Royal College of Occupational Therapists
Coleg Brenhinol Therapyddion Galwedigaethol

# WALES MENTAL HEALTH WORKFORCE CONSULTATION

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## About us

We're RCOT, the Royal College of Occupational Therapists. We've championed the profession and the people behind it for over 80 years; and today, we are thriving with over 35,000 members. Then and now, we're here to help achieve life-changing breakthroughs for our members, for the people they support and for society as a whole. Occupational therapists in Wales work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapy helps you live your best life at home, at work – and everywhere else. It's about being able to do the things you want and must do. That could mean helping you overcome challenges of learning at school, going to work, playing sport or simply doing the dishes. Everything is focused on increasing independence and wellbeing.

It's a science-based, health and social care profession that's regulated by the Health and Care Professions Council.

An occupational therapist helps people of all ages overcome challenges completing everyday tasks or activities – what we call 'occupations'. Occupational therapists see beyond diagnoses and limitations to hopes and aspirations. They look at relationships between the activities you do every day – your occupations – alongside the challenges you face and your environment.

Then, they create a plan of goals and adjustments targeted at achieving a specific set of activities. The plan is practical, realistic, and personal to you as an individual, to help you achieve the breakthroughs you need to elevate your everyday life.

This support can give people a renewed sense of purpose. It can also open new opportunities and change the way people feel about the future.

## Our response

**Wales Mental Health Workforce consultation response**

**Theme 1 Workforce Supply and Shape**
While it is easy to categorise all Allied Health Professionals (AHPs) together, occupational therapy is the largest and most well established AHP in the specialist mental health profession. We think we should be named separately and distinctly because of our unique role and position in services. We are missing from the document's list of who is core in specialist mental health services.

RCOT agree that the number of occupational therapy undergraduate training needs to increase. Health Education Improvement Wales (HEIW) state that occupational therapy (OT) student numbers for the next three years will be 221 lower than the requested numbers from local health boards.

Powys and North Wales have occupational therapy vacancy rates of between 25% and 33%. We would like an increase from the 179 places we currently have, to meet health boards' requirements.

RCOT notes that NHS Benchmarking does not have a category for occupational therapy. We are unsure how the Welsh Government are going to overcome this barrier to mapping changes in the workforce.

The mapping exercise needs to identify the whole of the occupational therapy workforce as OTs often have dual roles. For example, they may work 10 hours on an inpatient unit and the rest of the time in the community. Occupational therapists are doing an increasing amount of in-reach into specialist mental health services, and this must be included in the mapping. As part of this mapping of the workforce, protocols need to be established for partnership working across boundaries, with the third sector and covering the inclusion of peer support workers. This is needed to ensure each element of a system operates as an equal partner in the delivery of care.

RCOT wish to draw attention to the role that support worker staff play, especially in band 4 OT roles. This area of the workforce needs increasing visibility and support and an understanding of the way in which these roles can be recruited into and in time provide a route into the full profession. We are willing to support this work, which we believe should be led by HEIW.

The ambitions in these themes also need to include volunteers working in this sector. Across the sector, greater support must be provided to volunteer roles that support recovery and self-management. RCOT have concerns that volunteers sometimes experience a culture which is dismissive of their contribution, and we need to shift this culture. For example, volunteers should routinely be given reasonable travel expenses and food/drink when travelling and providing support. Scenario planning needs to include occupational therapy care pathways. These are important to ensure the best balance between using our occupational therapy expertise and more generic duties and roles. There are some concerns in our membership that as vacancies for other professional groups rise, remaining staff such as occupational therapists are increasingly being asked to take on medically driven duties.

**Theme 2 An Engaged, Motivated and Healthy Workforce**
Any proposed survey must cross directorates to include the whole mental health workforce. To increase uptake of a survey you need to ensure that occupational therapists and other AHPs are included in the circulation list. Occupational therapists for example, can sit in the Therapies division of health boards and can miss out on surveys, although they deliver specialist mental health services.

Supervision structures and practice in occupational therapy is generally regarded as being good in comparison to the anecdotal evidence we have from colleagues from different professional backgrounds. We suggest that the system can learn from what our profession do well to share this across professional groups.

Occupational therapists strongly feel that they need access to leadership opportunities as there is a large variance in access to these and they often lose out. Our members tell us, for example, that in recent years there has been a retraction from manager roles being open to nurses and AHPs. Many of these roles are now only being open to nurses, and posts are turned into senior nursing roles. In addition, we have no consultant occupational therapy roles; no funding for Band 8b posts, while other professions routinely get Band 8c or 8d posts. There is a glass ceiling for occupational therapists in specialist mental health services at band 8a. The serious impact of this is while our 8a OTs will have operational management for all mental health OTs, they are not included in service

development activity, are not considered operational partners, and have no budgets attached to their roles. Even when transformational money for consultant AHP roles is available, this has not been pursued by health boards because they do not understand the value and impact of these roles.

