



AOTI

Association of Occupational
Therapists of Ireland

Opening Statement on Standard Operating Procedure for the Assessment of Need



Joint Committee on Health
27th June 2018



Introduction

Thank you for inviting the Association of Occupational Therapists of Ireland to this meeting of the Joint Oireachtas Health Committee to discuss the standard operating procedure for the assessment of need under the Disability Act 2005. This is an important matter and AOTI welcomes your consideration of it.

The standard operating procedure (SOP) for assessment of need was developed by the HSE in order to ensure a consistent approach to applications for assessment of need. It was due to be implemented from 30th April this year but this did not happen because of concerns raised by numerous stakeholders.

AOTI published a statement in April 2018 on the proposed SOP in response to concerns raised by our members about the document. What follows is a summary of AOTI's concerns.



The Assessment of Need Process

Part 2 of the Disability Act 2005 has been enacted for all children born on or after 1st June 2002, enabling parents, guardians or professionals to apply for an assessment of need (AON) under the Act. According to the Act and subsequently published regulations, the AON must be commenced within three months of application and completed within a further three months. Occupational therapists are often one of the key professionals involved in the AON process.

Currently, the AON process is significantly impacting on available therapeutic resources for children. Occupational therapists are frequently required to prioritise AONs over other areas of practice which detracts from time spent carrying out non-statutory assessment of children and providing them with occupational therapy intervention.

It is important to note that, while the AON will often result in the therapeutic, health or educational needs of a child being identified, it places no obligation on services to immediately provide the named supports. This results in children being placed on lengthy waiting lists for intervention when the AON is complete.

In a recent survey of 98 occupational therapists undertaken by AOTI, the majority of participants reported that a typical AON, including direct assessment, observation, information-gathering and report-writing can take a practitioner anything from 2-12 hours to complete, with the majority taking between 4 and 8 hours. The variation in length of assessment is because of the uniqueness of each child and the need for varying levels of assessment depending on complexity.



Therapists reported that children are then placed on the Occupational Therapy waitlist for further occupational therapy assessment and intervention when the AON is complete. Waiting lists vary significantly across the country. The majority reported that it can take 8 months to 2 years for further occupational therapy assessment and intervention to be offered while just 30% reported that it would take less than 6 months. Participants highlighted that the AON process is already significantly impacting on the level of service that occupational therapy services can provide and the proposed SOP will only exacerbate this situation.

HSE Standard Operating Procedure for Assessment of Need

The SOP was developed with the intention of ensuring a consistent approach to managing requests for a statutory assessment of need and processing the resulting referrals. AOTI was not consulted during the initial drafting of the SOP. We do recognise the need for standardisation of AON processes and are keen to work with the HSE to achieve a process that best meets the needs of children and their families, that is evidence-based and that is in line with ethical and best practice. We cannot however support the SOP as it has been presented for the following reasons.

The reconfiguration of children's services has not happened in all Community Healthcare Organisations, which is a prerequisite for the SOP to work.

Reconfiguration allows children to access needs-led multi-disciplinary services within their locality if they present with complex needs, regardless of diagnosis. Non-configured areas continue to operate on the basis of diagnosis, leaving many children with undiagnosed complex needs without adequate



services. The absence of reconfigured teams in most areas means that many therapists are working in a uni-disciplinary manner and have no or limited access to other professionals that would enable them to complete the preliminary team assessments proposed by the SOP. Currently just two of the nine CHOs across the country are fully reconfigured with Children's Network Disability Teams.

The SOP has been introduced against a background of under-resourcing of children's disability services nationally, where there are lengthy waiting lists to access services and further waiting lists for intervention. Related to this is the lack of resources within the children's disability services to ensure timely diagnosis and intervention where a disability has been identified through the AON process. The SOP will therefore further restrict the provision of paediatric occupational therapy services.

To illustrate the reality of this, we wish to share an example from one non-reconfigured service in the South. This disability service took over part of the provision of autism services in their area 12 years ago. At the time of the establishment of this new autism service, 50 children were transferred into the service and one whole time equivalent occupational therapist was allocated. 12 years later, there are now 1,000 children linked with this service with only 3 whole time equivalent occupational therapists. The HSE's own recommendation is that there should be a ratio of 1.5 whole time equivalent occupational therapists per 100 children with a disability. This means that there should be 15 occupational therapists where there are only 3.

