Developing O&M Standards for Australasia

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In 2013, members of the Orientation and Mobility Association of Australasia ratified a Quality Framework for the O&M profession, including an OMAA Code of Ethics and OMAA Standards of Practice. The OMAA Quality Framework took a six member committee four years to develop and involved extensive collaboration across Australia and New Zealand. During the process, the Committee discussed such themes as best practice, exemplary performance, minimum standards, independence, and self-determination. A community model of O&M practice was devised, demonstrating the way that power is shared in relationships between the client, the O&M specialist and other stakeholders. The OMAA Quality Framework represents exemplary O&M practice in the Australasian region and is available on the OMAA website (http://www.omaaustralasia.com/qualityframework).

Background

The development of a quality framework for the orientation and mobility (O&M) profession in Australasia has a 40 year history. The development of professional standards and a code of ethics, certification of personnel, accreditation of courses, and registration as allied health service providers have generated ongoing debate since the O&M profession was first established in the region in 1971.

In 1994, the Orientation and Mobility Instructors’ Association of Australasia (OMIAA) had reached agreement about a code of ethics, minimum standards for training courses, and criteria for membership of the professional body. However, agreement could not be reached on how best to assess instructor competence (OMIAA, February 1, 1994). Unfortunately, the professional body dissolved in 1995, but was re-established in 2008 as the Orientation and Mobility Association of Australasia (OMAA).

Today, the O&M profession in Australasia numbers over 250 members, including dog guide mobility instructors, O&M teachers, and O&M assistants (Deverell & Scott, 2014). Ninety per cent of these people are employed in Australia and 10% in New Zealand, mostly by charitable organisations. The majority of dog guide personnel in the region hold both dog guide and O&M qualifications. Dog guide mobility is broadly regarded as a speciality within the context of O&M practice rather than being an entirely separate discipline. Some O&M teachers are employed by government education departments and usually have both special education and O&M qualifications. O&M assistants undertake an accredited course and are employed only by one agency in South Australia.
People teaching O&M in the South Pacific countries that are part of Australasia were not included in the OMAA’s 2011 census of the profession for two reasons. First, the OMAA has not yet developed effective communication networks with disability service providers in these countries. Second, our limited enquiries indicated that O&M providers in South Pacific countries tend not to have formally accredited post-secondary O&M qualifications. In 2008, a one-month O&M program was provided in Fiji for 16 personnel (primarily teachers) from South Pacific countries. The program was internationally sponsored, taught by experienced O&M specialists from Australia and New Zealand and some participants were in a position to offer O&M services to clients upon returning home (F. Gentle, personal communication, May 5, 2013). This program demonstrated an effective responsiveness to local needs, at the same time prompting deeper consideration of the defining characteristics of an O&M professional.

During recent discussions on O&M standards, two CEOs of Australian rehabilitation agencies questioned whether or not a university qualification is really necessary for an O&M specialist. Alternatively, some agencies expect their O&M personnel to have no less than a master’s qualification. This disparity in expectation within Australia can make it difficult for O&M specialists to move between agencies. While O&M training courses in Australia and New Zealand are all accredited by a tertiary institution demonstrating that the course design meets the qualification requirements, there is no agreed benchmark of O&M course content across Australasia. Course developers can and do voluntarily use the USA guidelines for personnel preparation programs (AER, n.d.) but inevitably shape the content to meet the staffing requirements of the O&M agency sponsoring the course.

The O&M profession in Australasia is widely dispersed and lacks critical mass, resulting in a default dependence on employers for ongoing governance of the profession. O&M would not have been established in Australasia without this level of employer support and a degree of co-dependence with employers is likely to be an ongoing characteristic of O&M in the Australasian region. However, the service profile of each O&M agency differs in response to the needs of local clientele; agencies promote their services to inform communities and attract public donation in regionally specific ways. While this approach is good for local awareness of O&M, there is no unified voice promoting O&M across the Australasian region.

