Submission by the Australian Institute of Health and Welfare to the Senate Employment, Workplace Relations and Education Reference Committee

Inquiry into the Education of Students with Disabilities

1. Introduction

This submission relates to the following aspects of the Terms of Reference: 1 (a) (i) and (ii).

The Australian Institute of Health and Welfare (AIHW) has been working on disability information and the promotion of national consistency in disability data for some time.

Based on this work, our advice is to:

- relate disability definitions to the main nationally and internationally recognised classifications;
- use national data dictionaries where available; and
- relate administrative data to population data (the main ABS surveys or the census).

This submission explains and expands on these recommendations, in the following sections:

- Definitions of disability (Section 2).
- The national data dictionaries in the health and community services sector (Section 3).
- Working with standard definitions to serve particular purposes—the example of disability support services (outlined in Section 4, with details at Attachment 1).
- Possible broad approach for the education sector (Section 5).

2. Definitions of disability

Disability is a universal human experience that can be measured on a continuum. The International Classification of Functioning, Disability and Health (ICF) provides a framework for the description of human functioning or disability, which is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6).

In May 2001 the new Classification of Functioning, Disability and Health (ICF) was endorsed by the World Health Assembly (WHO 2001). This marked the finalisation of a revision of the ICIDH (WHO 1980), a process that involved several years of redevelopment and testing by the World Health Organisation (WHO) and its Collaborating Centres, including the Australian Institute of Health and Welfare.

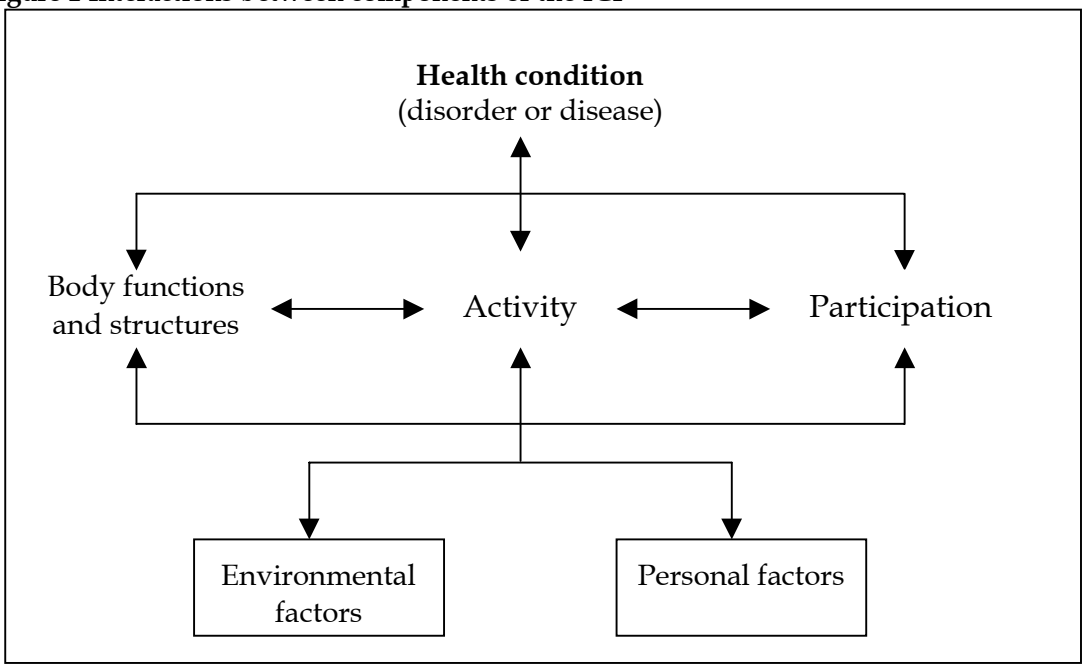
The ICF has been developed for use in describing functioning. It is now recognised as a core member of the WHO family of health-related classifications, complementary to the ICD (International Classification of Diseases), which focuses on diseases and health conditions.

