-year-old Henry had hypotonia, difficulty with motor planning, and physical weakness from an overall delay in muscle development due to a chromosomal disorder.[78] Henry's parents filed suit against the school district's decision – based again on a district pediatrician's recommendation – to afford two sessions per week of combined occupational therapy ("OT") and PT for only five school weeks.[79]

> [Henry's parents] complained: (1) the frequency and duration of OT and PT services recommended by the District w[ere] "grossly inadequate", … (3) OT and PT are two "distinct disciplines" which should be addressed and prescribed separately, (4) the medical evaluation by the District neglected to address several issues which would affect the physical education component of Henry's academic program, (5) the District "failed and refused to give due consideration to all tests, records, independent evaluations, [District] evaluations and recommendations, and parents' evaluations and recommendations for occupational and physical therapy"

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[72] *J.F. v. Sch. Dist.*, CIVIL ACTION No. 98-1793, 2000 U.S. Dist. LEXIS 4434, at *9, *13 (E.D. Pa. Apr. 7, 2000).
[73] *Id.* at *37.
[74] *See Id.*
[75] *Id.* at *9, *13.
[76] *G.S. v. Cranbury Twp. Bd. of Educ.*, Civil Action No. 10-774 (FLW), 2011 U.S. Dist. LEXIS 44933, at *7 - 8, (D.N.J. Apr. 26, 2011).
[77] *Id.* at *7 - 8, *41 - 42.
[78] *Woodside v. Sch. Dist.*, CIVIL ACTION NO. 99-1830, 2000 U.S. Dist. LEXIS 568, at *6 (E.D. Pa. Jan. 27, 2000).
[79] *Id.* at *7-8.

> in formulating the [mandates]. [Henry's parents] then requested that Henry be given … 1 hour of PT per week [for the duration of the school year].[80]

Effective PT interventions can lead to acquisition of and improvement in gross motor skills and functional mobility including balance (e.g., for sitting, standing, reaching, and/or safety); postural control (e.g., for sitting, standing, transferring and/or prolonged positioning); mobility skills (e.g., for transferring, locomotion, and/or wheelchair mobility); range of motion (for proper positioning and availability of movement); gross motor control (for purposeful, directed movements of the trunk and extremities); and gross motor coordination (for controlled movements of the trunk and extremities).[81] Only through the provision of comprehensive PT services can these gross motor skills – needed for maximization of function – be effectuated. When schools limit the scope of PT to, for example, monthly PT consultation for a teen with emerging ambulation skills[82] or five total sessions for another with pervasive developmental motor delays,[83] these goals will not be met, and public health ramifications will ensue.

III. THE IDEA REQUIRES PROVISION OF COMPREHENSIVE SCHOOL-BASED PT SERVICES

In 1975, Congress passed the Education of all Handicapped Children Act (later amended and renamed the Individuals with Disabilities Education Act, *supra*) to ensure all children – regardless of their disability – received "a free, appropriate public education."[84] State receipt of federal funding depended upon compliance with the Act, requiring schools, *inter alia*, to provide "related services … as may be required to assist a child with a disability to benefit from special education."[85] The Act named PT as one such related service.[86] In accordance with the United

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[80] *Id.* at *7-8.
[81] Michaud, *supra* note 3, at 1136.
[82] *D.B.*, 985 F. Supp. at 484.
[83] *Woodside,* 2000 LEXIS 568, at *6-8.
[84] Rodman, *supra* note 65 at 133; *See* 20 U.S.C. § 1400 et. seq.
[85] Rodman, *supra* note 65 at 133 (*citing* Education for All Handicapped Children Act of 1975, Pub. L. No. 94-142).
[86] 20 U.S.C. § 1400 et. seq.

