Orientation and Mobility Involvement with Scooter Travel in Australasia

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Health professionals have expressed concern about vision issues in relation to scooter travel, but despite low vision or legal blindness, scooter travel remains feasible. Safe scooter travel is the result of decision-making in relation to physical limitations and available sensory information. O&M specialists are the only health professionals with a skill-set in blind and low vision mobility and are therefore equipped to conduct functional assessment of scooter users with low vision. A survey of the O&M profession in Australasia (N=69) indicated that 67% of respondents had undertaken scooter work with clients, but 88% believed they would benefit from additional scooter professional development. Further research is needed to inform fair, consistent decision-making regarding scooter use.

Introduction

Scooters are becoming increasingly popular in Australia and New Zealand, but there is little regulation governing their use (Oxley & Whelan, 2008). In Australia, a scooter user is legally classified as a pedestrian and must travel below 10 kilometres per hour, riding on the footpath unless it is impracticable to do so (Australian Road Rules, 2006). In New Zealand, scooter users must not ride in a way that may cause themselves or others injury, or ‘travel at a speed that endangers others’ (New Zealand Transport Agency, 2011, p. 6).

Scooters have particular appeal for people who are elderly whose capacity for walking or driving is decreasing, but who nevertheless wish to remain active and independent (Edwards & McCluskey, 2010). There is no standard scooter training or assessment process and scooter users sometimes travel in a manner that places themselves and others at risk (Litman & Blair, 2010; McTaggart, 2007). There is valid concern in the Australian community and among health professionals, about vision, speed, and safety with regard to scooter use (Gibson, Ozanne-Smith, Clapperton, Kitching, & Cassell, 2011). Some allied health professionals seem particularly concerned if a person’s driver’s license has been revoked for visual or cognitive reasons, yet the person is able to return to the road unchecked, as a scooter user (Berndt, 2002). Scooter travel also poses new challenges to those responsible for the design of accessible urban infrastructure (Litman & Blair, 2010). Increased scooter usage and its associated manifold tensions have been described as the ‘scooter phenomenon’ (Steyn & Chan, 2008, p. 99).
A recent increase in scooter referrals to the Orientation and Mobility (O&M) service at Guide Dogs Victoria prompted curiosity about the ‘scooter phenomenon’ and its impact on the O&M profession in Australasia. This study will examine the scooter phenomenon from an O&M perspective and report the findings of a survey of the Australasian O&M profession investigating the experience of its members in power mobility (electric wheelchairs and scooters).

Due to the dearth of low vision research in relation to scooter mobility it has been necessary to examine driving and wheelchair studies, general low vision studies as well as general scooter resources. Multiple studies investigate both power-chairs and scooters and there are some similarities in the issues that arise in relation to their use.

**The scooter phenomenon**

The scooters under consideration in this study are three- or four-wheeled mobility devices, powered by a rechargeable battery pack. A scooter typically offers less postural support than a power-chair. The scooter user needs to be able to get on and off unassisted, maintain seating posture without falling in any direction once seated, and move the upper body and arms freely to steer the device (Shopmobility Ltd UK., 2011; Wilson, 1992). Scooters are usually steered by handlebars on a tiller with lever, dial, or button controls and some lighter weight models can be disassembled and loaded into the boot of a car (Chedd, 1996; Stogner, 2009).

People who use scooters tend to alternate between walking and riding, and may also use an ambulatory aid (e.g., crutches, cane, or frame) that requires transporting on the scooter when travelling in the community (Shopmobility Ltd UK., 2011). The scooter has a long wheelbase requiring significant turning room, and as a result is most suited to use beyond the home (Koontz, Brindle, Kankipati, Feathers, & Cooper, 2010). In contrast, a power chair is typically used by someone whose walking capacity is quite restricted, usually from a chronic or permanent condition (Kaye, Kang, & LaPlante, 2000). The power chair offers autonomy when the user cannot manage a manual wheelchair independently, is unable to walk between rooms in the home, or needs to manoeuvre the device in tight spaces (Department of Veterans’ Affairs, 2002).