Within this framework there can be many different definitions, relevant to different policy areas. Each policy area can locate itself in this framework, using it to define the areas of the framework that are of importance, and the threshold beyond which it is considered that someone has a disability.

The ICF interactive model

A person's functioning or disability is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6 and see Figure 1). Functioning and disability are both multidimensional concepts.

Figure 1 Interactions between components of the ICF



Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation.

The ICF provides a framework for the description of human functioning, on a continuum—not just at the extremes. This point is explicitly state in the classification. It is an important point although it is sometimes clouded because of the vital role that organisations of people with disabilities have played in the revision and their insistence that the classification be meaningful to them. The involvement of disability organisations in the revision process is a significant achievement of the ICF and has vastly improved its validity.

Because of the efforts taken to involve a wide range of disciplines and people in the redevelopment and testing, the ICF should be able to be used for a wide range of purposes.

Examples of ICF content

The three components of the classification are defined 'in the context of a health condition' and are Body Functions and Body Structures, Activities and Participation, and Environmental Factors. Each component is comprised of various domains, or separate sets of related physiological functions, anatomical structures, actions, tasks, areas of life, and external influences. Examples of components and related domains are given in Table 1.

Environmental factors represent an important new component of the ICF in recognition of their influence on functioning and disability.

Personal factors are also recognised but are not classified and are beyond the scope of the ICF. These factors might include age, sex, and Indigenous status, and would be selected by users according to the application.

Table 1 Examples of ICF components, domains (and blocks).

Component	Domains
Body Function	Specific mental functions e.g. memory function
	Sensory functions and pain e.g. hearing function, smell function, sensation of pain
Body Structures	Structures of the nervous system e.g. spinal cord and related structures
	Structures involved in voice and speech e.g. structure of mouth
Activities & Participation	Mobility e.g. getting around inside or outside home
	Self-care e.g. washing oneself, dressing
	Major life areas e.g. work and employment, remunerative employment
	Community, social and civic life. e.g. recreation and leisure, religion and spirituality
Environmental Factors	Products and technology e.g. products and technology for communication
	Support and relationships e.g. immediate family, health professionals
	Services, systems and policies e.g. education and training services, labour and employment, legal

Definitions

Key definitions of components are:

Body functions are the physiological functions of body systems (including psychological functions).

Body structures are anatomical parts of the body such as organs, limbs and their components.

Impairments are problems in body function and structure such as significant deviation or loss.

Activity is the execution of a task or action by an individual.

Participation is involvement in a life situation.

Activity limitations are difficulties an individual may have in executing activities.

Participation restrictions are problems an individual may experience in involvement in life situations.

Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. These are either barriers to or facilitators of the person's functioning.

Disability arises when any or all of the negative outcomes occur—impairment (ie. problems in body function or structure), activity limitation and/or participation restriction—when they are associated with a related health condition.

3. The national data dictionaries

The national data dictionaries were developed in the community services and health fields to promote national consistency in data definitions, concepts and collections. The National Health Data Dictionary (10th edition) and National Community Services Data Dictionary (2nd edition) consist of information models that provide frameworks for the dictionaries and nationally agreed definitions and classifications for data items and concepts. These dictionaries aim to improve the uniformity, completeness and quality of data about community and health care needs, the services provided and the outcome of these services.

Disability data elements are currently being prepared for Version 3 of the National Community Services Data Dictionary (NCSDD) in line with the new ICF. Data elements are based on the ICF concepts. These data elements will be available towards the end of 2002 and can be made available for comment if requested.

4. Example: applying standard definitions in the area of disability support services

The AIHW has worked collaboratively with the National Disability Administrators in developing national data for disability support services.

The ICF was an essential tool in the process of redeveloping the CSDA MDS. The redevelopment exercise demonstrated three general ways the ICF can be used:

1. *as a framework* to organise thoughts and ensure that major factors of interest are not omitted from the final data item or minimum data set;
2. as a set of classifications that can be used as a 'smorgasbord' from which to select the *domains* of most interest to stakeholders in the data that will be collected via the final data item or minimum data set; and
3. to provide *qualifiers* that assist the researcher to select a scale that is either directly related to an ICF qualifier or that ensures that the data collected will map to an ICF qualifier.

