Roots of recovery: Occupational therapy at the heart of health equity

Royal College of Occupational Therapists

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Foreword

As we begin to emerge from the pandemic, there seems to be growing awareness of the scourge that health inequity visits upon our society. But health inequality, which had grown in the decade from 2010, has deteriorated further in recent months. The task before us is urgent, and it is serious.

It is not that health inequality is a new phenomenon. Its causes, which have their origins across the social determinants of health, have been long understood. They are multi-faceted and cannot be addressed through health and social care alone. But we must play our part.

There is considerable work going on to understand how health inequality is exacerbated by other structural imbalances, to measure its impact and to recommend solutions. That is useful for three reasons: first, the better we understand, the more effective we can be. Second, shifts in technology may mean shifts in who is excluded. We need to know how the landscape is changing. Third, the greater the spotlight that is directed onto this area, the harder it is for politicians to ignore it.

But our health and social care systems are dealing with huge imbalances between demand for care and our ability to supply it. It can be difficult for local managers to take an eye away from the day-to-day of waiting lists and workforce shortages and widen their lens. Paradoxically, this is a time both of great change and little time in which to design that change.

That is why we have taken a different approach in this report. It seeks less to make the case against health inequalities than to set out practical ways in which decision-makers and system designers can use the skills offered by occupational therapy to make better use of existing resources.

Since I joined the Royal College of Occupational Therapists (RCOT) six months ago I have been struck by the passion, breadth of expertise and reach of occupational therapists. Occupational therapy is centred on people's day to day living - what they want and need to do and where and how they live. The profession thinks beyond health and focuses on the wider social determinants, making occupational therapists key players in rethinking how and where we deliver health and social care.

RCOT is asking members – who see health inequalities daily – what support and tools they need. Over the next 12 months we will work with our fellow professionals to co-create and deliver a plan of action which includes sharing examples of good practice and learning.

We hope that this report will be a useful tool for health and social care colleagues as we seek to limit, and then reduce, the health inequalities which afflict our nation.

Steve Ford

Chief Executive, Royal College of Occupational Therapists

Call to action

Occupational therapists have a valuable role to play in building individual and community health and wellbeing, improving and establishing equity of health and health outcomes through engagement in healthy occupations, education and work, and access to wellbeing and independence through primary care, rehabilitation in the community and suitable housing.

In this time of rebuilding, when there is the impetus of need, there is an opportunity and a momentum for national and local re-engineering of structures and funding. This report gives examples of where occupational therapy can be organised to effectively address health inequalities. Decision-makers are urged to engage with local occupational therapy services, and through them with local communities, to co-design and co-produce services that are truly accessible and responsive, so that services and workforces are best shaped and placed to achieve the most effective outcomes for those most in need.

Key recommendations

for effective deployment of the occupational therapy:

Awareness

1 **Cohesive and systemic planning**

It is vital that organisations and services do not plan or work in isolation, but take a joined-up approach to analysing, planning and meeting needs - a universal response. This includes involvement of the voluntary sector. Along with health, consideration needs to be given to the environment, healthy homes, work, education, and healthy occupations. Occupational therapists should be at the table to provide this strategic perspective.

A joined-up approach requires the sharing of information across services and systems, supporting safe and effective service provision, enabling occupational therapists to use resources sustainably, reducing repetition of data gathering, assessments and any overlap of services. Advanced and senior occupational therapists must have scope within their roles to work with their counterparts across sectors to agree actions to minimise duplication and ensure effective use of knowledge and resources

Action

2 Designing inclusive services

For healthy and sustainable communities to develop, those communities must be understood and involved. Services and workforces need to reflect and be shaped by the culture of the communities that they serve, with a shared understanding of the desired outcomes for the community and the service.

RCOT are working with the education sector to attract and support people into the profession from a range of backgrounds that reflect diversity within the UK.[1]

Advanced and senior occupational therapists must have scope and objectives within their roles to work with public and patient contributors and groups to co-design how services are accessed, delivered and evaluated.

3 Needs-led and place/localities-based services

Health needs and inequalities are greatest in particular places and in the groups who live there.[2] Any response needs to be shaped and located accordingly, drawing organisations together with a shared understanding of the needs and wishes of the local population.

Occupational therapy should be targeted where it has the greatest impact; locating occupational therapists with the right knowledge, understanding and skills where they can be accessible and effective:

- Where they can advise at planning and design level – housing and community rehabilitation.
- Where they can provide early interventions – in primary care and community services.
- Where they can enable and support education in schools, colleges, and universities.
- Where they can support people to be in, stay in and return to work, through primary care, occupational health and rehabilitation services.
- In training and advisory roles, for example, to social prescribers, housing providers, care homes and domiciliary agencies.

4 Fair access

For people to access occupational therapy expertise on an equitable basis there needs to be a flexibility and fluidity of access.

Access needs to be open, appropriate and fair to population groups who have been known to experience reduced access to, and satisfaction with, health and care services e.g., those in economically deprived communities, BAME groups, LGBTQIA+ groups. This may also include people who find it physically difficult to attend appointments and access local community resources.

Occupational therapy is still predominantly accessed through secondary and tertiary services and tends to focus on individuals, rather than on populations. Access to occupational therapy services needs to be early and easy, across the lifespan, preventing the development of long-term difficulties and addressing some of the wider social determinants of health. Services should be both universal across all aspects of life, and targeted - shaped and placed according to the needs of local population groups.

In some areas people can self-refer to social care, community mental health and rehabilitation services. They can directly access the right expertise when needed, but for this to be inclusive services need to proactively identify local population groups that are not currently reflected on caseloads, then work with them to co-create access points and services that accommodate their requirements and preferences.

