Occupational Therapy Australia

SUBMISSION
to the

SENATE COMMUNITY AFFAIRS COMMITTEE
on the

NATIONAL DISABILITY INSURANCE SCHEME BILL 2012

EXPOSURE DRAFT

January 2013

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with special thanks to the following occupational therapists for their input

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1.0 Executive Summary

This submission from Occupational Therapy Australia responds to the exposure draft of the legislation to create the National Disability Insurance Scheme (NDIS) and its associated bodies. Occupational Therapy Australia and its members warmly endorse the creation of the NDIS. Occupational therapists are all too aware of the challenges that currently obstruct the delivery of high standard person-centred support for Australians with disabilities and their families.

Occupational Therapy is the most commonly accessed allied health profession for people with disabilities, according to the AIHW. Among people aged 15–64 years with severe or profound disability, visits to occupational therapists made up 35% of the total visits to allied health professionals, far more than any other profession.[1]

This submission will provide feedback under three headings, and within each heading the relevant sections of the Bill are expressed in the order in which they appear in the Bill:

1. those particular parts of the legislation which we most welcome;
2. those elements of the legislation where we ask for amendment to the existing wording; and
3. those elements of the legislation where the necessary details are not yet provided.

Occupational Therapy Australia respects that primary legislation will not best address all of these areas of detail, and therefore asks for further information to be made available through the regulations or through the operating guidelines for the NDIS, or elsewhere. Occupational Therapy Australia is willing to participate in the discussions that will assist in providing these extra details.

The submission then goes on to offer more detail on aspects of the NDIS where it is our view that Occupational Therapy is well placed to contribute to a successful Scheme. Occupational Therapy highly values person-centred practice and has a long history of teaching person-centred practice to our graduates and practicing therapists. Occupational therapists are employed extensively in existing disability programs; including the provision of and adaption to home modifications and assistive technology, driving assessments and mental health, among other aspects of disability support, and we believe that the regulations that support this legislation should scope out the particular supports to be offered and how they will be delivered.

Occupational Therapy Australia is able to assist the Committee in any of its deliberations. The NDIS is a once in a generation opportunity to address the needs of people with disabilities, their families and carers, and the staff who seek to provide them with the highest levels of support and we commend the Government for moving the legislation.

> Occupational therapy is a client-centred health profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement
>
> **World Federation of Occupational Therapy (WFOT) 2012**

2.0 SUMMARY OF THOSE PARTS OF THE LEGISLATION THAT OCCUPATIONAL THERAPY AUSTRALIA WISHES TO HIGHLIGHT

In supporting the introduction of the legislation to create the NDIS, Occupational Therapy Australia particularly wants to state its support for the following:

8 Simplified outline

Occupational Therapy Australia applauds the intent of this section, allowing the community to better understand the intention and operation of the NDIS under the auspices of a recognised plain language expert or advisory group.

24 Disability requirements

Occupational Therapy Australia applauds the approach taken in this section with their emphasis on a range of impairments and the activities from which the person has limited participation. In particular, we welcome paragraph 2 which should capture episodic and progressive impairments.

25 Early intervention requirements

(a) Occupational Therapy Australia welcomes the definition of Early Intervention to include children with developmental delay and those interventions which take place soon after the onset of the condition.

(c) (ii) Occupational Therapy Australia welcomes the recognition in the Bill that working with carers and family can result in improved functioning for the person with disability. This is particularly so, but not uniquely, in the case of children and adolescents with disability. This is also true of Section 27 (f). It is our experience that an early intervention approach can significantly reduce long term costs.

47 Participant may change participant's statement of goals and aspirations at any time

Occupational Therapy Australia warmly welcomes this realisation of consumer choice and control. We would however suggest one addition - that consumers be given sufficient information such that they can make an "informed choice" to ensure they make cost effective and most appropriate selection of services to best meet their needs.

118 Functions of the Agency

1 (c) to develop and enhance the disability sector

Occupational Therapy Australia strongly endorses the function of the Agency in facilitating research, innovation and best practice. It is hoped that membership of an advisory group to the Agency in this regard will include representation from the profession of Occupational Therapy, which would recognise the leading role that occupational therapists play in research and innovation currently in the areas of maximising independence and social participation of people with disability; and in reporting within current schemes on reasonable and necessary supports. It is important that research funding is directed at the needs of consumers, and that adequate resources are made available to assist with the implementation of innovation and research into practice.