As a result of this integrative work, the new CSDA MDS 'support needs' question maps to the ICF, the ABS disability survey, and common assessment tools in the field. This work ensures that the CSDA service data can be related to the relevant

population data and to other service data which adhere to the national data dictionaries. More details are in Attachment 1.

5. Possible broad approach for education

In the area of education, a similar process could be undertaken.

The process would rely on clear policy statements about which students or target groups are entitled to assistance. This description (essentially of the degree of disability considered relevant to the education field) would then need to be related to the ICF (possibly via the NCSDD data elements), to the ABS survey definitions and, if available, to recognised tools of measurement in the education field. The steps could thus involve:

- choosing which ICF domains to use (in either or both of the Body Functions & Structures components and in the Activities & Participation component);
- deciding how to relate common measurements and assessments to each other and to the ICF framework;
- examining related population data;
- mapping all to the ICF framework.

The AIHW has reviewed the variation in administrative definitions of disability used in Australia and related these to concepts and definitions of the draft ICF (Madden and Hogan 1997). This exercise established that definitions used to identify students needing special assistance for study were mappable to the ICF. Impairment, activity limitations, participation restrictions and contextual factors (e.g. environmental factors) were all recognised or at least implied in education definitions. It thus appears a practical goal for current or revised definitions of disability used in the education field to relate to the ICF framework.

Because of the complex and universal nature of disability there are no simple answers—definitions and measures have to be worked out in the policy context.

However, relating the terms, definitions, measures and data collected to the available standards is essential for holistic analysis and policy monitoring. This is especially important for people with disability, as their experience often needs to be consistently described across various life areas.

Applying the ICF to a national disability data collection: The Commonwealth/State Disability Agreement Minimum Data Set (CSDA MDS)

1. Introduction

This User Guide module describes the ways in which the ICF was used when redeveloping the main administrative national data collection used in the Australian disability services sector. Section 2 provides a brief background to the Commonwealth/State Disability Agreement Minimum Data Set (CSDA MDS) collection and Section 3 details how the ICF was applied in the redevelopment of the CSDA MDS collection.

The CSDA MDS

Specialist disability support services in Australia are provided in the context of the Commonwealth/State Disability Agreement (CSDA). This Agreement provides for a national program ($2.5 billion in 2001-02) for people with disabilities who have ongoing support needs. The Commonwealth/State Disability Agreement Minimum Data Set (CSDA MDS) is both a set of nationally significant data items that are collected in all Australian jurisdictions (i.e. States, Territories and the Commonwealth) and an agreed method of collection and transmission.

Since 1994, the CSDA MDS collection has provided funding bodies, service providers, consumers and other stakeholders with valuable information about services delivered under the CSDA and the people receiving those services. Between 1994 and 2002 this information was collected on one snapshot day in the year. From late 2000, the CSDA MDS was redeveloped in a joint project of the AIHW and the National Disability Administrators. The redeveloped CSDA MDS was implemented in the second half of 2002 and now provides a range of data about all people with disabilities who receive a CSDA-funded service in a year.

Applying the ICF to the redeveloped CSDA MDS

The ICF was an essential tool in the process of redeveloping the CSDA MDS. The redevelopment exercise demonstrated three general ways the ICF can be used:

1. *as a framework* to organise thoughts and ensure that major factors of interest are not omitted from the final data item or minimum data set;
2. as a set of classifications that can be used as a 'smorgasbord' from which to select the *domains* of most interest to stakeholders in the data that will be collected via the final data item or minimum data set; and

3. to provide *qualifiers* that assist the researcher to select a scale that is either directly related to an ICF qualifier or that ensures that the data collected will map to an ICF qualifier.

In the case of the CSDA MDS redevelopment, the ICF Activities and Participation component[1] and qualifiers were applied in two main areas:

(a) Support needs; and

(b) Participation outcomes.

The next two sections detail the process of applying the ICF in the process of developing these data items.