States' policy of equal opportunity and participation for children with disabilities, the Act emphasized the availability of appropriate, individualized special education and related services designed to meet the unique needs of each child.[87] Despite widespread confusion, a close look at the legislative history and text of the IDEA, its amendments, and judicial interpretation provide clear guidance for the level of "educational benefit" required from special education programs and related services provided under its authority. Special education and related services, including PT, must be afforded in a manner that provide significant learning toward the goal of maximizing self-sufficiency, commensurate with the capabilities of each child. This includes provision of comprehensive PT services.

A. The IDEA Requires Special Education Programs Afford Significant Educational Benefit and Meaningful Individualized Progress

In 1982, the Supreme Court first interpreted the IDEA, construing its requirements narrowly. In *Board of Educ. of Hendrick Central School Dist., Westchester County v. Rowley*, the Court required that educational programs and related services afforded under the Act need only provide "some benefit" to the child with a disability.[88] "The purpose of the Act," said the Court, "was to provide a *basic* level of educational opportunity."[89] The Court focused on a handicapped student's mere *access* to educational opportunity, concluding that "the [A]ct was more to open the door of public education to handicapped children … than to guarantee any particular level of education once inside."[90]

[87] *See id.*; Vialu, *supra* note 8, at 350; Note, Education as Healthcare, *supra* note 60, at 190.
[88] *See Board of Educ. of Hendrick Central School Dist., Westchester County v. Rowley*, 458 U.S. 176, 189 (1982) (emphasis added).
[89] *Id.* at 189, 200 (emphasis added; also stating "neither the Act nor its history persuasively demonstrate that Congress thought that equal protection required anything more than equal access").
[90] *Id.* at 192.

In several decisions following *Rowley*, the Third Circuit held tightly to *Rowley's* text, finding individual special education and related service programs compliant with the spirit of the Act if they provided anything more than "trivial educational benefit."[91] In 1988, however, the Third Circuit pulled back on this narrow interpretation of the *Rowley* decision in *Polk v. Cent. Susquehanna Intermediate Unit 16*.[92] Resting in large part on the Act's text and legislative history, the *Polk* court held that compliance with the Act required more than provision of a special education and related service program affording trivial educational benefit.[93] The self-defined purpose of the Act, said the court, was to provide "*full* educational opportunity to all handicapped children."[94] Similarly, noted the court, the Senate Report on the 1975 Amendments defined related services, including PT, as services "necessary for a handicapped child to *fully* benefit from special education."[95] The court also pointed out that the House report echoed this language, circumscribing special education and related services to provide each disabled child with not only a free public education, but with a *full* public education.[96] The *Polk* court continued: a "key concern of and primary justification for" the Act resided in the "important goal" of fostering self-sufficiency in children with disabilities.[97] The court noted a "heavy emphasis" on self-sufficiency

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[91] *See e.g. Muth v. Central Bucks School Dist.*, 839 F.2d 113, 119-120 (3d Cir. 1988) (affirming the district court's finding that a student's educational plan appropriate under the Act where ample evidence supported that the educational opportunity provided at least "a basic floor of opportunity" consisting of "personalized instruction with sufficient support services to permit the child to benefit educationally from that instruction."); *Bd. of Educ. v. Diamond*, 808 F.2d 987, 991 (3d Cir. 1986) (stating "[t]he Act … requires a plan likely to produce progress, not regression or trivial educational advancement").
[92] *See Polk v. Cent. Susquehanna Intermediate Unit 16*, 853 F.2d 171 (3d Cir. 1988).
[93] *Id.* at 180.
[94] *Id.* at 181 (citing 20 U.S.C. § 1412(2)(A) (statement about purpose referencing the 1975 Amendments to the Act)).
[95] *Id.* at 181 (citing Sen. R. No. 168, 94th Cong., 1st Sess. at 42).
[96] *Id.* at 181 (citing H. Rep. No. 332, 94th Cong. at 11 (1975); See also 121 Cong. Rec. 19482 (remarks of Senator Randolph, W. Virginia, Chair, Senate Subcommittee on the Handicapped) (discussing the goals of the EHA as "achieving a goal of full educational opportunities")
[97] *Id.* at 181; See H. Rep. No. 332, 94th Cong., 1st Sess. at 11 (1975).