3.0 AREAS WHERE WE SEEK AMENDMENT TO THE CURRENT WORDING OF THE LEGISLATION

3 Objects of Act

3 1(b) participation

It is essential that "participation" goes beyond the outcomes of "employment and social participation". The objects of the Act should operationalise these terms in line with contemporary disability theory and a culturally competent view of Indigenous and multicultural groupings in Australian society. That is, independence includes interdependence; and social and economic participation is defined according to WHO ICF[2] chapters, where 'community, social and civic life' encompasses religion and spirituality, political life and citizenship; and 'major life areas' encompasses education, work and employment (including non-remunerative work; and training). In regard to children and young people with disability, it's particularly important that play and leisure are seen as legitimate areas of participation.

4 General principles guiding actions under this Act

2 People with disability should be supported to participate in and contribute to social and economic life to the extent of their ability

Carers often have the same aspirations and Occupational Therapy Australia would like 'and their carers' inserted to the wording in this paragraph after 'people with disability'.

3 People with disability and their families and carers should have certainty that people with disability will receive the care and support they need over their lifetime.

As needs change over the lifespan, Occupational Therapy Australia would like 'with particular reference to their needs at life transition points' inserted at the end of this paragraph.

11 (b) participate in the community and in employment

This is a narrow view of the areas of participation that should be enjoyed by people with disabilities and are enshrined within the UN Convention on the Rights of Persons with Disabilities (2006). While we appreciate that the NDIS cannot replicate programs in other sectors, Occupational Therapy Australia urges the Government to address the areas of participation outlined in the WHO ICF[3]. At the very least we ask for 'vocational education and training' to be inserted after 'employment'. Without these words, there is a very real risk that the scheme will not support people to complete the training and skills they require to enter and remain in the workforce.

5 General Principles

Occupational Therapy Australia strongly endorses this section but also recommends a similar section that sets out the principles for actions that affect carers and family members under the Act.

25 Early intervention requirements

(c) (i) Occupational Therapy Australia applauds the wide range of impacts expressed in the Bill in this section, but is concerned that the current wording does not capture the intent of interventions with children and adolescents with disabilities, and even some adults. In these cases the intent of interventions is to facilitate the development of functional capacities, and we call on the inclusion of wording to this effect is 25 (c) (i).

27 Rules

1 (f) fails to capture the needs of children, adolescents, and some adults, where interventions and support are intended to facilitate functional improvements. Occupational Therapy Australia suggests the inclusion of wording to capture possible improvements in functioning for some people with disability.

31 Principles relating to plans

31(b) While broadly supporting the principles outlined in section 31, Occupational Therapy Australia believes that 31(b) should be amended to recognize people who have legal guardians, such as children and those who have appointed guardians.

147 Appointment of members of the Advisory Council

5(b)(iii) seeks the appointment of someone who holds “skills, experience or knowledge in the supply of equipment, or the provision of services, to people with disability”.

Occupational Therapy Australia warmly welcomes the proposal to include people with this skill set in the Advisory Council. We contend that it is important to have representation from people who hold skills, experience or knowledge in BOTH the supply of equipment AND the provision of services, and that it would therefore be advisable to either allow up to two positions under 5(b)(iii) or to create separate subsections for the distinct skill sets represented here. It would be simplest to amend the wording of this subsection to allow for “at least two positions”.

People with an Occupational Therapist professional background, because of our extensive education, practice experience and research in these fields, would be best placed to be members of the advisory council under 5(b)(iii). There are many Occupational Therapists with high professional standing both nationally and internationally and we suggest amending this section to read

“At least two (2) Occupational Therapists who hold skills, experience or knowledge in the supply of equipment, or the provision of services, to people with disability”.

4.0 AREAS REQUIRING FURTHER DETAIL TO BE PROVIDED OUTSIDE OF PRIMARY LEGISLATION

3 Objects of Act

3 2(b) an insurance-based approach

It is important that this is further discussed outside of the primary legislation. Occupational Therapy Australia would prefer to see a societal perspective on costs and benefits. We urge the Government further examine the issue of appropriate economic measures, mainstream tools such as Assessment of Quality of Life (AQoL) and quality-adjusted life year (QALY) have been demonstrated to be biased against disability[4].