A power mobility survey (N=202) conducted in New South Wales found that scooter users tend to be much older than power chair users, with a median age of 81 vs. 57 years respectively (Edwards & McCluskey, 2010). As baby boomers approach retirement and the population ages, the number of people with low vision or legal blindness in Australia is projected to almost double in 20 years (Taylor, et al., 2005). Thus, it can be assumed that the number of scooter users will also substantially increase.

Maintaining independent mobility as long as possible is fundamental to a person’s dignity, health, wellbeing, and quality of life (Metz, 2000; Steyn & Chan, 2008; Zagol & Krasuski, 2010). A private vehicle comes closest to providing full mobility because of the ease, access, and autonomy it offers (Suen & Sen, 2004). A scooter can serve this purpose, but the transition from driving a car to scooter use is a complex process. Loss of license has been linked with depression, social isolation, loss of status,
and self-confidence, as well as declines in physical wellbeing (Oxley & Charlton, 2009). Ceasing driving reduces opportunity for participation in social activities, work, volunteering, shopping, healthcare visits, and faith based activities (McCarthy, 2009). A person who ceases driving must adjust his or her self-image, then re-adjust again if choosing to take up power mobility (Miles-Tapping & MacDonald, 1994). The transition and adjustment to non-driving is less traumatic if self-regulated by the driver (Molnar & Eby, 2008; Oxley & Charlton, 2009).

In Australia, visual acuities of less than 6/12 (20/40), or visual fields less than 120° (in New Zealand, <6/12 and <140°) render a person legally ineligible to drive (Austroads, 2003). However, the use of simplistic visual criteria to determine driving eligibility is not supported by the literature; such criteria give no clear indication of the degree to which a person is able to manage the multiple, complex visual tasks required for driving (Bohensky, Charlton, Odell, & Keeffe, 2008; Fildes, et al., 2008; Owlsley, et al., 1998). There are still unsafe drivers on the roads, yet some safe drivers have had their licenses unnecessarily revoked, and the lifestyle implications are enormous (Bohensky, et al., 2008).

**Regulation**

Scooters can be bought and sold by anyone. There are criteria in Australia that determine eligibility for scooter funding (e.g., Department of Veterans’ Affairs, 2009) but there is significant confusion over who may use a scooter (Australian Road Rules, 2006, Rule 244A). In the disability sector, scooters are associated with power-chairs. Government documents designed for scooter users indicate that the law says ‘a person must have a disability or significantly reduced mobility to legally use a scooter’ (Department of Veterans’ Affairs, 2003, p. 3; Vicroads, 2010). However, in the Australian Road Rules, motorised scooters fit the definition of a ‘wheeled recreational device or wheeled toy’ (Australian Road Rules, 2006, Rule 244A) and it seems that, as with bicycles, skateboards, roller blades and foot-scooters, a person’s right to use a scooter is assumed unless the device is employed in a manner that contravenes the law.

New Zealand law seems less ambiguous in relation to scooter use than Australian law because its definition of wheeled mobility devices includes both scooters and power-chairs (New Zealand Transport Agency, 2009). The Australian Competition and Consumer Commission (ACCC) have yet to come to an agreement regarding scooter regulation, but are working to foster collaboration between all relevant stakeholders. Therefore, health professionals must determine for themselves their degree of involvement in the scooter community (T. Minuta, personal communication, 27 June, 2011).

Multiple reports emphasise the importance of scooter training rather than regulation as the best means of maximising safe scooter use, and many contain suggestions about what should be included in training (Cassell & Clapperton, 2006; Edwards & McCluskey, 2010; Gibson, et al., 2011; Nitz, 2008; Steyn & Chan, 2008). There is no consensus in the literature about who should be responsible for providing this training, however the ACCC suggests that people needing training...
might approach reputable scooter suppliers or local councils (Australian Competition and Consumer Commission, 2010). While brief training might meet the needs of some scooter users, a more comprehensive approach seems advisable, even essential if a person’s functional limitations are substantial.