2. Support needs

Background

The search for a 'support needs' framework

A national indicator of disability support needs has been included in the CSDA MDS since its inception in 1994.

In 1999, as part of an initial review of the CSDA MDS, the AIHW undertook a project aiming to produce:

- a review of measures of 'support needs', the findings being related to policies, practices and developments in Australia in the disability field and in other closely related fields including the Home and Community Care (HACC) program;
- a presentation of options for data items which would encapsulate the main data needs and developments in Australia; and
- a discussion of each option in relation to its relevance, quality, relatability to other developments including HACC, and comparability to national and international developments in population measures of disability.

The work undertaken for this project was subsequently advanced during the redevelopment of the CSDA MDS. The methodology of both the 1999 'support needs' project and the
2000-02 redevelopment project are discussed below to illustrate the usefulness of the ICF in data development of this nature.

The 1999 'support needs' project was approached with the understanding that National Disability Administrators were interested in relatively high level support needs indicators, to which the data items currently collected in 'local language' in each jurisdiction could be mapped. The project was not concerned with standardising the assessment of individuals at a local level but rather about clarifying the concepts used to describe people's support needs so that information

[1] Much of the data development for this project was done using the ICIDH-2. The final data items are however based on the ICF. To avoid confusion, this module is written as if the entire data development process was undertaken using the final ICF.

gathered during assessment could be mapped up to a national indicator or indicators and used for national comparison.

The ultimate objective was therefore to develop options for a summary rating or indicator of support needs:

- which was comparable with population data, specifically data collected on individual support needs via the ABS Survey of Disability, Ageing and Carers;
- to which current State, Territory and Commonwealth practices, in as wide a range of services as possible, could be mapped[2];and
- which would be consistent with current national data dictionaries and collections, to increase the potential for national comparability and reduce the potential for duplication in collection.

A copy of the final support needs framework, included in the redeveloped CSDA MDS, follows the discussion of how it was developed.

Methodology

There were a number of constraints or factors to consider in the search for a 'support needs' framework.

Firstly, it was essential that any support needs framework relate to the definition of 'people with disabilities' in the 1998 CSDA:

> 'people with a disability attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:
>
> • self care/management
>
> • mobility
>
> • communication
>
> requiring ongoing or episodic support'.

Secondly, as noted above, it was also critical that the support needs framework be comparable with population data. This constraint implied that the framework would probably need to be a general support needs indicator, rather than a service-specific support needs indicator. That is, the framework would aim to indicate an individual's overall support needs, rather than their support in terms of services required.

Finally, it was critical that the support needs framework relate as closely as possible to existing data standards and practice in the area of disability and related support services.

We therefore aimed for consistency with (and an ability to map to):

- the CSDA definition of 'people with disabilities';

[2] The goal was to reflect enough of the language used in each jurisdiction to ensure that jurisdictions could translate the scales they use into an overarching scale (i.e. that the various types of language could be meaningfully calibrated into an overall scale to which their input could be mapped).

- the Australian Bureau of Statistics Survey of Disability, Ageing and Carers (1998);
- the National Community Services Data Dictionary Version 2.0 (then in draft);
- the existing CSDA MDS (to a slightly lesser extent);
- tools currently in use in jurisdictions; and
- other major data collections, assessment tools, data development activities and concepts of relevance, wherever possible.

The methodology for the 1999 'support needs' project was a two-stage process. In stage one, the issues surrounding 'support needs' were explored by:

- reviewing relevant literature including national and international data dictionaries and classifications;
- examining a range of relevant Australian data collections;
- investigating a number of well-known tools for assessing support need;
- analysing information provided by jurisdictions, detailing policy directions and the assessment tools and frameworks currently in operation or under development; and
- synthesising this information to elucidate the major issues for discussion at an AIHW-NDA workshop in November 1999.

In stage two, the AIHW:

- undertook further research and analysis in accordance with the direction provided by the workshop; and
- developed a number of support needs data options for NDA consideration.

Full details of the project will not be repeated here. Rather, we will outline the ways in which the ICF was used during the project.