Advocacy

5 Ongoing research

There is a significant amount of anecdotal evidence regarding work done by Allied Health Professionals (AHPs) to reduce health inequalities and influence the social determinants of health. More research is needed to quantify the breadth of impact of AHPs on health inequalities.[3] When considering how to re-shape and refocus activity to bring about change, planners and decision-makers need to consider what data would best inform them of service effectiveness and their positive impact.

Data needs to demonstrate when communities that are underserved by health and care services are being reached. National outcome-based data collection (rather than output-based) should evidence the impact services have on addressing access to and remaining in education and work, access to appropriate housing and self-management of health.

Introduction

The health of the population is not just a matter of how well the health service is funded and functions, important as that is: health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, and resources – the social determinants of health.[4]

Occupational therapists are unique in that they already work across organisations in health and social care, housing, criminal justice, employment, education, and the voluntary sector. Although there is currently limited published evidence of occupational therapists and other allied health professions directly reducing health inequalities, this report explains how decision-makers can create change by using the knowledge and skills of the occupational therapy profession to deliver measurable change. For those who design or manage services, it provides practical recommendations that have the potential to encourage better use of resources for improved outcomes, supported by examples of where occupational therapists are already making a difference.

As the UK recovers from the COVID-19 pandemic it is people who have been disadvantaged by social and economic factors that have been hardest hit.[5] Health inequalities in the UK have steadily risen over the last decade[2] and they have been magnified by the pandemic. The crisis vividly exposed how our vulnerability varies hugely, determined by a complex web of existing inequalities, across genders, age groups, races, income levels, social classes, and locations. People with long term conditions, disabilities and those shielding have also experienced reduced access to health and social care services as these were reprioritised to manage the COVID-19 demands.[6]

Governments and organisations across the UK and beyond have recognised these inequalities and have made recommendations[7,8,9,10,11,12] but implementation is complex and multi-faceted. Health and social care providers need to balance need with access to service provision whilst managing existing waiting lists, staff burnout and the risk of losing public support as they seek to re-establish services for illnesses not related to COVID-19.[13]

Given these mounting pressures and competing demands on the public purse, addressing health inequalities and their causes may not be seen as an immediate priority by health and social care providers, or the complexity of tackling these societal issues and the range of organisations required to work together to do so may put health inequalities in the 'too difficult' pile.

For occupational therapy personnel in all sectors, this is a time to challenge the more traditional structures and processes of service provision, to lead on innovation and to demonstrate the unique approach, skills and value of the profession.

For economic, justice and human rights reasons, reducing health inequalities should be a priority, and now is the time to act. This report focuses on two existing assets for delivering change: the occupational therapy profession and existing services. Both assets can be refocused and adjusted following consultation with/working in partnership with local communities and those affected by health inequalities, redirecting thinking and resources to where they will be most effective. Timely intervention in the community can prevent increases in long-term health and care costs, and early intervention in areas such as education, employment and housing can create routes out of poverty, ill health, and lower mortality.

Addressing health inequalities – why now?

Everyone, regardless of who they are and where they come from, has a right to health. This was first expressed in the 1946 Constitution of the World Health Organization (WHO), which defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[14]

[Health inequalities occur] 'because of the unequal conditions in which we are born, grow, live, work and age, including the social determinants of health such as income, wealth, education, welfare, housing, and access to green space. Not only do these fundamental causes lead to disadvantage over the course of an individual's life', [but the accumulation also] of 'historical events determines the relative disadvantage of individuals, places and communities.[15]

As the UK nations recover and rebuild post COVID-19, we have a duty to reduce these social injustices, to create a healthier, fairer, more resilient society.[16.17.18.19.20.21.22] This can only be achieved through governments tackling the root causes of poor health by investing in jobs, housing, education and communities and working closely with the statutory, third and private sectors. Furthermore, it is vital that equality and human rights considerations are incorporated into the policy response to the pandemic.[14]

Dimensions of inequality often overlap and reinforce each other. This has been seen in the communities most affected by the impact of COVID-19. These include those in Black, Asian and minority ethnic groups (BAME), people who are homeless, migrants, gypsy Roma and traveller communities, children from disadvantaged backgrounds, children with additional learning needs and people who are digitally excluded.[23.24.25] This is amplified by factors such as location, multi-occupancy housing, occupations with high social contact, frequent use of public transport, protected characteristics[26] and pre-existing health conditions. As the risk factors accumulate, people fall into a combination of categories,[27] leading to much higher rates of mortality.[2]

Health inequalities disproportionately impact on these groups of people living in particular areas or places.

To address these complex and interwoven factors requires a targeted and tailored response that is place-based, shaped and led by local need. Those who design or manage services need to engage with those communities most affected in a rebuilding process, taking into consideration the multiple factors that influence their wellbeing, using asset-based approaches, ensuring that services are responsive to the needs, culture, and norms of the community as defined by the community itself.[23.24.25.28.29.30]

The costs of responding to the COVID-19 pandemic have been huge, with debt now standing at nearly 100 per cent of GDP. Public sector net borrowing (PSNB) was 14.5 per cent of GDP in 2020–21, the highest since the Second World War, and a five-fold increase on 2019–20.[22]

The multiple calls for rebuilding funding may find the public purse empty - or severely limited. With clear evidence that health inequalities are consistently increasing, can society and our health and social care systems afford for this to continue? We need to consider the benefit of investment to reduce health inequalities and the social determinants of health now to gain long-term financial and social wellbeing and stability.

In the context of high demand and limited resources, decision-makers can look at cost-effective changes. This report gives recommendations for shaping and investing in existing occupational therapy services, enabling early intervention for increased returns in terms of improved health, social and long-term economic outcomes.