4 General principles guiding actions under this Act

1 physical, social, emotional and intellectual development

These terms will need to be operationalized outside of the primary legislation. When doing so, they should be based on the person with disability's perspective and not purely rehab-based, with particular reference to lifelong development and transition points.

4 People with disability should be supported to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports.

While strongly supporting the intention of this subsection, it is hoped that in the application of this section, it will be made explicit that people with disabilities, their carers and families will be provided with sufficient and appropriate information and supports to exercise informed decision making when they exert choice and control.

8 People with disability have the same right as other members of Australian society to be able to determine their own best interests, including the right to exercise informed choice and engage as equal partners in decisions that will affect their lives, to the full extent of their capacity.

Current best practice in relation to supported decision making would require the NDIA to ensure that people with disabilities are provided with accessible and relevant information on which to base their choices.[5] Occupational Therapy Australia is interested to better understand how people with disabilities and their carers will be resourced to become informed decision makers and is able to assist in discussions on this matter.

12 The role of carers and families

It is hoped that this statement will be operationalized outside of the primary legislation such that it provides more than an aspirational statement. Carers and families need support and information to assist their own choices and those of the consumer.

9 Definitions

Additional terms used in the Bill but not defined.

The use of terms such as "Assessment" and "Tools" in the Bill requires that these terms are defined under section 9, or else outside of the primary legislation. Occupational Therapy Australia believes that occupational therapists, by virtue of their widespread use of tools in current State and Territory services, are well placed to assist in the development of these tools, and could therefore make a contribution towards the development and definition of these terms.

25 Early intervention requirements

(b) Occupational Therapy Australia would hope that further clarity on the scope of the CEO's assessment of future needs will go beyond a narrow focus on further support from the Agency, and would examine the person's functioning across the areas of impairment. We also take this view in relation to Section 27 (d).

27 The National Disability Insurance Scheme rules

2 (a) Further clarification will be required outside of the primary legislation as to the skills, qualifications and experience of staff who are authorised to conduct assessments. Occupational Therapy Australia would be pleased to provide evidence of the suitability of the qualifications and skills of occupational therapists, particularly in relation to person-centred practice, as well as the current deployment of the profession in existing relevant Federal and State / Territory schemes.

It is hoped that assessments will be based in the WHO ICF approach to disability and reflect the Disability Support Pension (DSP) impairment tables.

29 When a person ceases to be a participant

1 (b) While cognisant of the need to mark a clear boundary between those supports that fall under the NDIS and those that come under Aged Care programs, it is hoped that the interactions between Community Care and the NDIS will be addressed outside of the legislation. Occupational therapists are very experienced in both residential aged care and community care and the Association can provide several examples where recipients of services can 'fall through the cracks' in boundaries between programs. It is hoped that by working through these examples Government will be able to provide consumers and their carers with certainty as to the supports (in Community Care and in the NDIS) that are available.

33 Matters that must be included in a participant's plan

1 (a) Occupational Therapy Australia applauds the use of person-centred goals and the language of objectives and aspirations of the consumer. However, there is considerable evidence that people with disabilities, having lived with rationed services, need support to recognise their rights and potential outcomes, and therefore to identify aspirations in line with fellow citizens. Tool(s) must be developed to enable consumers to map out potential outcomes and aspirations and contain prompts and examples to avoid 'unknown, unmet need'. Occupational Therapy Australia is willing to assist in this process.

Particular attention needs to be given to the needs of children in regards to both the tools that facilitate them to identify their goals and aspirations. Further, the goals and aspirations most frequently cited by children and young people are educational, or vocational, and without a clear statement of the validity of vocational training and education the NDIS will most likely not meet the goals and aspirations of children with disability. Occupational Therapy Australia urges the Government to expand the range of legitimate objectives of the NDIS with the inclusion of those precursors to paid employment.

6 Occupational Therapy Australia is also concerned that further details be outlined outside of the legislation in regards to who (people or agencies) are to be registered for the provision of supports.

34 Reasonable and necessary supports

34 (e) It is hoped that the Scheme will recognise the financial and other barriers that carers and families face to social and economic participation. This has been well documented elsewhere.