In Australia, occupational therapists have an established role in driving rehabilitation assessment, and support the transition from driving to non-driving (Unsworth, 2007). This process involves consideration of physical, cognitive, and sensory functioning, both off-road and on-road (Wheatley & Di Stefano, 2008). Occupational therapists also advise about driving alternatives, including scooter travel, and are authorised to facilitate applications for scooter funding (Di Stefano, Lovell, Stone, Oh, & Cockfield, 2009). While the scooter literature emphasises the importance of assessing vision for safe scooter travel, there are no data to support a clinical visual measure indicating the viability of scooter use (Berndt, 2002; Nitz, 2008). This lack of data makes evidence-based practice difficult for an occupational therapist assessing a scooter user’s visual function.

**Vision and scooter travel**

Low vision tends to be poorly understood by people who have no practical skill-set in blind mobility (Bolt, 2006). Clinical vision assessment employs an ability to read text in a static environment as the primary measure of whether or not a person can see. A person is considered legally blind with visual acuity less than 6/60 (20/200) (Australian Institute of Health and Welfare, 2007). While a legal blindness diagnosis indicates the value our culture places on print literacy, it gives little useful information about low vision in relation to mobility.

The O&M specialist assesses functional vision, as it impacts on mobility. *Light perception only* can assist navigation, and in O&M, the term *blind* tends not to be used unless the client has no light perception. If a client cannot visually recognise and manage drop-offs (e.g., steps, curbs, and platform edges) safely, then a primary mobility aid (human guide, long cane, or dog guide) is usually recommended (Deverell, Taylor, & Prentice, 2009). The author’s own experience indicates that a primary mobility aid is rarely required for daytime use until the client’s vision is well within the range of legal blindness, (e.g., less than 6/120 or 20/400 acuity), although low lighting conditions can cause mobility difficulties.

Many people with little or no light perception cross roads safely, and some ski, hike, or ride a mountain bike through rough terrain using no primary mobility aid (Kish, 2006). Just as a fully-sighted person, anyone with low vision or blindness must calculate the risks inherent in a mobility task against their skill to complete the task, and make their travel decisions accordingly.

Anecdotally, occupational therapists have suggested using the visual eligibility criteria for driving or for legal blindness to indicate the viability of scooter travel. With no evidence to support it, such regulation would be grossly discriminatory (Disability Discrimination Act, 1992). It is not vision that calls into question a person’s ability to travel safely, but the decisions she makes about physical, cognitive, and sensory limitations in relation to the travel environment.
Scooter travel can make the difference between a person living independently and having to move to supported accommodation. It can have an enormous impact on a carer who must otherwise push the manual wheelchair of an obese loved-one over steep ground or long distances. A scooter can ease the significant lifestyle limitations imposed by low vision or blindness. Vision impairment does not automatically infer cognitive impairment; low vision does not render a person incapable of managing speed or considering others during travel. These elements of competent scooter travel require executive function skills (insight, judgement, and impulse control), physical skills (coordination and prompt reflexes) and fundamental courtesy. O&M specialists have an ethical obligation to countermand such discriminatory assumptions about low vision and advocate for fair treatment of people with low vision and blindness (Orientation and Mobility Association of Australasia., 2011).

Rosen and Crawford (2010) provide a range of practical strategies for wheelchair and scooter use in relation to low vision and blindness. Their guiding principle is that the scooter-user must be able to preview the path ahead, through whatever means available or appropriate, at sufficient distance to be able to react safely to hazards. Their ‘possibility thinking’ is refreshing in an Australian health care culture where, anecdotally, scooter travel is not considered a viable option for people with low vision.