Mobilising existing assets

The most important contributors to a life in good health, including mental health, are to have a job that provides a sufficient income, a decent and safe home and a support network. More simply put – a job, a home and a friend.[31]

There are 41,315 occupational therapists registered with the UK Health and Care Professions Council (HCPC). With unique expertise in mental and physical health and an understanding of environmental and social factors, occupational therapists are found in roles across and beyond the health and social care systems.

As allied health professionals (AHPs) they have a substantial part to play in addressing inequalities and much is already being done.[32] With a strategic focus on the social determinants of health and combating health inequalities, they contribute to public health through interventions affecting the physical, mental and social wellbeing of individuals, communities and populations.[33]

The Kings Fund's AHP Framework on tackling health Inequalities outlines how practitioners can make a difference through an approach of awareness, action and advocacy at an individual, team and service level.[34] Within this approach occupational therapy works across the domains of a person (P), their occupations (O) and their environments (E) at all stages of a lifespan ideally placing the profession in a position to address work, housing, education and social isolation. Increasingly occupational therapists work in primary care and community settings, such as local authorities, schools and community mental health services.

Across the UK occupational therapists:

- Reduce the impact of existing inequalities on people's health outcomes and life expectancies by increasing their ability to access and participate in meaningful, productive occupations across their lifespan.[33]
- Intervene early to prevent a deterioration of circumstances, thereby maintaining or increasing independence e.g. falls prevention.[35]
- Increase healthy life expectancy and quality of life through implementing public health approaches that reduce the risks of people developing preventable illnesses/disabilities.[35]
- Provide the right information and tools for people with pre-existing long-term conditions to self-manage their health problems and ensure they live well.
- Promote and enable environments that support independence, choice, health and wellbeing.[35]
- Enable access to education and employment – two recognised routes out of poverty.[36]

Occupational therapists have significant experience working with populations affected by health inequalities, including people with characteristics protected under the Equality Act 2010[26] and people from inclusion health groups. This is the time to recognise and develop this role within existing services.

A selection of these settings is used below to illustrate how occupational therapy services may be organised to optimise positive outcomes for service providers and those who use them.

Primary care

“Long COVID is now causing increased disability threatening people’s abilities to work and function… early upstream access to OT support in primary care has never been more needed.” **GP, NHS Lanarkshire.**

Primary care has a core role in tackling the causes and consequences of health inequalities. It is uniquely positioned in the heart of many communities and is the trusted first point of contact for medical and social needs.[37] GP appointments make up 90 per cent of the public’s contact with healthcare professionals, providing a prime opportunity to reduce or minimise health inequalities.[38] It is crucial to understand the local population that the GP surgery or primary care area includes. Then, building on this knowledge, to enhance the skill mix in primary care to target and tackle local inequalities.[39]

Across the UK, there is an expansion of occupational therapy roles in primary care to meet the increasing complexity of need that frequently requires more than a medical approach at a much earlier stage than secondary care. Occupational therapists are bringing their comprehensive understanding of why people, groups and communities are not able to engage in occupations that have health benefits. This includes identifying stigmatised and segregated groups that are at risk of exclusion from purposeful or chosen occupations.

Occupational therapists deliver community-based interventions, shaped around the needs and culture of the population, that prevent, maintain and improve recovery and occupational participation. This includes working with and empowering people, groups and communities to actively promote and manage their own health.[40]

Often occupational therapists see people who struggle to access, or benefit from, the existing primary care services of medicine, social prescribing and talking therapies but do not need referral to secondary care services. People may have higher degrees of complexity and undifferentiated diagnoses, where the presenting problem is not clear, but they have indicators which suggest serious underlying social or medical risk.[41] An occupational therapist will work with them to make measurable changes in their everyday lives, so they are more active and able to look after themselves safely and effectively, to manage their home and access employment.

Work provides an income, benefits the family and society, and supports the economy. It is also an essential occupation to support longevity, health and wellbeing.[42] Parental unemployment, for instance, is associated with poorer academic attainment in children.[43] The GP is usually the first point of contact when someone’s health condition begins to affect their ability to work. Occupational therapists can support GPs with making judgements on fitness to work using the AHP Health and work report.[44] This provides recommendations in highly-specific terms about work ability, which GPs, employers and occupational health departments can implement to keep a person in work. Besides giving a detailed assessment of individual capacity and workplace requirements, occupational therapists can teach the person to manage any ongoing condition(s) and related symptoms such as pain

and fatigue and deliver rehabilitation through agreed goals with the employee and employer.

Case study

Occupational therapy in primary care in North Wales, Bwrdd Iechyd Prifysgol/Betsi Cadwaladr University Health Board

Awareness

The COVID-19 pandemic exacerbated the impact of already existing health inequalities in North Wales. Between 2017 and 2020 Wales had one of the highest populations of people living in poverty, with associated higher levels of health inequalities.

The protracted lockdowns led to an increase in loneliness, isolation, substance misuse and domestic violence, particularly for those who were shielding. This resulted in an increase in the need for urgent mental health support in primary care, backed by evidence from various sources, including the Population Needs Assessment for North Wales which clearly indicates that the number of patients with mental health problems is increasing.[45]

Action

Early in the first lockdown, the occupational therapy service in North Wales proactively acted to support primary care, reaching out to those who were shielding. This quickly grew into supporting individuals presenting at primary care with common mental health concerns.

From this, a co-production project developed, linking occupational therapy services with the I CAN programme – an established programme led by mental health services across North Wales offering drop-in community spaces, unlimited intensive employment support and volunteering opportunities, with an enhanced offer back to volunteers of support, supervision and reflective practice.

I CAN Primary Care was piloted with the occupational therapists completing assessments as an alternative to GPs, offering occupation-focused interventions and linking into local resources, including I CAN hubs. There were no restrictive eligibility criteria for access and the service was extremely responsive.