The establishment of professional O&M standards by a neutral body is necessary to bridge the parochial differences between employing agencies and to establish the profession as a mature stakeholder in the vision education and rehabilitation sector. Professional credibility is necessary to secure funding for O&M services and to build strong referral networks with other professions. Peacock (2010) suggested six considerations that help to define a profession as more than just an occupation:

1. Specialised knowledge and long training
2. Ethical standards and a commitment to provide a service for the public good
3. A national body with disciplinary powers
4. Willing, voluntary membership of the professional body
5. Governance by the membership, independent of government or major employers
6. Professional standards which exceed minimum legal requirements

Our challenge was to develop standards for the O&M profession in Australasia that would surpass parameters established by local employers and better represent the whole of Australasia, improve transparency, and benchmark accountability. In 2009, the OMAA established a Standards Committee to undertake this work.

This paper outlines the process undertaken by the Standards Committee in developing and ratifying the OMAA Quality Framework, and proposes a Community Model of O&M Practice that serves as a foundation for O&M service provision in the Australasian region.

Methodology

Participants and Time-frame

The OMAA executive nominated a chairperson for the Standards Committee. Over a period of months, the chairperson and executive invited interested OMAA members to join the Committee. The six member team brought perspectives from South Australia, Victoria, New South Wales, Queensland, and New Zealand and included professionals who had worked for comprehensive vision service providers, dog guide agencies, and government schools, as well as teaching tertiary level O&M programs.

The Committee participated in a teleconference every six to eight weeks in the first two years, and later on an ad hoc basis, with additional email contact as necessary. Development and ratification of the Quality Framework took over four years and included research towards certification of personnel and accreditation of O&M courses. Teleconferences happened during work hours but writing and review of documents was largely undertaken in volunteer time.

Scoping the Task

The Standards Committee began by clarifying its brief. While concerns initially centred on certification and accreditation, committee members were advised by an experienced O&M specialist that OMAA should make it a priority to establish strong communication networks with all O&M stakeholders across the region (D. McNear, personal communication, July 17, 2009). It was suggested that outcomes from a broad debate about professional standards would help to inform subsequent decisions about certification.

The Standards Committee consulted with nine O&M employers via email. Employers affirmed the value of independently developed O&M standards and emphasised the need to keep the process transparent and inclusive. The Committee took two years to source and review existing standards documentation from organisations and draft new OMAA standards documentation. An extensive process of review and redrafting was then undertaken before the new Quality Framework was formally ratified by the OMAA membership in 2013.

Reference Documents

The Standards Committee invited O&M employers to contribute any documentation
that might be useful for example, agency mission statements, O&M position descriptions, criteria for performance evaluation of O&M personnel, and course curricula from the current or recent tertiary level O&M programs they sponsored. Committee members reviewed the USA-based guidelines for accreditation of O&M courses (AER, n.d.) and also sourced and reviewed the standards documents of related professional bodies, among them the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP, 2009), South Pacific Educators in Vision Impairment (2004), Disability Professionals Australasia (2009), Skills for Care and Development (2008), the Australian Physiotherapy Association (2008), Occupational Therapy Australia (2001), the Victorian Institute of Teaching (2013, 2008), and the Australian Association of Social Workers (2010).

These professional bodies had all structured their standards documents differently, with variation in length and formality. The OMAA Committee chose to keep our code of ethics separate from standards of professional practice, and to write detailed standards because the nature of O&M practice is not well understood in the wider community. Committee members were aware of the need for a resource that would help to communicate the business of the profession to those interested in entering it, to trainee instructors, managers, recruitment staff and allied professionals, as well as to qualified O&M specialists. The resulting standards document is explicit and reads rather like assessment criteria for a training course, reflecting the educational bias of the lead author and the desire to create a tool that could be actively used for performance appraisal.

In generating standards of practice, the lead author systematically collated potentially relevant items from each of the reference documents. Through a process of grouping and regrouping these items, five domains were identified. These were: communication, O&M knowledge, O&M practice, community education, and professionalism. These domains and the items within them were arranged in table format then emailed to the other members of the Standards Committee for consideration. Regular teleconference meetings enabled each version to be critiqued, supplemented from the combined professional experience of the Committee and subsequently redrafted.

The code of ethics presented an easier challenge because the Committee had the ACVREP code as its starting point. There was some reallocation of content between the ethics and standards documents, and headings in the code of ethics were revised to make the document easier to navigate. Each version of the code of ethics was subject to the same rounds of review and redrafting as the standards document.

The comprehensive first draft contained five sections: a preamble outlining the purpose of the document, a brief description of O&M in the Australasian region, a holistic model of O&M intervention, the code of ethics, and the list of professional standards. This draft was reviewed by eight volunteers from the OMAA membership then offered to 10 O&M employers across Australia and New Zealand to provide feedback. Review
and critique was received via email, phone and some face-to-face consultation with both individuals and groups.