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A multi-disciplinary approach

The assessment of safe scooter travel becomes much more complex when low vision or blindness occurs in combination with deafness, physical limitations, or cognitive impairment. Functional performance can be variable from one day to the next, and can deteriorate fairly rapidly with the process of aging. It is also profoundly influenced by the person’s social, intellectual, emotional, and spiritual health (Hawks, 2010).

When scooter travel is affected by complex issues, as with driving rehabilitation assessment, it is essential to use a multidisciplinary approach to scooter training and assessment (Fildes, et al., 2008). Reputable scooter retailers understand the features of each device and its suitability to a range of conditions. Medical practitioners can advise about health conditions, helping
the client to consider whether or not the reduced exercise associated with scooter use might have an adverse effect on health (Vicroads, 2010). Physiotherapists know the spectrum of mobility aids available and consider the impact of scooter travel on physical wellbeing. Occupational therapists consider physical, cognitive, and sensory functioning in the context of activities of daily living and lifestyle choices. The O&M specialist contributes visual and non-visual travel strategies, and considers the nexus between the device, the client’s skills, and the travel environments encountered by the client.

A holistic approach, with collaboration between different disciplines, tends to lead to better informed scooter assessment and recommendations (Hawks, 2010). The viability of scooter travel for some clients might only be established after an extensive process of scooter trial, training, experimentation, and liaison with relevant stakeholders (Berndt, 2002). A driving assessor has significant legal power to determine the outcome for the driver, whereas the scooter assessor has no such power (Austroads, 2003). The scooter assessor can identify areas of concern and make recommendations about scooter use or travel restrictions, but has no authority to ensure compliance. The responsibility for safe scooter use ultimately resides with the user. This power relationship, founded on client self-determination, is quite familiar to the O&M specialist who is used to working towards mutual understanding with the client in matters of safety assessment and recommendations. Collaboration with the client increases the likelihood of effective self-regulation that has been shown to be an important factor in maximising driver safety (Molnar & Eby, 2008).

Currently, many in the allied health sector seem unaware that O&M specialists can offer functional vision assessment and training for scooter users. The O&M survey sought to investigate the current involvement of the Australasian O&M profession with clients using power mobility. Survey results can be used to clarify the role of O&M specialists within the allied health sector and establish appropriate professional development in relation to scooter travel.

**Methodology**

The Fourth Australasian O&M Conference in Sydney, November 2010 presented an opportunity for purposive sampling of the wider O&M profession. A survey was drafted and reviewed for double or misleading questions, then trialled with six O&M specialists and modified before being sent to the conference committee for inclusion in delegate satchels. The survey included a brief explanatory statement. Conference delegates were told that survey results would be published and brought to the O&M professional body to support the development of recommendations about the involvement of O&M specialists in scooter assessment and training. During plenary sessions, conference delegates were reminded about the survey and invited to complete and post it in the box available at the information desk. Following the conference, the survey was also circulated to the email group of the O&M Specialists’ Association of Australasia with an invitation to participate. Emailed responses were received over a two month period.
Participation in the survey was considered evidence of informed consent.

Sixty-nine O&M specialists currently working in Australia or New Zealand responded to the O&M scooter survey which represents about one third of the profession in Australasia. There are no fully qualified O&M specialists based in the smaller Pacific Island nations that are also part of Australasia (e.g., Fiji, Tonga, Samoa). ‘Roads and walking paths are often in poor shape, which limits O&M in general’ (F. Gentle, personal communication, 6 October, 2011), and the ‘scooter phenomenon’ is not apparent in these developing countries.

Results and discussion

Participants were asked what year they completed their O&M training (Figure 1), their highest O&M qualification (Figure 2), and where they were working at the time of the survey. The largest numbers of respondents were from Victoria (24) and New South Wales (21), followed by South Australia (10), Queensland (6), Australian Capital Territory (3), Tasmania (2), New Zealand (2) and Western Australia (1). This distribution of respondents is loosely representative of the distribution of the profession across Australasia, although New Zealand and Western Australia were underrepresented.

A range of age and experience was indicated, with respondents gaining their O&M qualifications between 1974 and 2010.