35 Rules for statement of participant supports

This section leaves a great deal of discretion for the implementation of the Scheme. Occupational therapists have considerable expertise in the provision of services to people with disabilities and would be willing to participate in future discussions about these matters.

36 Information and reports for the purposes of preparing and approving a participant's plan

2(b) (i) The Bill does not make it clear who is authorised to provide an assessment. This should be clarified outside of the primary legislation.

2(b) (ii) The Bill does not make it clear who is authorised to provide a medical, psychiatric or psychological assessment. This should be clarified outside of the primary legislation.

The Bill does not make it clear why the CEO needs recourse to both 2(b)(i) and 2(b)(ii) and this should be clarified outside of the primary legislation.

Occupational Therapists are currently approved assessors and disputes assessors within existing State and Territory programs, and Occupational Therapy Australia is willing to participate in further discussions about this issue.

42 Meaning of managing the funding for supports under a participant's plan

2(c) It is not explicit in the legislation who will be eligible to apply to become a registered plan management provider and what safeguards and standards will apply to them, whether as individuals or organisations. Further clarity on these matters outside of the primary legislation would be welcomed.

48 Review of participant's plan

4 Occupational Therapy Australia believes that this may leave too great a level of discretion in the remit of the CEO and would suggest some indicators be made transparent in the regulations that would lead the CEO to consider a review of a participant's plan is required.

50 Information and reports for the purposes of reviewing a participant's plan

In line with our comments on Section 36, Occupational Therapy Australia calls for far greater clarity on the qualifications, skills and expertise required to undertake assessments as identified but not explained at 2(b)(i) and an at 2(b)(ii) and it is not clear why both subsections are required.

69 Application to be a registered provider of supports

Occupational Therapy Australia seeks further clarity, outside of the legislation, on the application process, skills, qualifications and safeguards that will be in place to ensure quality supports are provided through the NDIS. We are willing to participate in discussions towards that end.

70 Registered providers of supports

1 Further clarity will be required in the rules of the Scheme and Occupational Therapy Australia looks forward to these being made public.

73 National Disability Insurance Scheme rules for registered providers of supports

1 Occupational Therapy Australia awaits further details and transparency about 1(a) (b) and (c) and is willing to contribute to these discussions.

74 Children

5 While supporting consumer choice and control, Occupational Therapy Australia would seek clarification of the circumstances in which the CEO would determine that subsections (1) and (2) do not apply to a child participant in the Scheme.

5.0 OCCUPATIONAL THERAPY AND DISABILITY SUPPORT

There are several areas of interest for occupational therapists – notably the types of supports to be provided to people with disabilities and how these supports will be offered. Occupational therapists are the major allied health profession currently involved in the provision of supports to people with disabilities[6], through State, Federal and NGO programs and across a range of portfolios. The profession is keen to ensure that people with disabilities transition seamlessly into the new Scheme and continue to receive quality supports to which they are entitled in person-centred practice environments.

The legislation is understandably unclear about the specific kinds of goals that will be supported, and the precise natures of the supports that will be offered to give life to the aims of the NDIS. For example, Section 14 states that funding will be made to

"assist people with disabilities to:

i. *realise their potential for physical, social, emotional and intellectual development; and*
ii. *participate in social and economic life."*

But this doesn't begin to outline the kind of supports that will be offered.

Occupational Therapy Australia believes it is critical to understand the current supports and services that people with disabilities receive, so that these can be assessed for incorporation into the NDIS, and can then, if included, be developed with the practice guides, standards and normal clinical guidelines for evidence-based practice that will need to be developed over time to ensure consistent high standards of support for people with disabilities.

The following parts of this submission will therefore identify the main areas of occupational therapist interventions with people with disabilities, and outline the centrality of person-centred practice (and family-centred practice for children with disabilities) to the profession.

It is hoped that these sections will assist the Committee to discuss the types of supports to be included in the NDIS and the standards that need to be enshrined to deliver them. Occupational Therapy Australia is willing to participate in ongoing discussions with Government to assist in the development of these areas.

5.1 PERSON-CENTRED AND FAMILY-CENTRED PRACTICE

It is clear from various Sections of the Bill (for example Section 4(4), 5 and 47) that the NDIS will offer participants person-centred supports. Occupational Therapy Australia recognizes that primary legislation is not the place for the full operationalisation of person-centred practice such as Clinical Practice Guidelines, practice standards, accreditation standards and other measures to ensure good practice. Nevertheless it is vital that full consideration is given to person-centred practice as it is central to a successful new paradigm for people with disability when setting their goals and receiving supports.