(where possible) as a goal of special education, and concluded that special education and related services conferred under the Act must stimulate significant learning to comport with this goal.[98]

In 1997, after examining the States' progress under the Act, Congress found that while "substantial gains" had been made in educating children with disabilities, more needed to be done to guarantee these children adequate access to appropriate services.[99] In response, Congress passed the 1997 Amendments to the Act – and, later, the 2004 Reauthorization – to "place greater emphasis on improving student performance and ensur[e] that children with disabilities receive a *quality* … education."[100]

The text of the 2004 reauthorization clearly conveyed Congress's intent to confer broad meaning to the term "educational benefit." First, the purpose provision stated that special education and related services be designed to "prepare children with disabilities for further education, employment and independent living."[101] Second, the Act now required transition services focusing on improvements in skills that would "facilitate the child's movement from school to post-school activities, including independent living, or community participation."[102] Third, the Act specifically included related services for, *inter alia*, acquisition of daily living skills.[103] These textual choices not only allow – but demand – the structure of special education and related services to support life beyond the school years and beyond the school building.

Immediately following the 2004 reauthorization, the Sixth Circuit, in a thorough examination of the legislative history and text of both amendments, explicitly recognized the abrogation of the *Rowley* Court's narrow interpretation of the IDEA and provided a new governing

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[98] *Polk*, 853 F.2d at 182.
[99] *Forest Grove School Dist. v. T.A.*, 557 U.S. 230, 239 (2009) (citing S. Rep. No. 105-17, p 5 (1997)).
[100] *Id.* at 239 (2009) (citing S. Rep. No. 105-17, p 3 (1997) (emphasis added).
[101] 20 U.S.C. § 1400(d)(1)(A) (emphasis added); *See also* Vialu, *supra* note 8, at 350.
[102] 20 U.S.C. § 1401(34)(A)-(C).
[103] 20 U.S.C. § 1401(34)(A)-(C).

standard for IDEA claims.[104] The court explained: "[s]ince 1997, the IDEA has required 'a [student's special education and related services] to confer "meaningful educational benefit" gauged in relation to the potential of the child at issue.'"[105] The court echoed the Third Circuit's language as it interpreted the intent of Congress to, at a minimum, "require a program providing meaningful educational benefit towards the goal of self-sufficiency."[106]

In 2017, in *Endrew F. v. Douglas Cty. Sch. Dist. RE-1,* the Supreme Court finally addressed the mixed support for the *Rowley* decision, in the shadow of the Third and Sixth Circuit decisions, *supra*.[107] The Court offered, "When all is said and done, a student offered an educational program providing 'merely more than di minimis progress' … can hardly be said to have been offered an education at all."[108] The IDEA, said the Court, "demands … an educational program reasonably calculated to enable a child to make progress appropriate in light of the child's circumstances."[109]

In summary, the legislative history and text of the IDEA require broad construction of the meaning of "educational benefit" in the provision of special education and related services for children with disabilities. Judicial precedent demands the same. These programs must be individually tailored to each child's unique needs. They must provide opportunities for significant learning, for progress considering the child's individual circumstances, and for preparedness for life beyond the classroom including independent living, employment, community participation, and self-sufficiency of the child.

B. The Scope of School-Based PT Services Under the IDEA Must Not be Limited by the Medical or Ongoing Nature of Care or the Cost of Provision

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[104] *Oakstone Cmty. Sch. v. Williams*, No. 2:11-cv-1109, 2013 U.S. Dist. LEXIS 197022 at *6 (S.D. Ohio June 12, 2013) (citing *Deal v. Hamilton County Bd. of Educ.*, 392 F.3d 840 (6th Cir., 2004)) (emphasis added).
[105] *Id.* at *6 (citing *Deal v. Hamilton County Bd. of Educ.*, 392 F.3d 840, 862 (6th Cir., 2004)).
[106] *Deal v. Hamilton County Bd. of Educ.*, 392 F.3d 840, 864 (6th Cir., 2004).
[107] *See Endrew F. v. Douglas Cty. Sch. Dist. RE-1*, 137 S. Ct. 988 (2017).
[108] *Id.* at 1001 (citing *Rowley*, 458 U.S. at 179).
[109] *Id.* at 1001.