Advocacy

The I CAN programme offers easier, earlier access to prevent and mitigate health inequalities, practical help, and a focus on opportunities for people to get active again in their everyday lives.

Outcomes

An early evaluation of the programme demonstrated that:

- Occupational therapists offered self-management interventions in 76 per cent of cases, compared with five per cent offered by the GP.
- In 67 per cent of cases, GP appointment/s were avoided, either because an occupational therapist was able to complete the appointment or because follow-up appointments were not needed.
- In 26 per cent of cases, a referral to the community mental health team was avoided.

Over a five-month period, working one day per week in the project, the occupational therapists saw 386 patients. The projected average cost-saving per person who saw an occupational therapist was £327.59.

> “Whilst this has of course assisted in relieving the GP workload, [the occupational therapists] have given care GPs could not have provided. They have had support from our clinical team where necessary, and we have all benefitted from case discussions and reviews. However, their contribution has been very significant, particularly where they have enabled patients to manage anxiety and avoid medicalising it or indeed avoided medication, by using strategies I as a GP could not offer.”
>
> **GP** [46]

> “I was a mess. Thanks to her [the occupational therapist], my life is back on track.” **Patient**

Key elements to maximise impact

Establish and support occupational therapists where they can:

- Act as first contact practitioners in primary care, so people can initially self-refer before having a diagnosis, and can be directly triaged to the most appropriate services, e.g. mental health, frailty and falls, requests for GP fit notes.
- Collaborate with people living with a range of health problems and chronic conditions, to overcome barriers so that they can participate in the occupations of life and improve their health and wellbeing.
- Identify those people and groups who may be isolated or underserved by services and who therefore may not access occupations, activities or services, and then advocate between primary care staff and these people and communities to increase engagement in services and occupations that have health benefits.
- Work in partnership with communities, e.g. people experiencing homelessness, asylum seekers and traveller communities, to design services that are accessible and acceptable, reducing any marginalisation or stigmatisation, and building independence in health management.
- Identify early, and work with, those who are vulnerable to cumulative health and social risk factors, such as reduced functional ability and independence, loss of ability to cope and social isolation, work stress and sickness absence, and mental health crises.

Return on investment

- Occupational therapists, as advanced clinicians or first point of contact practitioners in primary care teams, can assess and intervene early before crisis occurs. GP patient contact costs £184 per hour (without qualification costs), compared with £120 for an advanced occupational therapist. [47]
- Public Health England has shown that moving a person from unemployment to work would save more than £12,000 per person over a one-year period.[48] For every £1 invested in work stress prevention, a saving to society of £2 is made over two years.[49]
- Occupational therapists can work with people with multiple pathologies such as diabetes and frailty to improve independence and self-management with safety, reducing demand and costs to primary and social care services.

Integrating occupational therapy into primary care offers a cost-effective solution that reduces pressure on GPs, reduces referral to secondary care, enhances timely hospital discharge, and keeps people independent at home.[50]

For every £1 invested in work stress prevention, a saving to society of £2 is made over two years

Housing

Observation shows that poor quality, unaffordable housing disproportionately impacts certain groups, including those from lower income households and people from minority ethnic backgrounds.[51] Living in housing that is not fit for purpose increases the risk of a range of preventable health conditions, such as respiratory and cardiovascular diseases, as well as mental health conditions such as depression and anxiety.[52] Conversely, safe and warm homes and good neighbourhoods improve physical and mental health and wellbeing and build strong communities.[53]

There is a need to increase the supply of purpose-built accessible housing, but 80 per cent of the homes that we will live in by 2050 already exist.[54] Fewer than 10 per cent of homes in England have design features that make them 'visitable' by people with disabilities, whilst around 400,000 wheelchair users are living in homes that are unsuitable for them.[55] Nearly half (47 per cent) of disabled respondents to the UK Disability Survey reported having at least 'some difficulty' getting in and out of where they live.[56]

Occupational therapists are integral to the provision of home adaptations. They have expertise in designing and adapting homes that can enable people to remain independent and safe, especially those with complex health and social care needs. Adapting people's existing homes enables them to remain within communities, which may be important in meeting their social, cultural and support needs. Home adaptations are valuable in overcoming environmental barriers arising not just from physical disabilities, but also from cognitive, neurodevelopmental, sensory and psychological needs.

Around two thirds of Disabled Facilities Grant applications are for people aged 60 and over.

With more than 90 per cent of older people living in mainstream housing, the implications of our ageing population on demand for adaptations is significant. As more people live for longer, often with multiple long-term health needs, it is important to take an integrated and holistic approach to housing needs, considering all the ways in which people's safety, independence, health and wellbeing are affected by their homes. This includes fire safety and security from crime.

Housing also affects children. Those living in poor or overcrowded conditions are more likely to have physical and mental health problems in the short and long term. There is also a long-term impact on children's life chances, with greater likelihood of lower educational attainment, unemployment and future poverty.[57] Recently, the need for home-schooling during the COVID-19 lockdowns, inevitably increased the education gap in children who did not have a suitable learning environment.

Everyone has the right to a home in which they can thrive. This belief closely aligns with the principles of occupational therapy. There are already housing departments and housing associations that benefit from employing or working in partnership with occupational therapists to provide expertise in designing and adapting homes to meet needs, increase independence and safety, and provide access.[57]

Key elements to maximise impact

Establish and support occupational therapists where they can:

- Develop greater and more holistic understanding of people's needs among multidisciplinary colleagues involved in the delivery of home adaptations or home safety.