The profession of Occupational Therapy has a well-established set of standards that identify and institute person-centred practice. When working with children, the profession also identifies and teaches family-centred practice, recognizing that the child's family and carers (both in the home and in the school and other environments), must be included in all aspects of the care to ensure it meets their needs and is taken up successfully.

The profession is certainly not the only profession that offers person-centred practice, but being the most widely used of the allied health professions by people with disabilities[7], and having invested in developing a generation of professionals who offer person-centred practice, it is timely to note these tools and standards at this stage for the Committee to consider.

Person-centred practice is fundamental to Occupational Therapy. The World Federation of Occupational Therapists (WFOT) describes Occupational Therapy as "a client-centred health profession which is concerned about promoting health and well being through occupation"[8]

WFOT sets the minimum standards for all Occupational Therapy education in Australia. The development of therapeutic and professional relationships that are based on "*client centredness or client directed therapy, collaboration, mentorship, coaching, motivation, hope, empowerment, client choice, treating people respectfully*" (WFOT, 2002, p17) has been a minimum standard for Occupational Therapy programs for over a decade.[9]

Person-centred practice is a basic competence for all new graduates into the profession. Within the profession's accreditation standards for new graduates, the very first element of the first competency is s/he "adopts a client-centred approach to practice", and this is then given life through 10 assessable performance criteria.[10]

Further, occupational therapist competency 3.1 states that a new Occupational Therapy graduate must demonstrate person-centredness during their intervention, with three assessable performance criteria, and competency 5.1 states that the occupational therapist must "facilitate the active participation of the client in service provision" with six assessable performance criteria.[11]

These elements are far more than words on paper. All Australian Occupational Therapy courses are asked to document how they educate their students to meet these competency standards, and courses are assessed by accreditors to find evidence that the course is imbued with a person-centred approach. Assessors will routinely interview students and clinical placement supervisors (students spend 1,000 hours of clinical placements in their qualifying courses) to ensure that a person-centred approach is being taught.

Assessors also examine the use of consumers as educators within Occupational Therapy courses, for example as guest lecturers.

The models of Occupational Therapy taught in all Australian programs are explicit that the person is central to decision-making.

Occupational Therapy has standards, education programs and guidelines in place which provide a rigorous person-centred approach (and family-centred approaches for work with children) in for all graduating and practicing occupational therapists.

Occupational Therapy Australia is willing to contribute to the development of codes, standards and guidelines for person-centred practice for the NDIS.

5.2 HOME, WORKPLACE AND SCHOOL MODIFICATIONS

These modifications can be described as changes to a building's structure, or furniture through equipment or modification which enable people with disability to remain in place and as independently as possible while minimizing risk.

Occupational therapists are the only registered health professionals with the education and clinical skills in assessing a person with disability's function in terms of roles, tasks and activities, through assessing the person's habitual movement patterns, or attempting to perform a particular task, their cognition, the available carer and/or support services available, take body (anthropometric) measurement. An occupational therapist can then structure or modify the environment and prescribe assistive technology to allow for the person and carer to be able to be independent in the activities they wish to undertake.

Occupational therapists use a range of skills in these assessments and supports:

- assessment of the environment. Internally and externally in all rooms and areas;
- assessment of the person's understanding and belief of environment;
- assessment and collaboration with the person and carer to problem solve the most efficient and cost effective means of achieving optimal function;
- assessment of the biomechanical, physical, sensory-motor, cognitive function of person with disability and carer;
- knowledge of the required legislation and codes that govern design;
- the interaction between the person with disability and their carer and the environment;
- the occupational therapist also possess the knowledge through the inter-joining across all subject areas of the curriculum that environment is a core concept of Occupational Therapy, and is inter related to equipment and function.

Occupational therapists, by the nature of their training, are comprehensively taught modifications both as at qualifying level and in postgraduate training. The interplay between all areas of a person with disability's and their carer's function and the knowledge of the required legislation is a learned formally in courses and also learned and experientially through supervised practice[12].