Within the IDEA, Congress defined "related services" broadly, encompassing supportive services that were (1) "designed to enable a child with a disability to receive a free appropriate public education," and (2) "required to assist a child with a disability to benefit from special education."[110] In the category of related services, Congress included, *inter alia*, speech-language pathology and audiology services; interpreting services; psychological services; and occupational and physical therapy.[111] Unfortunately, the text of the IDEA offered little guidance on the scope of these related services, in general,[112] and no express guidance as to the provision of PT services.[113]

The Supreme Court has taken little opportunity to specifically interpret the related services provision of the IDEA. It has generally required related services be afforded under the IDEA when, and to the extent, necessary to provide a disabled child with meaningful access to his or her education, by enabling the child to remain in school during the day.[114] Beyond that floor – requiring related services as an avenue to enable mere access to education – the Court has offered some basic guidance. First, the Court recognized the distinction between "medical services" – excluded from the IDEA's coverage when requiring a physician – and "school health services" – not excluded when capably provided by a "qualified school nurse or other qualified person."[115]

[110] 20 U.S.C. § 1400(26)(A); *Cedar Rapids Cmty. Sch. Dist. v. Garret F. by Charlene F.*, 526 U.S. 66, 73 (1999).
[111] 20 U.S.C. § 1401(26)(A); Vialu, *supra* note 8, at 350; Note, Education as Healthcare, *supra* note 60, at 190.
[112] *See* 20 U.S.C. § 1400 et. seq.; *See also* American Academy of Pediatrics, Council on Children with Disabilities, *supra* note 10, at 1221.
[113] Vialu, *supra* note 8, at 350; s*ee* 20 U.S.C. § 1400 et. seq.
[114] *Garret F.*, 526 U.S. at 73.
[115] *Id.* at 71 (1999) (citing 34 CRF §§ 300.16(a), (b)(4), (b)(11) 1998; *id.* at 73 (citing 20 U.S.C. § 1401(a)(17) (stating "[t]his general definition of 'related services' is illuminated by a parenthetical phrase listing examples of particular services that are included within the statute's coverage. 'Medical services' are enumerated in this list, but such services limited to those that are 'for diagnostic and evaluation purposes. The statue does not contain a more specific definition of the 'medical services' that are excepted from the coverage of Section 1401(a)(17)."

The Court also clarified that the “continuous character” of certain services lacks any relationship to the medical nature of a related service.[116] While continuous services may be more costly and may require additional school personnel, they are not necessarily more “medical” in nature.[117] The Court acknowledged that by including “physical therapy” in the enumerated list of related services, Congress necessarily contemplated schools hiring these additional, licensed health care professionals, as well as the continuous and ongoing nature of these services.[118]

In addition, the Court has offered guidance regarding the cost of related services, including PT. A “chief selling point” of the IDEA, said the Court, was its forward-looking financial structure.[119] Investing in children with disabilities early in their lives – and maximizing their function and self-sufficiency – would eventually redound to societal benefit, as greater numbers of these children would grow to become productive (or at least less dependent) citizens.[120] The Court acknowledged that "taxpayers will spend many billions of dollars over the lifetime of these handicapped individuals simply to maintain such persons as dependents on welfare and often in institutions,[121]" knowing full well that education and therapeutic intervention during childhood leads to long-term, societal financial savings.[122] The Court concluded that since the IDEA fails to employ cost in its definition of related services, accepting a cost-based standard as the “test for