Using the ICF to develop a 'support needs' framework

1. Using the ICF as a framework

The ICF domains and scales were used as the framework to which all of the other classifications and tools described above were mapped. That is, the ICF acted as a central, comprehensive framework and set of classifications in which to organise our comparative analysis and seek areas of commonality.

Preliminary analysis of the literature and tools for this project raised the issue of whether a support needs framework should primarily relate to the concept of Activity or Participation or both. However, it was recognised that disability support services provided under the CSDA may address any area of Activities and Participation, and any area of Activities and Participation may affect the intensity of support needed. It was therefore agreed that it was unnecessary to attempt to split the Activities and Participation single list for the 'support needs' question in the new CSDA MDS (See Chapter 7 the Activities and Participation component of the ICF for further discussion). The final support needs framework includes concepts that may be considered Activities and/or Participation.

2. Using the ICF as a 'smorgasbord' for selecting domains

Domains from the Activities and Participation component were selected, generally at the chapter heading level (e.g. Chapter 3 'Communication'). All chapters within the Activities and Participation component were included in the support needs framework. However, in the following cases:

- ICF chapters were grouped (i.e. Chapter 1 'Learning and applying knowledge' was combined with Chapter 2 'General tasks and demands);
- ICF chapters were separated (i.e. Chapter 8 'Major life areas' was separated into two separate items 'Working' and 'Education');
- a block from one ICF chapter was grouped with another ICF chapter (i.e. the block of 'Economic life' from within Chapter 8 'Major life areas' was grouped with Chapter 9 'Community, social and civic life').

Such grouping or separation was only done when it was either considered to be more meaningful/less onerous for service delivery agencies or to improve the degree to which the framework related to the ABS Survey of Disability, Ageing and Carers, existing CSDA MDS, and other related classifications and tools. Examples were also included for each support needs domain or 'life area' in the support needs framework. These are selected categories from within each relevant ICF chapter (e.g. for the support needs life area 'self care' the examples used are d510 washing oneself, d540 dressing, d550 eating and d530 toileting).

The selected domains and examples were tested with consumers, service providers and jurisdictions during the redevelopment of the CSDA MDS and refined where necessary.

3. Using the ICF to select qualifiers or scales

This was probably the most difficult aspect of the data development exercise. There was considerable consistency in the type of domains included in various classifications and tools examined during the 1999 'support needs' project. However, the scales used varied and sometimes related to the whole person and sometimes the person in relation to the specific service required.

The final selected scale relates directly to the ABS Survey of Disability, Ageing and Carers, enabling comparison with population data. The scale relates most closely to the qualifier concepts of difficulty and assistance with Activity (in the NCSDD V2.0; AIHW 2000) and incorporates both concepts of assistance via personal assistance and/or via the use of aids or equipment (i.e. Environmental Factors).

The support needs scale also relates to the ICF performance qualifier for Activities and Participation:

> 'The *performance qualifier* describes what an individual does in his or her current environment. Because the current environment includes a societal context, performance can also be understood as 'involvement in life situation' or 'the lived experience' of people in the actual context in which they live. This context includes the environmental factors – all aspects of the physical, social and attitudinal world which can be coded using the Environmental Factors component' (WHO 2002:15).

The way in which the selected support needs scale relates to the ICF performance qualifier is outlined in Table 1. It should be noted that the support needs scale point '3) Does not need help/supervision in this life area but uses aids or equipment' does not map directly to the ICF performance qualifier. Instead it gathers additional information about one aspect of the individual's environment. This is consistent with the ICF quote above.

Table 1: Mapping the support needs scale to the ICF performance qualifier

ICF uniform qualifier	Support needs scale
NO problem	Does not need help/ supervision in this life area and does not use aids or equipment
MILD problem	Sometimes needs help/ supervision in this life area
MODERATE problem	Sometimes needs help/ supervision in this life area
SEVERE problem	Sometimes needs help/ supervision in this life area
COMPLETE problem	Unable to do or always needs help/ supervision in this life area

Support needs framework or 'information matrix'

How often does the service user need personal help or supervision with activities or participation in the following life areas?