While others, qualified or semi-skilled, could install ramps, rails and other modifications to comply with the Australian Standards, and National Construction Code, the 'human technology' elements of working to understand the complexity of each individual, and to work with them in a person-centred way, and assessing how a particular person uses this particular aide, that occupational therapists do to a high standard because it is part of the profession's training. This element ensures a greater level of adoption to the modifications and less risk of injury to the person and those who support them.

5.3 ASSISTIVE TECHNOLOGY

"Assistive technologies", or AT, refers to devices and systems which enable people to manage their daily activities and participate in life tasks. This may include non-complex devices such as long handled reachers, or complex devices and systems such as environmental control units enabling control of home appliances through a switch. AT is closely linked to the environment in which it is used, and the tasks which the person wishes to accomplish. Occupational Therapy Australia supports the ARATA position statement.[13]

For AT to be appropriately used, the health professional must understand the person, the task and the environment.

Occupational therapists perform person-centred assessment of the person's goals and capabilities i.e. what the person with disability wishes to accomplish and the effect of impairment upon his / her abilities to do so. The occupational therapist evaluates barriers and facilitators within the environment, and deploys their knowledge of the interventions which may best support the individual (for example, the combinations of retraining, task adaptation, environmental adaptation and specific AT devices).

Additionally, a knowledge of task and environmental analysis means occupational therapists can assess the other elements necessary to tailor AT to fit the person and their selected tasks within their environments of use. Occupational therapists are the only profession whose training combines these elements.[14]

Thorough knowledge of human anatomy and pathology to understand the impairment, its likely progression, and whether there are contra-indications. That is, what the person's condition is like and how it might progress or be supported to improve over time, and ensuring that any intervention does not cause harm. For example, the location of an installed handrail could assist in transferring from the toilet, could serve to strengthen and increase range of movement, or could cause shoulder injury if located inappropriately.

AT provision is part of occupational Therapy undergraduate training in approaches to enable human activities of daily living. Occupational therapists are the only profession to have skills across task adaptation, environmental adaptation, technical drawing and design.

No other profession is educated across the breadth of AT applications, as evidenced by the recognition of OTs as primary prescribers in all State AT funding schemes (that said, nurses for example may cover pressure care, physiotherapists cover gait aids, orthotists and podiatrists perform some aspects of AT also).

There is some evidence that non-complex AT can be provided by other professionals, with training (for example occupational therapists training rural physiotherapists to install some bathroom equipment). Occupational therapists in some areas train allied health assistants or others to provide non-complex AT for personal care or domestic activities.

There is considerable evidence[15] that people with disabilities are more likely to abandon AT devices if appropriate 'soft technology', meaning human elements such as shared problem-solving, tailored fitting, trial, consideration of aesthetics and practical issues (weight of devices, transportation etc) are not adequately provided. Several studies identify that soft technology skills are not readily adopted by other professionals (such as nursing) and are complex to learn, and that the lack of 'soft technology negatively impacts the outcomes with non-occupational therapist (or non-OT-trained) providers.

5.4 DRIVING ASSESSMENTS

Occupational therapists are recognised internationally as the health professionals responsible for comprehensive driver screening and assessment. Typically, a therapist will perform a pre-road screening and assessment as a preliminary step to detect areas of concern before deciding if and when to engage in on-road testing. For most individuals, a critical component of the pre-road evaluation includes evaluation of cognitive function, especially the higher level executive functions critical to safe driving.

Driving is a complex task that requires vision, physical abilities, visual perception, emotional control and cognition. Executive function (EF) is a construct proposed to explain higher order regulatory cognitive processes[16] and while many definitions exist, is generally accepted to involve the interplay of various components, including decision-making; abstract thinking; planning and carrying out plans; mental flexibility; deciding which behaviours are appropriate under what circumstances; time management; insight and judgment; concept formation and categorisation.

Generally, driving difficulties can be overcome in three different ways:

i. Modifying the vehicle.

ii. Education in the use of adaptive equipment

iii. Teaching the driver compensatory techniques

Occupational therapists are extensively employed to conduct driving assessments and to perform all three of the interventions above to enable people with disabilities to drive safely. They are widely employed in this role in Australia. This area of work is restricted in NSW to those occupational therapists with at least five years' practice experience and those who have successfully completed specific training.