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[116] *Id.* at 76.
[117] *Id.*
[118] *Irving Independent School Dist. V. Tatro*, 468 U.S. 883, 893(1984) (stating, “Congress plainly required schools to hire various specially trained personnel to help handicapped children, such as ‘trained occupational therapists.’”).
[119] *Rowley*, 458 U.S. at 181-82.
[120] *Id.* (stating, “A chief selling point of the Act was that although it is penny dear, it is pound wise -- the expensive individualized assistance early in life, geared toward teaching basic life skills and self-sufficiency, eventually redounds to the benefit of the public as these children grow to become productive citizens. See H. Rep. No. 332, 94th Cong., 1st Sess. at 11 (1975) ("with proper educational services many of these handicapped children would be able to become productive citizens contributing to society instead of being left to remain burdens on society"); 121 Cong. Rec. 19492 (1975) (remarks of Senator Williams); id. at 19505 (remarks of Senator Beall)).
[121] *Rowley*, 458 U.S at 201 n.23.
[122] *Rowley*, 458 U.S. at 181.

determining the scope of the provision [of related services would] … create some tension with the purposes of the IDEA."[123]

In summary, the Court's interpretation of the scope of related services, including PT, under the IDEA provides a clear command that PT intervention must not be limited by the medical or ongoing nature of the services or the cost of its provision.

C. The IDEA Requires Comprehensive School-Based PT Services be Provided to Children with Physical Disabilities

When faced with questions pertaining specifically to the criterion for the prescription of school-based PT under the IDEA, courts have done little to clarify the requirement of PT's "educational benefit." Instead, they simply reiterate the IDEA's verbiage: PT is to be afforded when necessary to give students the "full benefit" of special education instruction.[124] The Supreme Court has no decisions guiding the provision of PT under the Act. The Third Circuit *Polk* decision, *supra*, shed some light on the requisite "educational benefit" for NJ schools. The case involved the appeal of a district court's affirmation denying direct school-based PT services for a child with (*inter alia*) a physical disability.[125] The district court rested its denial on *Rowley* and the Third Circuit's then-existing *Rowley* interpretation. That court concluded the current program of indirect PT services complied with the spirit of the IDEA since it provided the student with at least *some* educational benefit.[126] In a surprising decision, however, the Third Circuit did not affirm; instead, the Circuit court declared the district court had "erred in evaluating this … child's [physical

[123] *Garret F.*, 526 U.S. at 73 (1999); *See also* Rodman, *supra* note 65, at 139 (arguing that although he needs of children with physical disabilities may be great, the relative numbers are arguably small, and the aggregate expenses are modest compared to expenses for other high-needs populations and finding that related services represented 20% of a $5,000 additional per pupil expenditure or $1,000 per student, supporting the view that the aggregate expenses of related services for these children is "within modest limits").
[124] *Marshall Joint Sch. Dist. No. 2 v. C.D.*, 616 F.3d 632, 661 (7th Cir. 2010) citing 20 U.S.C. §§ 1401, 1406(26); *Battle v. Pennsylvania*, 629 F.2d 269, 272 (3d Cir. 1980).
[125] *Polk*, 853 F.2d at 172.
[126] *Polk*, 853 F.2d at 172.

therapy] program by a standard under which even trivial advancement satisfied the substantive provisions of the [IDEA's] guarantee[s]."[127] Then, the *Polk* court went a step further and delved into the needs of children with physical disabilities as they pertain to the provision of school-based PT services.[128] The court acknowledged some of the public health concerns, discussed *supra*:

> For children [...] with extensive physical disabilities [...] that often interfere with development in other areas, physical therapy is an essential prerequisite to education. For example, development of motor abilities is often the first step in overall educational development. ...[T]he PT itself may form the core of a severely disabled child's special education. ... For some students, PT is not merely a conduit to education but a major portion of the child's special education, teaching basic skills.[129]

The *Polk* court continued: "[t]hat [a child with a physical disability] may never achieve the goals set in a traditional classroom does not undermine the fact that his brand of education (training in basic life skills) is an essential part of [the IDEA's] mandate."[130] Through teaching skills of self-sufficiency, citizens who might otherwise become "burdens on the state" can be transformed – to the greatest extent possible – into productive members of society.[131]