Feedback on the first draft came in four forms:

1. Reflections of the application of standards in the local workplace – this was interesting, but did not contribute much to the redrafting process

2. Detailed copy-editing, identifying grammatical and formatting inconsistencies that were readily corrected

3. Identification of missing content pertinent to the reviewer’s local context – this feedback was particularly helpful in ensuring that the document represented the wider Australasian region; several of the reviewers had experience teaching O&M in South Pacific countries

4. A broader perspective that focused on the ways the content would be read by those outside the O&M profession, as well as those within it, the ways that the sections of the document related to each other, where there was repetition or omission, and whether there were inconsistencies or deficiencies in overall tone and impact

As a result of the feedback received, the decision was made to divide the draft document. The description of the O&M profession evolved into a journal article, accepted for peer-reviewed publication (Deverell & Scott, 2014). The committee finalised the code of ethics and standards of practice as separate documents, locating them on the OMAA website as part of a broader quality framework (http://www.omaaustralia.com/qualityframework). Committee members also included on the webpage, interim information about certification of personnel and accreditation of O&M training courses. The holistic, or community model of O&M is detailed below.

OMAA members and O&M employers were notified via email that the documents were posted on the website, and were given a month to provide feedback. Once this feedback was synthesised, the final version was uploaded again. The link was again provided to the OMAA membership with other pre-reading several weeks before the OMAA’s Annual General Meeting in November 2013. The OMAA Quality Framework was formally ratified via teleconference at this meeting.

Discussion

The development of standards documentation required careful consideration of language and tone. The members wanted to ensure that the new documents accurately represented current Australasian O&M practice. As the first draft was being debated by the Committee, members took the opportunity to revisit some foundational tenets of the O&M profession, exploring notions of best practice, exemplary practice, independence, self-determination, and shifts in power in the instructor-client relationship.

Best practice

At face value, ‘best practice’ seemed a worthy notion to uphold in writing O&M standards. However, one of the Committee members pointed out that the best practice notion is associated with evidence-based practice, typically founded on positivist research methodology (Merlin, Weston, & Tooher, 2009). This approach depends on
randomised controlled trials using large cohorts to generate practice guidelines based on a line of best fit between participant outcomes. The result is a generic, norm-referenced, cost-efficient starting point for medical intervention. But does best practice really represent what takes place during O&M intervention? Committee members agreed that O&M intervention should always begin with individual assessment, enabling us to tailor responses to each unique client’s needs.

After abandoning the language of ‘best practice’, the Standards Committee debated the relative merits of developing ‘minimum standards’ of professional performance versus ‘exemplary standards’. A focus on minimum standards appeared to lead towards the development of multiple documents – minimum standards for new graduates, for practitioners working with specialised clientele, for experienced practitioners in supervisory roles and for O&M assistants. The differences between these standards, O&M course accreditation and criteria for certification of practitioners became unclear. Questions arose regarding who might police the standards and the task of developing standards seemed overwhelming.

Instead, the Committee opted to generate a set of exemplary standards that represented mastery of the profession rather than mere competence – an aspirational statement that would challenge O&M specialists to voluntarily improve their performance from any point in their career. An aspirational statement appeared preferable to reinforcing the mediocrity of minimum standards, and these exemplary standards could serve as a foundation for future consideration of certification and accreditation issues.

**Independence**

Independence has long been recognised as the primary purpose of the O&M profession – its raison d’être. However, the committee agreed that holding ‘independence’ at the centre of O&M action can result in an expectation that having received the training, the client should always choose to travel independently.

Independence is a fairly Western construct and, if adopted as the ultimate goal of O&M, can actually serve to socially isolate clients, limit their mobility choices and make O&M services redundant to the many people with low vision or blindness whose cultural context gives priority to relationships and sharing. A great deal of O&M action takes place in social contexts and is supported quite naturally by the people encountered therein.

There is the added complication that our O&M clientele have increasingly complex sensory, physical, and cognitive issues. The client might be non-verbal, intellectually disabled, use a wheelchair, or never have the skills to live independently, but this does not mean O&M services are redundant. Rather, O&M professionals look for opportunities to enrich quality of life by expanding the client’s range of movement choices.