- Promote understanding and early consideration of building regulations related to ease of access, safety and use by the elderly and people with disabilities.
- Work with local planning departments and have a clear process for receiving proposals at the pre-planning or an early stage for input, comment and re-design, to ensure the best design, and reduce the need for compromise later.
- Provide expert information and advice, specifying home adaptations for people with complex health and support needs.
- Complete post-occupancy/post-adaptation audits and outcome measures to capture the impact of good design on individuals and their families, to inform planning and adaptation processes.

Return on investment

- Once developers and registered providers work with occupational therapists on a scheme, the learning can be applied to future projects, thus minimising occupational therapy involvement, saving time and money but still resulting in better homes.
- Accessible, warm, decent housing is a fundamental contributor to enabling people to remain living well and independently at home.[58] Integrating services across social care, housing and health can achieve this, preventing or delaying the need for further costly care and support services.
- Home adaptation has significant returns on investment in falls prevention with older people. Even non-serious falls that do not require medical or social intervention can affect peoples' lives, for example by causing increased anxiety, functional decline and social isolation. The 20 per cent of people whose fall is deemed serious may go on to Accident and Emergency, be admitted, then discharged to a care home or their own home with ongoing social care support, all incurring significant costs.[59]
- The provision of home assessment and modification reduces the number of falls that require a hospital admission. For every £1 invested in providing assessment and modifications, £2.17 is saved in care costs and the quality of life benefits are equivalent to £7.34, indicating there is a positive return of £6.34.[60]

Case study

Re-housing wheelchair users in Tower Hamlets

Awareness

Tower Hamlets has one of the most diverse populations in the UK. The employment rate is below the national average, levels of poverty are high and there is an increasing need for in-work welfare support. Healthy life expectancy is below the national average and residents have a higher-than-average need for social care services.

Action

The Project 120 initiative was launched in 2012. Its intention was to rehouse all 120 of the wheelchair users then waiting for accessible housing, to accommodation that was built to meet their needs. Since then, over 290 wheelchair users and their families have been rehoused across the borough.

A team of five occupational therapists and one therapy assistant have expertise in accessible design and are skilled in identifying person-centred solutions to meet the occupational needs of people with complex health needs and disabilities.

The team works closely with developers, architects, the council's own affordable housing team and housing associations to ensure the right properties are built to the right specifications and people are moved into them quickly. They work with residents to ensure that their individual needs will be effectively supported by their home environment.

Advocacy

The local authority exceeds the requirements of the London Plan to ensure that at least 10 per cent of newbuild social housing is fully wheelchair accessible from the outset. The project has made savings for the council as the occupational therapy team contribute to designing lower cost wheelchair accessible properties instead of the council adapting less suitable properties, which is a more expensive process.[61]

Children, young people and families

Children learn through doing. The health and development of children and young people is significantly affected by the conditions in which they are born, live, learn and play. Children and young people at highest risk of poor health outcomes are those living in deprived areas,[62] and unequal access to education has profound consequences for individuals and communities.

There is a strong correlation between educational attainment, physical and mental health and life expectancy, within and across generations. Similarly, there is a correlation between income, employment and quality of life[9,63]

Marmot et al reported that 'inequalities experienced during school years have lifelong impacts – in terms of income, quality of work and a range of other social and economic outcomes including physical and mental health'.[4] Factors associated with inequalities in educational attainment include economic disadvantage, ethnicity, disability, gender, and whether a young person has been in care or has special educational needs.[64]

Occupational therapists can enable children, especially those most at risk of disadvantage, to develop skills and resilience to access education and realise their potential. They have the skills and expertise to:

- Identify the occupations that children or young people do well and those that they find difficult.
- Identify the personal, environmental and task-specific factors that support or limit children's performance and participation.
- Recommend alternative approaches or techniques, teach new skills and suggest changes to equipment or the environment to support children's development, participation and achievement.[65]

Occupational therapists address the needs of children and young people at home, in early years settings, in mainstream and special schools, and at college/university. Young people may require different levels of service provision at different times as their needs change.[66] Occupational therapy is delivered through a framework of universal, targeted and specialist interventions:

- Universal interventions – provision of training, information and support to help parents/carers and the children's workforce embed opportunities to promote physical and mental health into children's daily routines and activities, optimising their development, health and wellbeing.
- Targeted interventions – delivered in partnership with families, educators and third sector organisations and working across traditional service boundaries to provide early intervention for children/young people whose development, health and wellbeing is at risk.
- Specialist interventions – direct intervention with individuals with the most complex needs/circumstances, using a strength-based approach that fosters self-management and independence.

Key elements to maximise impact

Establish and support occupational therapists where they can:

- Support the early years workforce to develop foundation skills and resilience for learning into children's daily routines and activities.
- Build the capability of school staff to identify and address children's physical and mental health needs early, for example, inputting into undergraduate primary teachers' training.
- Identify the barriers that prevent or enable children/young people to access full time education, including identifying unrecognised additional needs and trauma and organisational/systemic barriers affecting school attendance/exclusion.
- Work with families and carers to develop and support children's development, learning, healthy occupations and independence.
- Work across traditional service boundaries to address physical, social and mental health needs that impact on learning.
- Support students with physical, learning and/or mental health needs in further/higher education to complete their courses and realise their potential.

