02nd March 2015

College of Occupational Therapists

Office of the Minister and Deputy First Minister: Call for evidence to the Children's Services Co-Operation Bill

Submission by the College of Occupational Therapists

The College of Occupational Therapists is the professional body for occupational therapists and represents over 30,000 occupational therapists, support workers and students from across the United Kingdom of who about 900 are in Northern Ireland. Occupational therapists are regulated by the Health Care Professions Council. There are in the region of 100 occupational therapists working with children and young people with special educational needs in Northern Ireland.

Occupational therapists work holistically and are outcome focused. They have multi-dimensional training that addresses the physical, psychosocial, sensory processing, developmental levels and needs of children and young people. Occupational therapists will spend time finding out about the child's and family's typical daily life and what they want, need or are expected to do. They will then work together with the child, family and other key people to evaluate what helps or hinders their involvement in daily life roles. Together, possible solutions will be developed, such as exploring alternative ways of doing things or making changes to the environment to support participation.

The College of Occupational Therapists supports the Children's Services Co-Operation Bill

The College of Occupational Therapists is supportive of the Children's Services Co-Operation Bill which if passed, will place a statutory duty on all Executive Departments to collaborate and work together in the planning, commissioning and delivery of children's services and will include enabling legislation to allow the pooling of budgets.

The College of Occupational Therapists would like to see a clear legal obligation on Government Departments and agencies to work together to meet the needs of children in a comprehensive and holistic way.

Why is this important to occupational therapists in Northern Ireland?

It is important because occupational therapists work across many departments and agencies such as health, education, juvenile justice and housing. They also work across different settings such as home, school and in the community as well as working in partnerships with parents, carers, teachers, educators and other disciplines. In order to address the assessed needs of each child holistically all of these parts of the processes and systems in the delivery of children's services need to be well co-ordinated and collaborating with each other.

The occupational therapist depends on good co-ordination and collaboration between departments and agencies to deliver a holistic service to meet the assessed needs of the child.

There are more children with special educational needs attending schools of their choice which can be either a special school or a mainstream school. These children may need occupational therapy services and these often need to be co-ordinated across a number of agencies or departments.

For example a child with significant needs may need the following:

- Housing adaptation
- Provision of a specialised wheelchair
- Support with the education curriculum
- Environmental recommendations for school
- Individual therapeutic interventions such as with self-care

Collaboration is required across services to be effective

What are the issues presently?

1. Occupational therapists are funded by the Department of Health, Social Services and Public Safety (DHSSPS). They are being asked to provide services in both Health and Education settings yet occupational therapy services are not factored in when Education plans services. HSC Services have their own priorities driven by statutory requirements which occupational therapists help them to meet. Education has legislative requirements which occupational therapists are expected to contribute to. These are two organisations with differing priorities and separate funding streams.

2. Services are disjointed at present with individual departments responsible for certain elements and no way always of ensuring a cohesive delivery. For example there is a need for a protocol regarding provision, management and maintenance of equipment recommended by occupational therapists but which are the responsibility of the Education and Library Boards.

3. Demographic changes due to increased life expectations and increased diagnosis of children requiring services need to be factored in planning services. As more children with complex needs survive and require a lifetime of services, there is increased need for occupational therapy services such as recommendations for complex housing adaptations and equipment, (e.g. specialised seating, wheelchairs, showering) and hands on therapy intervention to enable function and participation. These children are surviving longer and into transition from nursery to primary education, from primary to secondary education and from secondary to higher/further education or employment.

4. There is also a requirement for occupational therapy services to support children and young people with varying levels of assessed needs so that they can access the educational curriculum and reach their potential. It is becoming more important to ensure occupational therapy services are being utilised to the full to support the maximum number of children in the environments they are in. Occupational therapists can work at three major levels within health, social care, education, voluntary or public health arenas (Arbesman et al 2013):

Level 1: Whole – population or universal programmes designed for all children and young people. For example:

- Whole school programmes promoting mental health (rather than preventing mental illness) have been successful (Wells et al 2003), including participating in leisure occupations (Daykin et al 2008).