The Committee agreed that self-determination, rather than independence, better represents what is aimed at in Australasia O&M practice. The client who is equipped with skills for independent travel and with decision-making skills can make...
informed choices about how s/he wishes to move.

This respect for the client’s choices is fundamental to a phenomenological philosophy that holds the client and the instructor equally valuable in the relationship (Berndtsson, 2009). It represents a significant departure from the Cartesian philosophy that typically underpins medical care and leads towards a more prescriptive approach to intervention (Leder, 1992).

**Power in relationships**

The past few decades in allied health services have seen a move away from a directive approach based on the therapist’s often standardised notion of what is best for the patient or client, towards what is known as a client-centred approach (Dow, Haralambous, Bremner, & Fearn, 2006). This change is well-intentioned. However, the search for accurate language and a model that best expresses the relationships involved in O&M intervention prompted closer consideration of the term ‘client-centred practice’.

Placing the client at the centre of the model automatically puts everyone else at the periphery, and rules of confidentiality mean that collaboration between other stakeholders is impossible unless permitted by the client.

While it might seem politically correct to give the O&M client all the power, the client does not live in social isolation and seeks O&M intervention because s/he does not have all the answers. Family and friends can wield significant influence, and the O&M specialist is the keeper of a unique body of knowledge and skills that might be relevant to the client’s context. Is the customer always right as the client-centred model would suggest, or are more complex dynamics involved in O&M relationships?

In O&M, the development of knowledge about the client’s abilities and limitations as well as the physical and social environment, is a shared, embodied, exploratory process (Mettler, 2008). The O&M specialist and the client collaborate, often with others to work out what can be achieved by the client. A true O&M practice ‘model’ needs to represent the reflexive, constructive nature of the client’s relationships both with other people and with the physical environment. One of the authors (Deverell) considered that the continuous interweave of a Celtic trinity knot, a cord without ends, effectively represents this share and flow of power in O&M relationships (Figure 1).

The client’s O&M action – any movement undertaken in the course of the day, whether independently or accompanied – is at the centre of the model as the reason for O&M stakeholders to come together. The outer ring serves as a boundary around these O&M relationships containing the many contexts in which the client’s O&M action occurs.

There is then the consideration of space. Herod (2011) proposes that an orb spider’s web provides a useful alternative to a linear model of scale when considering relationships – the filaments of the web are relatively insubstantial yet the space between the filaments is elemental to the structure of the whole. In the same way, the spaces between the cords or relationships in the Celtic knot are as significant as the cords.
themselves: much of what influences the client’s O&M action remains unspoken and invisible, but is no less important in being tacit.

Unlike many health-related professional contacts, O&M relationships tend to occur in infinitely varied, client-specific contexts. The Community Model of O&M is so named because ‘community’ can refer both to a social network and to a physical location, capturing this essential combination of people and places in O&M practice. O&M specialists aim at equipping the client to access the physical and social community in meaningful ways, but also empower the community to engage with the client. The first draft of this model was presented for discussion at the Fourth Australasian O&M conference (Deverell, 2010) and has since been refined by Deverell into the version shown in Figure 1. The Committee welcomes comment on the Community Model of O&M from clients and professionals alike.

**Conclusion**

O&M was established in Australasia over 40 years ago and with it, a professional body. However, the establishment of professional standards that exceed employer boundaries has proved to be a challenge. Electronic
communication available in recent years has done much to reduce the tyranny of distance. Teleconferencing and email have enabled the OMAA to develop a Quality Framework that represents a multitude of O&M contexts across the region. This Framework is central to the credibility of the profession, making explicit the ethical and professional standards which uphold exemplary performance (Peacock, 2010). The Framework endeavours to use clean language, representing the more egalitarian (than paternalistic) nature of O&M relationships today.

The O&M profession in Australasia is maturing and seeking to establish its own identity and position, somewhere in between the global O&M community and the local O&M agencies that have sponsored and nurtured its development to date. The collaboration involved in developing the OMAA Quality Framework has laid the groundwork for further communication between O&M employers and the professional body regarding O&M qualifications and O&M research. The fledgling OMAA is leading this work but has yet to connect effectively with O&M providers in South Pacific countries. A clearer understanding of O&M needs and service profiles across the whole Australasian region is necessary as the OMAA seeks to represent, support, and equip all those working in the context of O&M.

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