Over half (55%) of respondents had worked with clients using a power chair, some with children in school settings, and most (80%) indicated they would like further training in O&M with a power chair. There has been increasing interest and involvement in O&M work with people who have multiple disabilities and vision impairment, so this experience and interest in power chairs was not surprising (Sauerberger, Sifferman, & Rosen, 2008). But even more respondents (67%) had worked with clients using a scooter, conducting assessments (65%) or training (58%). The terms *assessment* and

![Figure 1](image1.png)  
*Figure 1. Decade completed O&M qualification.*

![Figure 2](image2.png)  
*Figure 2. Highest O&M qualification.*
training were not clearly defined in the survey and might have been interpreted with some ambiguity, so the differences between these data sets have not been explored in detail.

Confidence and qualifications

The increase, with experience, in the number of people expressing confidence with scooter assessment (Figure 3) and training (Figure 4) was to be expected. The confidence categories (not confident; confident with support; and confident) cannot necessarily be interpreted as a continuum. For example, some participants might always choose ‘confident with support,’ even after years of experience, because they believe that a multidisciplinary approach to

Figure 3. Confidence conducting scooter assessments.

Figure 4. Confidence conducting scooter training.
scooter work gives a better outcome for the client.

The inverse relationship between the level of O&M qualification and the number of people not confident to conduct scooter assessments was interesting, and indicates that a higher educational qualification does not necessarily mean that a graduate is better-equipped for the tasks inherent in the O&M role (Figure 5). The difference in confidence levels could be explained in part by the fact that those with a certificate or diploma in O&M had mainly qualified in the 1970s and have had a great deal of on-the-job experience since then. Degree and Graduate Diploma qualifications have been available in Australia in the past 20 years; Graduate Certificate and Master qualifications have been available in Australia during the past 10 years. Few respondents (8%) indicated that scooter training was included in their initial O&M qualification (Figure 6). The variation in confidence might be related to differences in generic O&M skills taught during initial training or the degree to which O&M specialists are encouraged to think broadly about the scope of an O&M specialist’s role; or varying opportunity for involvement with scooter clients in the course of O&M work. O&M courses in Australasia rely on a close association with a specific O&M service provider, so differing agency policies regarding O&M involvement in scooter work are likely to impact on the level of attention given to scooters in O&M courses.

It is currently unclear whether or not scooter training during the initial O&M qualification is preferable to professional development later, after the new graduate has had opportunity to consolidate skills in functional vision assessment with ambulatory clients.

**Professional development**

Three quarters (74%) of the respondents had undertaken some kind of professional development in scooter travel, mostly external to their initial O&M qualification (Figure 6). The professional development categories were not well classified in the

![Figure 5. Confidence conducting scooter assessments according to O&M qualification.](image-url)
survey and there was some overlap in responses. The list did not include internet or print resources, although there are many available. Nevertheless, the majority of respondents (80%) indicated that they would like further training with power-chairs and scooters (88%).

Open comments

Twenty-nine respondents (42%) used the opportunity at the end of the survey to make an open comment about O&M in relation to scooter travel. A selection of these comments is included here to illustrate the themes which arose. Pseudonyms have been used to ensure confidentiality.

The need for further scooter professional development for O&M specialists was affirmed. Some respondents suggested that professional development should include information about: the different scooter models available; advice on selecting a scooter; strategies for scooter use with vision impairment; information about liability and insurance; investigation of scooter travel in conjunction with a guide dog. For example, Jennifer said:

I would like to know that the techniques I am using are what others are also advocating. I’d like better information about product features that we should

be advocating for our clients (3 vs. 4 wheel, scooter vs. wheelchair).

But respondents did not just want information rather they also valued practical experience. Greg suggested:

Training should include a practical component, if possible instruction and travel on an electric wheelchair and motorised mobility scooter; also deaf/blind use for EW + MMS, information regarding licensing if required and state/territory variations [in regulation].