The person can undertake activities or participate in this life area with this level of personal help or supervision (or would require this level of help or supervision if the person currently helping were not available)	1) Unable to do or always needs help/ supervision in this life area	2) Sometimes needs help/ supervision in this life area	3) Does not need help/ supervision in this life area but uses aids or equipment	4) Does not need help/ supervision in this life area and does not use aids or equipment	5) Not applicable
a) Self-care e.g. washing oneself, dressing, eating, toileting					
b) Mobility e.g. moving around the home and/or moving around away from home (including using public transport or driving a motor vehicle), getting in or out of bed or a chair					
c) Communication e.g. making self understood, in own native language or preferred method of communication if applicable, and understanding others					
d) Interpersonal interactions and relationships e.g. actions and behaviours that an individual does to make and keep friends and relationships, behaving within accepted limits, coping with feelings and emotions					
In the following questions 'not applicable' is a valid response only if the person is 0 - 4 years old.					
e) Learning, applying knowledge and general tasks and demands e.g. understanding new ideas, remembering, problem solving, decision making, paying attention, undertaking single or multiple tasks, carrying out daily routine					
f) Education e.g. the actions, behaviours and tasks an individual performs at school, college, or any educational setting					
g) Community (civic) and economic life e.g. recreation and leisure, religion and spirituality, human rights, political life and citizenship, economic life such as handling money					
In the following questions 'not applicable' is a valid response only if the person is 0 - 14 years old.					
h) Domestic life e.g. organising meals, cleaning, disposing of garbage, housekeeping, shopping, cooking, home maintenance					
i) Working e.g. actions, behaviours and tasks to obtain and retain paid employment					

Source: CSDA MDS Service User Form, 2002

3. Participation outcomes

Background

A 'participation module' was also developed as part of the CSDA MDS redevelopment project. The resulting draft 'participation module' is included here and is an additional resource for jurisdictions to add in the CSDA MDS. It is not included in the national CSDA MDS.

Using the ICF to develop a 'participation module'

1. Using the ICF as a framework

The overarching goal of the CSDA is to enhance the quality of life for people with disabilities by assisting them to live as valued and participating members of the community. Thus, quality of life and participation are critical concepts in terms of measuring outcomes for individual consumers. Participation is defined in the ICF as 'involvement in a life situation'. Participation is taken to mean not just 'doing' an activity, but having an autonomous role and experiencing real involvement and satisfaction.

The ICF concept of participation is thus consistent with the philosophy of the CSDA, the Australian Disability Service Standards and the *UN Standard Rules on Equalization of Opportunity for People with Disabilities*. Thus, the Activities and Participation component of the ICF appeared to be a useful starting point for developing a framework or module that related to all of these philosophies.

2. Using the ICF as a 'smorgasbord' for selecting domains

A range of life domains was selected from the Activities and Participation component. These domains were selected in discussion with consumers and funding departments and attempt to relate to the areas of most interest to consumers as well as the overall human rights focus of the CSDA.

Domains from the Activities and Participation component were selected, generally at the chapter heading level (e.g. Chapter 6 'Domestic life'). However, in the following cases:

- particular aspects of ICF chapters were drawn out into the participation 'life area' (i.e. Chapter 3 'Communication' was used in total but the block called 'Conversation and use of communication devices and techniques' was drawn up into the heading to increase its prominence; Chapter 4 'Mobility' was used in total but the blocks on 'Walking and moving' and 'Moving around using transportation' were drawn up into the heading to increase their prominence);
- ICF chapters were separated (e.g. Chapter 8 'Major life areas' was separated into two separate participation life areas 'Participation in education, work and employment' and 'Participation in economic life');

- ICF chapters were not referred to in the participation module (i.e. Chapter 1 'Learning and applying knowledge', Chapter 2 'General tasks and demands' and Chapter 5 'Self care').

Examples were also included for each participation 'life area'. These are selected categories from within each relevant ICF chapter or block (e.g. for the participation life area 'Domestic life' the examples used are d610 acquiring a place to live, d620 acquisition of goods and services, d630 preparing meals, d650 caring for household objects and d660 assisting others).