In summary, the IDEA requires special education programs be individually tailored to each child's unique needs. They must provide opportunities for significant learning, for progress considering the child's individual circumstances, and for preparedness for life beyond the classroom. The Supreme Court has validated that neither the continuous and ongoing nature nor the cost of PT services afforded under the IDEA may be significant factors in determining its provision to qualifying students. The Third Circuit *Polk* decision set self-sufficiency as the

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[127] *Id.*
[128] *Id*. at 176.
[129] *Id.* (citing SEE C.E. PEARSON & C.E. WILLIAMS, PHYSICAL THERAPY SERVICES IN THE DEVELOPMENTAL DISABILITIES).
[130] *Id.* at 183.
[131] *Id.* at 182 (interpreting the legislative intent and history's emphasis on self-sufficiency, "with proper educational services many of these handicapped children would be able to become productive citizens contributing to society instead of being left to remain burdens on society" See H. Rep. No. 332, 94th Cong., 1st Sess. at 11 (1975)).

requisite goal for provision of PT services under the IDEA in its jurisdiction, including NJ. To comport with the IDEA, PT must afford meaningful educational benefit toward these goals,[132] and it must stimulate significant learning and potential for progress considering each child's circumstances.[133] Only through the provision of comprehensive PT services in NJ's schools can these goals be met.

IV. TO MITIGATE PUBLIC HEALTH CONCERNS, NJ SHOULD COMMAND CLEAR LEGISLATION REQUIRING COMPREHENSIVE PT INTERVENTION, AS REQUIRED UNDER THE IDEA

Unfortunately, the IDEA does not specify how to determine the need for or amount of PT services to include in a child's special education program.[134] Clearly, PT is appropriate when needed "to assist a child with a disability to benefit from special education."[135] Without firm statutory guidance on the level of "benefit" required to meet the judicially interpreted standard, however, tremendous variability results in children's qualification for and access to PT intervention in NJ's public schools.[136] Failing to offer comprehensive PT in NJ's public schools as part of a qualifying child's special education plan compounds public health concerns and leads to a variability of PT provision that often falls below the standard commanded by the IDEA.

A. Lack of Clarification Regarding the Scope of NJ PT Provision Under the IDEA Leads to Substandard Variability in Services and Fails to Mitigate a Public Health Concern

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[132] *Deal*, 392 F.3d at 864.
[133] *See Polk*, 853 F.2d at 182.
[134] SUBCOMMITTEE ON DOSING, SCHOOL-BASED PHYSICAL THERAPY SPECIAL INTEREST GROUP, SECTION ON PEDIATRICS, APTA, DOSAGE CONSIDERATIONS: RECOMMENDING SCHOOL-BASED PHYSICAL THERAPY INTERVENTION UNDER IDEA RESOURCE MANUAL 1 (2014).
[135] Susan K. Effgan & Marcia K. Kaminker, *Nationwide Survey of School-Based Physical Therapy Practice*, 26 PEDIATRIC PHYSICAL THERAPY 394, 394 (2014).
[136] Vialu, *supra* note 8, at 350 (citing S.K. Effgan & S.E. Klepper, *Survey of physical therapy practice in educational settings*, 6 PEDIATRIC PHYSICAL THERAPY 15, 17 (1994) and M.K. Kaminker et al., *Decision making for physical therapy service delivery in schools: a nationwide analysis by geographic region*, 18 PEDIATRIC PHYSICAL THERAPY 204, 210 (2006).