- Working with teachers in the classroom has improved the legibility, speed and fluency of children's handwriting (Case-Smith et al 2012)

- Occupational therapists are uniquely qualified to promote lifestyle change to address issues such as obesity (Reingold and Jordan 2013). This could include applying play activities in a nutritional education programme (Munguba et al 2008).

- Implementing a 'whole school' approach to occupational therapy services in mainstream schools enabled close relationships with school staff to be developed which influenced the participation of all children in school occupations (Hutton 2012).

Level 2: Targeted, or selective services designed to support children and young people who are at risk of poorer health or wellbeing outcomes. For example:

- Occupational therapy-led life skills programmes for children with learning delays and disabilities improved self-management skills and decreased aggressive and antisocial behaviours (Carter and Hughes 2005; Drysdale et al 2008).

- Social behaviours of adolescents on the autism spectrum were improved through an occupational therapy programme based on role play (Gutman et al 2012).

- Lifestyle management programmes for children with cystic fibrosis can improve peer relationships and decrease loneliness (Christian and D'Auria 2006).

Level 3: Intensive, or specialist occupational therapy services provided for children and young people with identified mental, physical, emotional, learning or behavioural needs which impact on their participation in life roles. For example:

- Working with children with acquired brain injury using an individualised intervention approach - Cognitive Orientation to Daily Occupational Performance (CO-OP) that teaches cognitive strategies necessary to support successful performance (Missiuna et al 2010).

- Using parent coaching approaches to improve the participation of children on the Autistic Spectrum in their chosen occupations (Dunn et al 2012).

- Focusing on enabling participation in chosen occupations is the most effective intervention approach for children and young people with Developmental Coordination Disorder (Morgan and Long 2012).

- In relation to Cerebral Palsy, intensive (>90 hours) intervention which focuses on the function and movement of the upper limb has been effective in improving outcomes for children with hemiplegia (Miller et al 2014; Sakzewski et al 2014).

- A combination of direct occupational therapy and partnership- based home programme, is effective in improving motor and functional outcomes, provided appropriate support, coaching and monitoring is available (Novak and Berry 2014).

5. Transition is also a difficult time for families and young people yet they don't always get the support required to ensure a smooth transition from school into further education/work or from paediatric services to adult services. For example, children with muscular dystrophy on reaching school leaving age require intense support to meet all of their needs (physical / emotional / medical). Transition is a difficult time for these young people and families, yet occupational therapists have highlighted that they don't get the support required to ensure a smooth transition from school into further education/work or from paediatric services to adult services. This can result in some of the young adults staying at home and consequently becoming increasingly isolated with no structure to their day.

6. Planning of school / Colleges (HEIs) and leisure buildings requiring environmental assessments without collaboration or consultation with occupational therapists and which result in not meeting the needs of children or young people with disabilities. If occupational therapists are not involved from the outset, this can result in having to make more costly adaptations later.

7. The coexisting needs of children with; for example, Autistic Spectrum Disorder and mental health problems or those with Attention Deficit Hyperactivity Disorder who self-harm, requires integrated planning across the services that can meet their multi-faceted needs.

What could be improved if the Children's Bill was passed?

- Procurement, supply and management of equipment. Occupational therapists would like to see a dedicated management system of equipment put in place.

- Smooth transition for children with special educational needs at trigger points, such as primary to post primary, into further education and into adult services.

- Interface between Health and Education along with improved collaboration at all levels leading to improved services.

- Collaboration and co-ordination between all departments in order to achieve the 6 high level outcomes in the planning, commissioning and delivery of children's services.

- There is the potential for added benefits such as a reduction in financial waste and duplication and one example is in the area of equipment purchased by Education and Library Boards and this relates to point 2.

  The six high level outcomes are all part of core values in occupational therapy. We feel that to ensure a holistic view and support for all children it is necessary for departments to work together. However we would like to see that it is truly integrated and co-ordinated working and that each department does not come with a singular view for their 'part' in achieving it which maintains a fractured approach.

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