3. Using the ICF to select qualifiers or scales

Two scales are included in the 'participation module':

- Extent of participation (judged by service provider or assessment process); and
- Satisfaction with participation (judged by consumer, with advocate if necessary) in relation to duration, frequency, manner or outcome.

These are the qualifiers in the National Community Services Data Dictionary Version 2.0 (AIHW 2000), as they are based on quite extensive research and development. The qualifiers are consistent with the uniform qualifier for Activities and Participation (the performance qualifier) in the ICF. The scales also enable data collated using the 'participation module' to be related to some population data collected via the ABS Survey of Disability, Ageing and Carers. The use of the scales, together with the context in which the component information is gathered (e.g. through client satisfaction surveys etc.) make it clear that the 'participation module' is a framework for collating information about Participation rather than Activities.

How to use the 'participation module'

It is important to note that the draft 'participation module' or framework is not a proposed question that would appear on a form. That is:

i. The 'module' indicates the output and concepts of the module rather than the precise wording that would be used in questions. Separate mechanisms would be used to gather information from consumers and service providers (see Figure 1).

ii. The separate recording for the service provider and person is in line with the established principle that quality of life measures should be based on both 'objective' and 'subjective' measures.

iii. If adopted there would need to be guides for use etc. Guides for use would explain the ICF framework including the importance of environmental factors. This could bring in social attitudes i.e. the 'valued members' aspect of the CSDA goal.

The participation framework or multi-purpose 'participation module' is proposed for use as a broad outcome indicator meaningful in the CSDA field. The participation module could be used in the course of service administration: when conducting 'satisfaction surveys', discussing people's overall goals and developing individual

service plans (e.g. in case management reviews); and in assessing overall quality of life (see Figure 1).

As with 'support needs' there are many quality of life and satisfaction measures and instruments. However, based on work done during the development of the ICF, it is considered likely that these will map to the 'participation module' (see also Chapter 5 for a discussion of measurement of Participation). The way the participation module might relate to other existing (or future) information and planning processes is illustrated in Figure 1.

It is important to note that this sort of module would aim to look at outcomes relating to a whole person, across life domains. The outcomes at this broad level (e.g. satisfactory participation in domestic life) would be difficult to attribute to specific service interventions. However, information about them could be very useful at a more general or program level: for instance, to answer questions about the quality of life for people with disabilities (accessing CSDA-funded services) and consider priorities for action. Information could also be useful for planning services to meet people's participation goals.

Draft 'participation module' or framework ('information matrix')

Life area	Extent of participation (judged by service provider or assessment process)	Satisfaction with participation (judged by consumer, with advocate if necessary) in relation to duration, frequency, manner or outcome
	1. Full participation **2. Mild participation restriction** **3. Moderate participation restriction** **4. Severe participation restriction** **5. Complete participation restriction**	**1. High satisfaction with participation** **2. Moderate satisfaction with participation** **3. Moderate dissatisfaction with participation** **4. Extreme dissatisfaction with participation** **5. No participation** **6. No participation and none desired**
Participation in communication and conversation (e.g. producing and receiving spoken, nonverbal, formal sign or written messages, involvement in conversation, discussion with or without use of communication devices and techniques)		
Participation in mobility within the home and community environment (e.g. changing and maintaining body position; carrying, moving and handling objects; walking and moving; moving around using transportation)		
Participation in domestic life (e.g. acquiring necessities such as a place to live and goods and services; household tasks such as preparing meals; caring for household objects and assisting others)		
Participation in interpersonal interactions and relationships (e.g. relating with strangers, formal and information social relationships, family and intimate relationships)		
Participation in education, work and employment (e.g. informal education, preschool, school, vocational and higher education; work preparation such as apprenticeships; acquiring, keeping and terminating a job, remunerative or non-remunerative employment)		
Participation in economic life (e.g. basic and complex economic transactions, economic self-sufficiency)		
Participation in community, social and civic life (e.g. community life, religion and spirituality, recreation and leisure, political life and citizenship, human rights)		