Return on investment

- There is a graded relationship between level of educational qualifications and health. Adults with higher educational attainments have better health and lifespans. Better education for parents also improves health outcomes for their children.[64]
- Unemployment rates are higher for adults with few or no qualifications and skills.[63] Better educational outcomes open doors to better employment, income and living standards, along with behaviours and health, thereby benefiting communities and the economy.
- A review on school exclusions by Timpson[67] highlighted that excluded pupils often have significantly lower levels of attainment at GCSE level, which can lead to poorer economic outcomes. The report also highlighted some evidence that school exclusion is a factor in participating in or being a victim of crime. In 2014, 23 per cent of those sentenced to fewer than 12 months in custody had been permanently excluded from school.[68]
- Continuing in education after leaving school is associated with living a longer, healthier life. In 2014 it was demonstrated that every additional four years in education return £7.20 in the value of health and other outcomes for every £1 spent.[69]

Case study

Paediatric occupational therapy, Swansea Bay University Health Board

Awareness

A waiting list existed for children and young people's occupational therapy in Swansea Bay Health Board. The service redesigned practices across local authorities to have a single method of working; this included training clinicians with new skills to identify and clinically reason those most in need, changing systems to create a more flexible workforce and work more prudently and preventatively supporting an

increased amount of children and young people and their families, whilst being more accessible.

Training and groups for teachers and parents were developed to equip them with skills to support children. An occupational therapist was available to teachers and parents post-training to further empower them. This reduced waiting times from 45 weeks to seven weeks. Referrals to the service also decreased because of the ability to carry out preventative work. Patient-related outcomes improved – measured by patient-reported experience and outcome measures (PREMs and PROMs).

The restrictions of COVID-19 caused escalating needs with a significantly higher number of families faced with reduced support networks, enforced home-schooling and many other barriers to wellness.

Actions

When restrictions were put in place 'Parenting in a Pandemic' was developed, offering an accessible virtual intervention group facilitated by the service. Parents of school-aged children come together online to explore and share the challenges of managing their child's behaviours and emotional needs. The session content is co-produced with parents. The emphasis is on creating a supportive, needs-led network where strategies, resources and advice are shared, and sustainable support maintained. Being online reduces barriers, such as the cost of travel and the need for childcare. Parents without access to suitable technology were supported by schools or IT Wales.

every additional four years in education return £7.20 in the value of health and other outcomes for every £1 spent.

Advocacy

Outcomes:

- Being online has increased the accessibility of services, with a greater proportion of the population supported.
- Working across sectors ensures the programme is sustainable.
- There has been 0 per cent dropout from virtual parenting groups.
- 100% of families were extremely confident or somewhat confident that the programme and advice given has improved family life.

"These sessions were amazing and real... No textbook, and how the occupational therapist came back with answers from the top of their head, that's 10/10 for myself, they understood us parents and supported us."
Parent participant.

Working across primary care, secondary care, education, the third sector and involving parents enabled the development of a transferrable, sustainable project, evidenced by excellent patient outcomes. The project is now running with funding from two GP clusters across Neath.

Community rehabilitation

The World Health Organization has defined rehabilitation as 'a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments'.[70] Article 26, Habilitation and Rehabilitation, of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) calls for 'full inclusion and participation in all aspects of life'.[71]

Rehabilitation has far-reaching health, social and economic benefits. It delivers better outcomes and improved quality of life, improving functional outcomes, reducing length of hospital stay and enabling timely return to education, work or occupation and community living.[72.73.74]

Community rehabilitation is now a crucial part of recovery for those people affected by COVID-19, including those presenting with Long COVID or a deterioration in pre-existing conditions and mental health. Effective rehabilitation can reduce the physical, psychological, emotional, social, and economic impacts of the pandemic.[74]

Rehabilitation helps people to live well with long-term conditions. It is known that people from deprived populations are more likely to have multiple long-term conditions[75], and 17 per cent of the UK population is expected to have four or more chronic conditions by 2035.[76]

People with low incomes and those from minority groups report difficulty accessing support to manage their long-term conditions.[77] There are known inequalities in access to rehabilitation[78] and poorer experiences of health services are reported by some social and ethnic groups.[79] It is necessary to increase the availability of rehabilitation for those in greatest need. The routes to receiving support must be developed in partnership with communities to ensure access is inclusive for the local population reflecting diversity, cultural and personal needs.

In the community, occupational therapists may act individually or within combined allied health professions rehabilitation teams. Occupational therapists within rehabilitation are specialists in:

- Self-management approaches: occupational therapists support people to adopt healthy behaviours and strategies that enable participation in daily life and to achieve outcomes that have meaning for them, and support people with complex needs to overcome barriers to accessing existing opportunities such as social prescribing.
- Personalised care: occupational therapists embed personalised care through training and supervising others, including support workers, informal carers, care home and home care providers.
- Independent living: the profession's understanding and expertise on the relationship between occupations and the environment is pivotal in supporting people to return to living meaningful lives.[80]
- Assistive technology: occupational therapists review care packages and advise on the use of assistive technology to minimise reliance on carers.[81]

Key components for delivery

Establish and support occupational therapists where they can:

- Coproduce multidisciplinary community rehabilitation services that provide support based on needs rather than conditions.
- Provide accessible and timely community rehabilitation for those in greatest need and in the most deprived areas through localities/ place-based services.

- Collaborate across primary, secondary and voluntary sectors.
- Address physical, psychological and social needs holistically, as part of integrated rehabilitation pathways.

Return on investment

- Community rehabilitation can save significant amounts of taxpayer money through early intervention reducing the need for more costly health and social care. It also reduces demand on residential care settings by enabling people to remain safe and well in their own homes. Conversely, without access to community rehabilitation, there is a reduction in quality of life, an increase in the risk of social isolation and greater long-term costs for health and social care budgets.[78]
- Recent research into the cost benefits of rehabilitation in complex cases has shown that lack of investment in rehabilitation and patient support during the first year after hospital discharge increases costs to the NHS in the longer term. Failure to provide rehabilitation and support services in the first year (on average £4.1k per patient) leads to increased dependency and excess care and accommodation costs (on average £14.6k). This would suggest that investment in community rehabilitation services could save the NHS money to the tune of approximately £10k per patient, per year.[82]
- Community rehabilitation reduces hospital admissions[83] and demands on primary care by enabling people to manage their conditions and prevent deterioration in their health. Where hospital care is required, early community rehabilitation can reduce the length of admission[84] and therefore the cost.
- Research from the Health Foundation estimates that if people who feel least able to manage their long-term conditions were supported to manage them as well as those who feel most able, 436,000 emergency admissions and 690,000 A&E attendances could be avoided each year.[85]

Case Study

Occupational Therapy Services, Glasgow City Health and Social Care

Traditional service structures employ occupational therapists in either health or social care. The creation of Glasgow City Health and Social Care Partnership (HSCP) meant occupational therapy staff came under one partnership and this offered the opportunity to review how occupational therapists worked.