Greg’s comment about licensing is an example of the uncertainty regarding scooter regulation in Australasia. In the USA, scooters are registered, but there is no national register in Australia (Kaye, et al., 2000). Neither is there any licensing procedure for scooter users. This uncertainty about regulation leads to particular concern about liability. James commented that:

Recent discussions with my client services team raised some challenging issues regarding scooter travel and whether OMIAs are really qualified (and covered by professional indemnity insurance) if we provide advice and training to someone using an aid that is not specifically recognised as a vision related mobility aid. We have significant concerns about this issue

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<th>None</th>
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<tr>
<td>informal, on the job</td>
<td>26%</td>
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<tr>
<td>part of my O&amp;M qualification</td>
<td>8%</td>
</tr>
<tr>
<td>equipment retailer</td>
<td>15%</td>
</tr>
<tr>
<td>independent living centre</td>
<td>13%</td>
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<tr>
<td>other: rehabilitation services (occupational therapy or physiotherapy), council workshop, training day with professional body, conference, test-driving client’s scooter</td>
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Figure 6. What kind of scooter training have you received?
and need to be better informed about the safety and indemnity issues.

This legal concern demonstrates how inadequate or conflicting regulation can significantly undermine professional confidence. In fact, O&M specialists are very competent to calculate risk. For example, they train clients who are blind to cross the road; they assess the impulsivity of clients with acquired brain injury; and they also train clients to use aids which are not specific to vision, such as buses and trains.

From a financial perspective, Australasian O&M employers (mostly charities or education departments) carry insurance that indemnifies O&M personnel for actions undertaken in relation to their client work. From an ethical perspective, a driving instructor or assessor is not generally held accountable when a provisional driver has a car accident, travelling solo. As with driving, the responsibility for safe scooter travel lies with the scooter user, who may be fined by police if the device is used in a manner that contravenes the law (Australian Road Rules, 2006; New Zealand Transport Agency, 2009).

Several respondents made comments about workplace policies and procedures. Fiona gave a reminder that maintaining paperwork is good professional practice, particularly if there is a chance that scooter recommendations might be contended:

*Since client can ignore all advice or instructor’s concerns, I believe documentation in file is critical.*

Some respondents noted that their involvement with scooter travel was restricted due to employer policies on scooter travel.

Some respondents commented that their involvement with scooter travel was determined, and sometimes restricted, by employer policies on scooter travel. Lauren explained:

*...our clients sign a disclaimer because [my agency] does not recommend the use of scooters by someone with a [vision impairment]. If our clients receive a [low vision] program they have to agree that they are solely responsible for their scooter mobility.*

Working for a different employer, Janaka added:

*We [are] now not allowed to work with scooter programs due to lack of training and difference in walking speed vs scooter speed - have to have [an occupational therapist’s] ok that client is fine to use scooter.*

Other agencies have established a protocol which empowers O&M specialists to act on behalf of clients. Sharni reported:

*[My agency’s] position is that visual acuity alone should not be the sole determinant of user eligibility, i.e., consideration must be given to how the individual uses their residual vision, their cognitive and physical ability and understanding of the device itself.*

Erica expressed concern about discrimination against people on the basis of their vision, reinforcing the need for functional scooter assessment:

*Also important that even totally blind person has the right to use a [motorised mobility device]. Depends on speed, behaviour and attitude.*

James affirmed the value of multi-disciplinary collaboration, commenting that:

*Training local OT’s or Physios can be very useful. Working together and*
sharing ideas and experiences gives results to clients.

This multi-disciplinary collaboration might mean two people working together with one client, or involve larger numbers of people, as in the case of Ann:

I was involved with a council access group. We organised a workshop for local MM scooters. Two challenges - the “hoons” - dangerous drivers - did not turn up. Secondly, the supplier said that scooters imported from overseas can go much faster than Australian scooters.