In the face of vague federal guidance, but despite seemingly clear judicial interpretation, neither professional PT organizations nor the NJ Legislature have proffered clear authority on providing PT services under the IDEA. Acknowledging the lack of federal statutory guidance, professional PT organizations have attempted to provide instruction regarding qualification for and provision of these services. Unfortunately, this guidance repeatedly falls short of practical applicability. For example, the American Academy of Pediatrics Council on Children with Disabilities suggested a standard interpretation of the related services provision. They indicated PT should be afforded when it is necessary for the child to maximize or receive the full benefit of special education.[137] The Council, however, failed to further define what it meant by "maximizing" or "receiving the full benefit" of a special education program, thus leaving the physical therapist with limited capacity for standardized application.[138] Overall, the Council's guidance was vague and lacked legal precedent; in large part, it merely suggested that school-based physical therapists consult their state practice acts for further information.[139]

In another organization's attempt to clarify, the School-Based Physical Therapy Special Interest Group, Section on Pediatrics (a subdivision of the American Physical Therapy Association), put forth dosing considerations for the provision of school-based PT.[140] The Group reiterated that "the IDEA does not specify how [to] determine the amount of physical therapy services to include," and they presented considerations that they determined should guide the "clinical reasoning and decisions of school-based [physical therapists].[141]" In 2014, they published a self-proclaimed "Resource Manual."[142] Even in that Manual, they described a standard for

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[137] 20 U.S.C. § 1406(26); American Academy of Pediatrics, Council on Children with Disabilities, *supra* note 10 at 1221-22.
[138] *See* American Academy of Pediatrics, Council on Children with Disabilities, *supra* note 10, at 1218.
[139] *See* AMERICAN ACADEMY OF PEDIATRIC PHYSICAL THERAPY, *supra* note 62, at 2.; See N.J. Admin. Code § 39A.
[140] *See* SUBCOMMITTEE ON DOSING, SCHOOL-BASED PHYSICAL THERAPY SPECIAL INTEREST GROUP, *supra* note 134.
[141] *Id.* at 1.
[142] *See id.*

determining PT services under the IDEA in verbiage that mimicked the outdated *Rowley* model, *supra*, stating "physical therapy services may be recommended if … required for students to *access* the curriculum."[143] Although published prior to the Supreme Court's *Endrew F.* decision (*supra*, clarifying the IDEA demands an educational program reasonably calculated to enable progress appropriate in light of the child's circumstances), this Manual suggested a mere "access" standard, undermining the text, history, and judicial interpretation of the IDEA's requirements available at the time of publication.[144]

Despite the lack of provisional guidelines in the IDEA and the lack of professional guidance, the NJ legislature has also failed to address the issue with any specificity. In fact, the New Jersey Physical Therapy Practice Act is one of only three state PT practice acts that completely fails to proffer any guidance for determining the criterion for or scope of PT services under the IDEA.[145] New Jersey's Special Education statute is also silent on the issue, even where it does address related services under the IDEA.[146]

The confluence of lack of clarity afforded by the IDEA, vague guidance by PT professional governing bodies, and lack of statutory guidance by the NJ legislature leaves NJ school-based physical therapists and LEAs confused about the qualification for and the scope of PT services commanded under the IDEA. In the face of these challenges, and combined with the fiscal concerns of LEAs, comprehensive services demanded by the IDEA are not universally proffered in NJ's public schools. Substandard variability in PT services for children with physical disabilities has resulted, and a public health concern has been left inadequately addressed.

B. To Mitigate Public Health Concerns, NJ Should Command Legislation Requiring Comprehensive PT Intervention for Qualifying Children with

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[143] *Id.* at 1.
[144] *See id.*; *Endrew F.*, 137 S. Ct. at 1001.
[145] *See* Vialu, *supra* note 8, at 351; N.J. Admin.Code § 13:39 et seq.
[146] *See* N.J. Admin. Code § 6A:14:3-9 and 6A:14:5.1 - 5.2.

Physical Disabilities in All Public Schools, in Accordance with a Proper Reading of the IDEA

Health care professionals frequently view school-based physical therapy services in terms of their medical necessity or helpfulness for children with physical disabilities.[147] While this standard is required in the health care setting, it has not been the standard for school-based PT services provided in NJ's public schools under the IDEA.[148] However, comprehensive PT is one of the most effective ameliorative tools for mitigating the public health concerns stemming from childhood physical disability.