Awareness

A key ambition is to ensure rehabilitation is available for people that require it, regardless of the care group they are in. To reduce hand overs between occupational therapists, duplication of assessment and waits for different occupational therapy services; occupational therapists need to use all the skills they had at the point of registration in addition to other specialist skills they may develop such as assessment for major adaptations and brief mental health interventions.

Action

A competency-based model was developed for occupational therapists working across the teams. These were based on the knowledge that all occupational therapists graduate with a common level of knowledge. The “green” competencies could be done by anyone, the “red” competencies remained very specialist but most work was focused on the “amber” tasks to ensure these areas become “green”.

Advocacy

The model is now rolling out to include more care groups, such as learning disabilities, addictions and homecare. These populations have previously limited access to rehabilitation as either viewed as having limited rehabilitation potential or requiring a specialist service. Evaluation of peoples experience of the service is used to review and develop the model and its roll out.

Outcomes

Rehabilitation is offered at the right time and place and by the right person. Occupational therapists can maintain and support the care, assessment, and outcomes for an individual, where previously a person was referred to another occupational therapist based in a different part of the service. The service is widening access to occupational therapy, with shorter waiting times and fewer staff involved.

An Occupational Therapy Continuous Improvement Group has been established to take forward the findings of an evaluation of staff experience of the core competency work and use case study analysis for ongoing review

Community mental health

Mental health problems can influence education, development, employment and physical health. Early intervention is vital in providing effective support and better recovery outcomes. Occupational therapists are leading in innovative mental health service design to reduce the pressure on primary care and ensure timely interventions.[86]

Marginalised people experience a 'triple barrier' regarding their mental health needs, with higher rates of mental health problems, difficulty in accessing services and a poor experience of mental health interventions. Gradients of social disadvantage correlate to much poorer mental health outcomes.

Occupational therapists are a significant part of the mental health workforce in the UK. Approximately a third of all occupational therapists are embedded in statutory mental health services across the lifespan. By focusing on social justice, lived experience, access and joining up services, meaningful change can be created.[87]

Being able to access local and community-focused mental health support from occupational therapists is crucial. Occupational therapists can offer bespoke mental health interventions where required, in the context of care pathways which are co-produced and co-delivered with people who use services. Barriers to meeting mental health needs such as drawn-out referral processes should be addressed with flexible access such as self-referral and advice clinics. Occupational therapists can also offer advice and consultation across wider services, shaping multi-agency and flexible services around occupational needs rather than mental health diagnosis.

Occupational therapists:

- Are uniquely trained to address both mental and physical health working across all ages and at all stages of people's mental health recovery.
- Address employment and education needs - collaborating with occupational health services, employers and education providers to support and maintain good mental health.
- Improve the physical health of people with mental health problems, incorporating and promoting healthy occupations.
- Work with people that are underserved by health and social care services, such as those experiencing homelessness, to offer tailored mental health support.
- Help to create services that are informed by lived experience and focused on functional benefit. This translates interventions into meaningful change in the person's everyday life, ensuring their personal goals are achieved.
- Work with communities to build social environments that facilitate positive relationships, confidence, and healthy routines for occupational participation.

Key components for delivery

Establish and support occupational therapists where they can:

- Provide tailored access points to early occupational therapy intervention and advice across statutory and voluntary organisations, particularly for people facing multiple barriers.
- Address employment needs for people with mental health problems and their employers.
- Inform decision-makers in statutory and voluntary services at a local strategic level, to shape and focus services for greater impact.
- Offer training in life skills for those at risk of becoming or already part of the criminal justice system.
- Participate in local strategy and service planning to address mental health inequalities, focusing on early intervention and positive changes in everyday lives that will gain better outcomes.
- Improve engagement, empowerment, and recovery for, and understanding of, marginalised people with mental ill health.


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Return on investment

- Improvement in mental health leads to better attendance and engagement with education, with the ongoing benefits which that brings. This tends to go hand in hand with positive lifestyle changes such as healthy eating and exercise. People who experience this are less likely to require ongoing input from GPs and long-term mental health services.[88]
- Stress, anxiety and depression are responsible for almost half of working days lost in Britain each year[89]. Individual therapy such as stress management offers a 3:1 return on investment. Vocational rehabilitation for people with poor mental health and support for employers increases work attendance and confidence, with resulting personal, organisational and economic benefits.[90]

Case study

Tackling inequalities experienced by people with autism, Cheshire and Wirral Partnership NHS Foundation Trust

Autism is a lifelong neurodevelopmental condition. Most autistic people do not have a diagnosis, which calls for greater awareness and recognition in healthcare settings. Autistic people can present to any mental or physical health service with a co-occurring condition. Often teams do not feel confident in knowing what reasonable adjustments may be helpful in supporting a person to access or engage in an intervention.