They are involved not only in evaluation of off-road driving pre-requisites, but have undertaken driver instruction training so that they can assess driving potential and teach driving skills. Occupational therapists are well qualified for such a role, as they have been educated to "predict and recognise the presence of impairment that can severely affect task performance".[17] The therapist also has "formal training in the application and adaptions and compensating skills which can minimise the effects of disability".

In evaluating or teaching a person with disability to drive, an understanding of the anatomical, cognitive and psychological components of the task can be essential for success. It is here that the occupational therapist can assist the driving instructor.

While other skilled staff could also carry out a number of the interventions required to assist people with disability to drive, occupational therapists are uniquely placed to work from a person-centred perspective to address all aspects of the role.

5.5 MENTAL HEALTH

Occupational therapists are recognised by Australian Health Ministers Advisory Council (AHMAC) as one of the five professions in mental health – alongside medicine, nursing, psychology and social work.[18] This standard acknowledges the valuable contribution of occupational therapists within mental health.

Occupational therapists work with people to overcome limitations and to assist them to meet their goals. These limitations may be caused by a mental health disorder, and occupational therapists regularly work in mental health settings in the public, private and community settings.

People with disabilities are more than twice as likely as the rest of the population to see a mental health professional[19,] and a wholistic understanding of the person and their carers and supports is therefore central to the occupational therapist's approach to supporting their goals across their physical and mental needs.

Occupational therapists are concerned with enhancing functioning primarily related to people's activity performance and activity limitations, their participation in society and participation restrictions, and the personal and environmental factors that either support or create barriers to their activities and participation. Hence, occupational therapists consider the physical, intrapersonal, interpersonal, and environmental dimensions that influence functioning and occupational development.

Through the use of occupational analysis, skills development, life-style redesign and environmental adaptations, occupational therapists work collaboratively with consumers and carers to enable and support the development of a greater sense of self, health, wellness, and community living options.

The domain of occupational therapy in the mental health field is concerned with understanding and addressing:

- the occupational consequences of mental health problems and mental illness;
- the occupational needs of people, who are at risk, and have mental health problems and mental illness; and;
- the ways in which people's environments support and restrict their functioning, recovery, and occupational development.

Psychologists and social workers are routinely employed alongside occupational therapists in mental health roles, and mental health nurses to a lesser extent. The NDIS should give consideration to what professionals and other staff are to be accredited to perform mental health interventions with participants, and we call for occupational therapists to be included in the make up of this part of the workforce.

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6 ENDNOTES

[1] Australian Institute of Health and Welfare 2011. **The use of health services among Australians with disability**. Bulletin no. 91. Cat. no. AUS 140. Canberra: AIHW. Figure 3, page 7.

[2] WHO (2001) ICF

[3] Ibid.

[4] Colgan, Moodie & Carter (2010) **The Economic Study** (part of The Equipping Inclusion Study series) Deakin University

'It is also important to flag that this economic analysis has focused on reporting the cost per QALY results to facilitate considerations of value-for-money against a nominated yardstick ($50,000 per QALY). Assessing value-for-money in this way, however, runs the risk of placing special needs groups, such as AT users, in 'double jeopardy'. This is because groups like our case study participants already have lower health status due to their disability; and yet it is this very disability that prevents them from scoring highly in generic quality of life instruments. Lower quality of life results in response to possible improved services will in turn yield poorer cost-effectiveness results vis-a-vis other client groups who have the full QoL response range available to

them. This in turn may bias resource allocation decisions against them, where such decisions are influenced by cost-effectiveness results. This situation is referred to as 'double jeopardy' and is illustrated by our case study results' (page 202).

[5] Watson, J. (2012). *Listening to those rarely heard: Decision making support within NDIS funded services.* Paper presented at the NDS **Preparing for the new world conference** 2012, Hilton Hotel, Adelaide, Australia.

[6] AIHW (2011)

[7] AIHW (2011)

[8] World Federation of Occupational Therapists (2011) **Statement on Occupational Therapy** available at http://www.wfot.org/AboutUs/AboutOccupationalTherapy/DefinitionofOccupationalTherapy.aspx accessed 21/01/13

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[19] AIHW (2011) page 11 "*people aged 16–64 years with 12-month mental disorders, people with severe or profound disability were more likely than those without disability to consult mental health professionals (41% versus 15%)"*