However, an ad hoc multidisciplinary approach does not necessarily address the confusion engendered by conflicting and unclear regulation. There is an opportunity here for allied health professionals to collaborate in developing a protocol for scooter training and assessment that clarifies the professional roles of all those involved in the scooter culture, and the referral pathways between them. Brydie commented:

[I’m] unclear who is authorised to determine if a person has ‘difficulty’ walking, and how far would it be ‘difficult’ to walk, if your aim is to replace the car.

The question of authorisation arises when a client wishes to apply for government funding to purchase a scooter. Although currently occupational therapists are the preferred assessors for scooter applications, some clients have functional limitations, such as low vision, which are beyond the occupational therapy skill-set. Less than five percent of scooter users obtain their device through a government assistance scheme, so it seems that assessment for scooter funding applications is not in huge demand, but clients do seek assistance with the scooter selection process (Edwards & McCluskey, 2010). Janaka said:

It would be good to know more about types of scooters available - I always ask for a joint session if needing to choose a scooter with a client.

Education about scooter features and available funding schemes would equip O&M specialists to collaborate more effectively with occupational therapists in the matter of scooter selection, assessment and funding applications.

**Conclusion**

Results of the O&M scooter survey suggest that two thirds of the Australasian O&M profession is already involved in scooter assessment or training of clients with low vision, but that O&M’s confidence to undertake this work is varied. There was a call from survey respondents for standardisation of scooter training and assessment procedures and professional development in O&M scooter work. The value of interdisciplinary collaboration was affirmed, particularly between O&M and the occupational therapy profession. It seems wise, therefore, for O&M specialists to collaborate with allied health professionals, particularly from occupational therapy, in the development of a multidisciplinary scooter protocol and a professional development process. A stronger understanding of each profession’s role in the matter of scooter training and assessment, and the generation of clear referral pathways would seem to be a useful contribution to creating a safer scooter culture.

People who are in transition from driving to alternative mobility options already tend to be apprehensive about their mobility status. It seems important that scooter
publications contain clear, consistent information about scooter use. However, there are inconsistencies in the way scooters are understood and defined by Australian law, traffic authorities, funding bodies, and allied health professionals. Until these inconsistencies are resolved, confusion about scooter regulation seems likely to continue to undermine consistency in professional practice.

Power-chairs and scooters are similar in the way they access the community, but the functional abilities and limitations of their users can be vastly different. Scooter travel is a potentially freeing mobility option, not just for people with an injury or disability, but for anyone needing a single-user vehicle for unhurried local travel. Needing to demonstrate disability in order to justify scooter use seems an out-dated requirement in a culture which has clear anti-discrimination legislation and strives to focus on ability rather than disability.

Beyond the O&M profession, there appears to be some doubt about whether or not scooter travel with low vision is possible. However, this study has shown that significant numbers of O&M specialists are already involved in scooter training and assessment, indicating that some people with low vision want to use scooters and seek to benefit from the skill-set in functional vision and mobility which O&M specialists have to offer.

In a health care culture of evidence-based practice, O&M specialists have an ethical responsibility to research and provide a body of evidence to the wider community about functional vision in relation to scooter use. Access to evidence will empower health professionals to make fair, informed decisions regarding the viability of scooter travel, and avoid escalating undue anxiety over low vision. Such research might involve interviews with scooter users who have low vision, and investigation of the practical challenges, and their possible solutions, that arise during low vision scooter travel in the community.

Referral to an O&M specialist is recommended for any scooter user with low vision whose vision or functional performance raises safety concerns. To be fair, the viability of scooter travel for a client with low vision or blindness needs to be determined on the basis of individual training and functional assessment by an O&M specialist, rather than through clinical vision measures made in a static environment. Scooter assessors have no power to ensure that a client complies with assessment recommendations. Stakeholders in the scooter industry, including O&M specialists, can do everything in their power to promote a safe scooter culture, but ultimately, the responsibility for scooter travel lies with the scooter user.

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ry=motorised%20scooter%20%20%20australian%20road%20rules.


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