Autistic people are more vulnerable to a range of co-occurring physical and mental health conditions yet getting the best treatment for them can be hampered by differences in communication, social interaction, and presentation as well as help-seeking behaviours, which can lead to secondary conditions and premature death.[91]

Awareness

Approximately 80 per cent of autistic people experience mental health problems.[92] Improved recognition of autism and use of reasonable adjustments to make mental health services more accessible and effective can improve health outcomes and reduce the significant health inequalities faced by autistic people.

Action

The Autism Service at Cheshire and Wirral Partnership NHS Foundation Trust has been co-designed to provide diagnostic and post-diagnostic support to autistic people and their supporters across Cheshire and Wirral. The occupational therapist worked with autistic people, their families, colleagues and commissioners to co-design and develop a predominantly occupational therapy/psychiatry diagnostic and post-diagnostic adult autism service, recognising the importance of making every contact count within the resources available.

The service provides practical recommendations and specific strategies to improve a person's ability and confidence to function day to day, manage their stress and their vulnerability to mental illness. The occupational therapist works with people to clearly articulate specific reasonable adjustments to reduce any distress caused through misunderstandings and misinterpretations and to support them to engage in health interventions, employment and education. These reasonable adjustments are clearly noted on a person's electronic health record and are shared with their GP.

Advocacy

Outcomes:

- Mental health teams in the trust report being more autism-informed in their interactions, providing a better patient experience with improved care and outcomes.
- These experiences have been fed into national policy and practice[93], supporting services across the country, ensuring that the needs of autistic people are not overlooked and health inequalities for autistic people are addressed.

Criminal justice system

Place-based systems of care take responsibility for all people living within a given area, bringing organisations together around the population they serve.[94] An example of this is occupational therapists working within prison services.

People who are incarcerated or detained, from young offenders through to those serving longer sentences, can have complex health and care needs. They have the right to health and wellbeing[95] and should have access to good integrated health and care support.[96]

Occupational therapy offers a valuable contribution to working with the general prison population (many of whom may have experienced occupational deprivation during their life due to social, economic and environmental factors) as part of a 'whole prisons approach' in which the wider determinants of health are addressed. Interventions might include:

- health promotion activities,
- life skills programmes,
- interventions to help people who are incarcerated or detained gain insight into lifestyle choices and that promote prosocial behaviour; and
- helping prepare for re-integration into the community, including through educational and vocational rehabilitation programmes.

Occupational therapists also work in partnership with prison services to identify and address an individual's health, care and environmental needs, as well as risk factors, particularly for those with additional needs due to mental or physical ill-health or learning disabilities.[97]

Key components for delivery

Establish and support occupational therapists where they can:

- Work with prison offender managers/ resettlement officers to design effective interventions to support individuals to take up opportunities within the prison and post release.
- Advise on design of prison facilities to encourage productive engagement and accessibility.
- Meet the legislative requirements for the assessment of social care needs in prisons and approved premises.[98,99]

Return on investment

Occupational therapy within prison services aims to equip people with the life skills that they may not have gained earlier in life. Intervention prevents reoffending by building in protective factors such as thinking and decision-making skills, using a person's strengths and developing a positive sense of identity, which leads to greater resilience both during and after a prison sentence.

Case study

HMP - Cardiff

Introduction

The mental health team within HMP Cardiff provides assessment, care and treatment for those in custody that require input from either primary or secondary care services. The occupational therapy team have a clear mission statement of encouraging and facilitating occupational engagement in an environment of occupational deprivation.

Awareness

During the COVID-19 pandemic those being newly received into custody needed to isolate for fourteen days before they could mix with the rest of the population. The occupational therapy service realised it would need to change practices to ensure that activities and input were available to this group to manage the excessive time confined to their cells.

Action

The service produced temporary isolation care plan templates. The care plan included their wishes about how they would like to maintain contact with the service during isolation as well as what resources could be provided to ensure that they could engage in activity while isolated. Additional help was provided for those with known literacy issues and those who were unlikely to return the forms independently. The occupational therapists also produced

a ‘Things to do when isolating’ booklet that included activity ideas, relaxation and breathing techniques, self care and hygiene tips. The prison print shop produced booklets so they were available on all wings. The booklet was available with a mixture of pictorial activities and text to reflect varying levels of literacy. All individuals on our caseload had either an individualised care plan or one to one discussion around their needs in which resources for in cell activities were discussed and provided.

Advocacy

The work increased the service’s understanding of the realities of being housed in such a small and restrictive environment without access to a wider range of options to occupy mind and your body. By listening to the experience of people who previously had periods of isolation, the occupational therapists had a much clearer narrative of the impact and experience of this.

The outcomes of these temporary care plans were shared with all those in the team that were working with the individual to widen knowledge throughout the prison.

Outcomes

- Support was informed by people with lived experience. New people entering the system had tailored activities during the isolation period.
- The isolation pack was shared with other services on forums.
- The ‘Things to do when isolating’ booklet can be adapted and continue to be of used post Covid-19 isolation regulations given that our population spend so much time in their cells.

Conclusion

History seems to demonstrate that times of national crisis can lead to developments and system changes for the better for people, societies and countries. When ‘Necessity is the mother of invention’, crises can be a force for co-operation, creative thinking and positive change, with increased resilience and preparedness should a similar event happen again.[101]

Health inequalities are unfair and unjust, particularly when poor health itself is the result of factors that can be changed, such as access to education, work or suitable housing. Interventions to reduce health inequalities are cost effective, not just in reducing longer term health or social care costs, but also in reducing the social and community costs, such as harmful behaviour or substance misuse.

The Royal College of Occupational Therapists is calling for decision-makers, service leaders and practitioners across all sectors to co-operate, working with their local communities, to re-imagine services in a way that will help to improve health inequalities and health outcomes for everyone across the UK. Occupational therapists have the skills and motivation, are based in the right places, they just require the opportunities to drive this system change.

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