The current reality of a child referred to this service is as follows:

- Preliminary screening occurs prior to the child entering the service and an indication of an Autism diagnosis is highlighted



- Diagnostic assessment is completed within 2.5 years of application, following which a diagnosis of Autism (if present) is confirmed within 6 weeks
- If the diagnosis is confirmed, the child will then be placed on waiting lists for further interventions. In the case of Occupational Therapy services, the waiting list for further assessment/intervention is over 12 months.

In other words, this child has to potentially wait up to three and a half years for Occupational Therapy intervention.

If this service introduces the SOP within the current system, a third layer of waiting lists will be created prior to diagnostic assessment. This will create further delays on referring children for diagnostic assessment. Without a diagnosis, children with Autism risk losing out on places in special ASD units in schools and children with Autism in mainstream education will not be able to obtain access to Special Needs Assistance. This may prevent some children from accessing education at all, which is a breach of their Constitutional rights. As a result of the additional demands the SOP will place on this already under-resourced autism service in the South, it is considering suspension of all therapeutic services, in order to be able to meet the requirements of the SOP and the additional service demands it will create. There simply will be no capacity to provide occupational therapy intervention and children will be placed on waiting lists for occupational therapy indefinitely.

The SOP proposes only a 90 minute timeframe for assessment.

As noted previously, the majority of occupational therapists currently spend between 4 and 8 hours per referral for Assessment of Need. The 90 minute assessment timeframe proposed by the SOP does not afford the therapist time to assess the child across a variety of environments (e.g. school, home and clinic), which is considered best practice for comprehensive assessment. Initial meetings with services can also be anxiety-inducing for families and children and this is likely to impact on the child's presentation and potentially the



outcome of the assessment. In addition, the 90 minute timeframe creates a risk of over-reliance on short observations, paper screening and parent report to guide clinical decision-making. A fixed 90 minute period for assessment does not allow an occupational therapist to gather all the information they may need to make a proper assessment of the child

The SOP requires clinicians to identify, after a 90 minute assessment, whether the child has a permanent disability that warrants further assessment in order to confirm a diagnosis. It also requires that therapists provide strategies to parents/carers by the end of the 90 minute assessment. AOTI is concerned that this places significant pressure on therapists to make a very important decision with what may be limited information, resulting in potentially inappropriate referrals to diagnostic services or provision of inadequate and potentially harmful intervention strategies to the parents/carers. Furthermore, occupational therapists can only provide intervention strategies when they have completed an occupational therapy assessment and the AON is not an occupational therapy assessment. Therefore, the approach outlined in the SOP is lacking an evidence base and will compromise safe and ethical practice.

The SOP places occupational therapists in breach of the CORU Code of Professional Conduct and Ethics for Occupational Therapists.

Among the many requirements within the CORU Code of Professional Conduct and Ethics for occupational therapists, it states that therapists must:

- Act in the best interests of service users
- Treat each service user as an individual in a client-centred manner.
- Respect and, where appropriate, speak out on behalf of service users
- Communicate sensitively and effectively with service users taking into account any special needs when communicating with children



- Carry out their duties and responsibilities in a professional and ethical way to protect the public
- Be responsible for any service or professional advice they give
- Be able to justify any decisions they make within their scope of practice and that they are always accountable for what they do, what they fail to do, and their behaviour
- Meet professional standards of practice and work in a lawful, safe and effective manner.
- Be an advocate for service users

Each of these requirements is compromised by the proposed SOP and this places occupational therapists in direct conflict with the requirement of the CORU Code of Professional Conduct and Ethics for occupational therapists. This is a matter of serious concern for AOTI and for our members and one that must be addressed by the HSE.

Summary

AOTI recognises the need for standardisation of Assessment of Need however we can only support an AON process that best meets the needs of children and their families and that does not place occupational therapists in an impossible situation where they are caught between HSE and CORU requirement. We have requested that the HSE engage directly with AOTI and other stakeholders to ensure a full and thorough consultation on the SOP for the Assessment of Need and to resolve the concerns expressed. To date there has only been one meeting which took place one month ago. AOTI is keen to engage with the HSE on the development of any future policies affecting children and indeed more broadly so that difficulties such as these can be prevented.