Source: CSDA MDS Network Guide, 2002

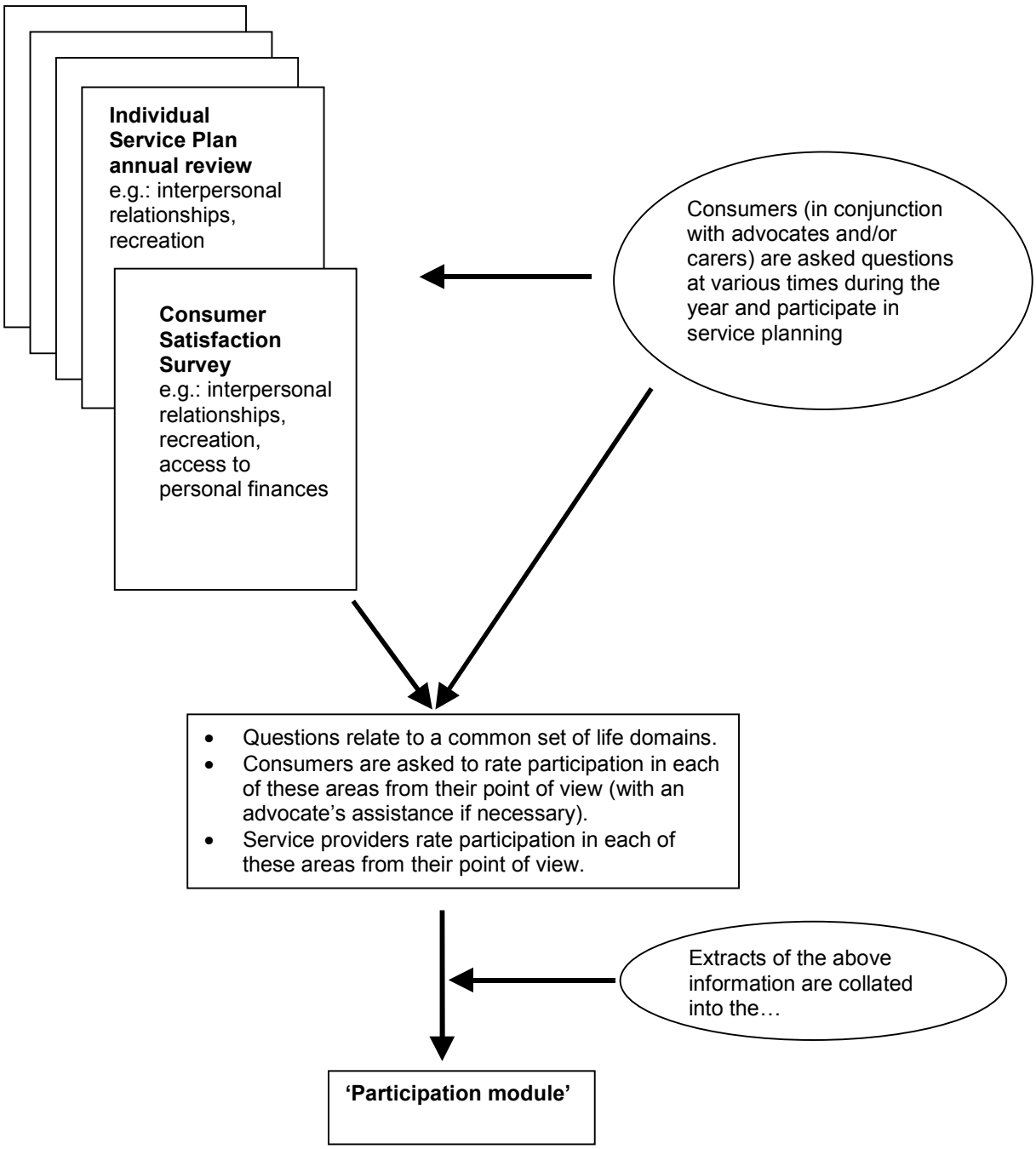


Figure 1: The relationship of the 'Participation module' to other information collected