The IDEA mandates broad latitude in defining the educational needs of children with physical disabilities, and it allows wide discretion to structure special education and related services – including PT – to support maximization of self-sufficiency.[149] To comport with the purpose and goals of the IDEA and subsequent judicial interpretation, "educational benefit" must be construed broadly. Comprehensive school-based PT services must be afforded to children with physical disabilities in NJ's public schools to comport with the IDEA's intent of individualized progress.[150]

Irrespective of the lack of federal statutory guidance, education remains a state responsibility. Public education and the operation of schools are more deeply rooted in local control than any other tradition.[151] In the implementation of the IDEA, federal lawmakers and courts function as mere generalists, lacking expertise in the education of children with physical disabilities.[152] Therefore, New Jersey legislators are tasked with ensuring the IDEA's mandates

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[147] American Academy of Pediatrics, Council on Children with Disabilities, *supra* note 10, at 1221-22.
[148] *Id.*
[149] *See* Vialu, *supra* note 8, at 353.
[150] *Deal*, 392 F.3d at 864.
[151] *Battle*, 629 F.2d at 277-78 (quoting *Milliken v. Bradley*, 418 U.S. 717, 741-42 (1974)).
[152] *Deal*, 392 F.3d at 865.

are met on a state level. To mitigate public health concerns, the NJ Legislature should command the provision of comprehensive PT services to qualifying children in the public schools, as required under the IDEA.

V. CONCLUSION

Clearly, public health concerns arise from the failure to provide consistent and comprehensive physical therapy services to children with physical disabilities. When these children lack access to consistent PT intervention, every aspect of their development is mired, and their potential for self-sufficiency and productive citizenry is limited. New Jersey's public schools, because of their unique structure that includes access, provision of funding, and teams of professionals, provide an optimal venue to provide PT services to these children.

Under the federal IDEA, PT service provision is required when necessary for a student to benefit from special education. Judicial interpretation of the purpose and intent of the IDEA is clear: provision of school-based PT under the IDEA must be uniquely tailored to offer each child a potential for meaningful progress toward a goal of maximum self-sufficiency. Unfortunately, neither professional PT organizations nor the NJ legislature has offered mandatory guidelines clearly identifying the IDEA's command. This lack of federal and state statutory authority and professional guidance leaves NJ school-based physical therapists to follow LEA interpretation and control.[153] Not surprisingly, the LEAs tend toward a narrow interpretation of the IDEA to mitigate cost.[154] In the end, many of NJ's children with physical disabilities lack access to the

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[153] *See* 13:39A-2.5(b) (sole reference to school-based physical therapy practice or guidelines in the NJ PT Practice Act is in this section, referencing reporting of a schedule of services to a health care professional in the outpatient setting versus to the child study team in the school setting. Even this guidance is redundant, as it is already required by the IDEA.); N.J. Admin. Code § 6A:14:3-9 and 6A:14:5.1 - 5.2; N.J. Admin.Code § 13:39 et seq.; *See also* Vialu, *supra* note 8, at 350.

[154] *See* Vialu, *supra* note 8, at 353; Rodman, *supra* note 65 at 139 (citing Building the Legacy: IDEA 2004. Available at http://idea.ed.gov. Accessed July 19, 2013).

comprehensive PT services commanded by the IDEA and necessary to maximize their functional independence.

To mitigate public health concerns and to comport with the clear purpose, intent, and requirements of the IDEA, the NJ legislature needs to clarify the scope of school-based PT practice to include a clear and broad definition of "educational benefit." NJ needs to pass legislation ensuring that every public school in NJ is affording comprehensive PT intervention to qualifying students with physical disabilities as required under the IDEA. Only when this occurs will this public health concern be mitigated. This legislation will ensure that one of NJ's most vulnerable populations – children with physical disabilities – receive the comprehensive PT services they need, and the comprehensive PT services commanded by the IDEA. These services will afford these children the opportunity to maximize their self-sufficiency; optimize their entry into adulthood and independent living; and become, to the greatest extent possible, contributing members of society.