Compounding this problem is the fact that staff on the ground are fighting numbers and volume of activity which means they have no time for development activity or leadership training/mentorship. Having a much clearer 80/20% split in roles, for example for 80% clinical time and 20% development time would help build OT capacity for leadership. Occupational therapists need time and support to move into these roles.

RCOT strongly feels that HEIW needs to promote better use of the compassionate leadership principles that were published last year. We need to have a more compassionate culture. We have increasing numbers of staff experiencing mental health problems themselves. As a result of this, they get compassion fatigue, and we need closer attention to stress markers in the workforce.

Our members would also like a better explanation of how the proposed model for Social Care Wales Care managers approach is different from the Stepping into Leadership program.

The proposal for a Professional Support Unit is reasonable but it is not clear how it will interact with occupational health and line managers. We think this unit would benefit from inclusion of occupational therapy. Occupational Therapists are experts at supporting people with their health and work problems, giving detailed, tailored specific advice about self-management in the workplace and possible workplace modifications. We already have established roles in occupational health, and this can be built upon. Our work in this area could include employment of occupational therapists to develop resources for the workforce to inform work/life balance for example.

**SBU Health Board In Work Support Service - Case Study**
Participant Barrier/s: Mental health, including depression and suicidal thoughts

**Participant barrier/s:**
The participant accessed the In Work Support Service after seeing a leaflet at his GP surgery during being off work for four weeks with depression. He has experienced episodes of depression throughout his life but expressed that this was the lowest he had felt.

The participant normally enjoys a highly specialist job, but because of two significant life events, he felt unable to cope with work, especially the level of detail and precision that was required. By the time the participant accessed the In-Work Support Service, he was feeling very strongly that his life was not worth living and he had made many plans and had full intentions to end his life using methods that he discussed with the occupational therapist.

**Support provided:**
The participant completed an initial assessment with an occupational therapist and explained his situation and the emotions he was feeling. After discussing his suicidal ideation, the therapist contacted the GP who arranged additional support. The participant then had four additional follow-up calls with In-Work Support, where he was able to use the sessions to explore options around improving his mood and being able to move forwards, despite the complex life events he was experiencing. He set goals towards being able to focus less on suicidal thoughts and engage more fully with daily activities related to fitness, being outdoors, learning a new skill and re-connecting with old friends. The importance of keeping physically active to help manage his mood was discussed during the one-to-one sessions. Following on from this, the participant began walking to

the shops and buying items and this is turn encouraged him to feel more able to gradually pay more attention to his self-care, which contributed to an improvement in mood.

After four sessions, he explained that he hoped to return to work and the AHP Health and Work Report was completed, in collaboration, to help his employer understand what would help with a return to work. He eventually returned to work on a phased return and confirmed that returning to work had "energised" him and given him increased "momentum" to move forward with his recovery. He expressed his gratitude that earlier sessions had focused on giving him the hope that he would recover enough to feel positive about his life and work again. He said he did not currently have any suicidal ideations but had really valued the fact that he could talk about his previous feelings in an open and honest way without judgement.

**How the support helped to overcome the barrier/s:**
The participant said that he had found that having weekly planned appointments at set times very beneficial. Using a graded and goal-setting approach to return to valued activities, which helped to structure his daily life when he felt unable to work was also cited as being helpful.

The therapeutic support helped him to understand the reasons for his unhelpful and negative thinking and the use of CBT based strategies helped overcome and manage these thoughts. It also provided the opportunity to discuss options for returning to work and ongoing reassurance that although he was currently unwell, he would still be able to recover and return to work in future.

**Outcome / benefit(s) for the participant and / or employer:**
The support provided by In Work Support helped to rebuild the participant's confidence to complete daily activities and routines. This in turn helped to improve his mood and outlook to the point where he eventually felt able to return to work on a phased return.

The employer benefited from the fact that the participant was supported to return to work in a timely manner, with supportive recommendations from the AHP Health & Work Report, and looked forward to him contributing fully to his work role.

Clinical outcomes scores using the EQ5DL outcome measure demonstrated improvements in self-care, engagement in 'usual activities' and 'anxiety/depression' symptoms with improvements in self perceptions of health and wellbeing.

**Theme 3 Attraction and Recruitment**
RCOT have information that shows occupational therapy vacancy rates between 25%- 33%.
Historically campaigns to increase the workforce have targeted nurses and doctors.
Several years ago, the Welsh Government told RCOT that our profession would be in the next phase of the workforce campaign. RCOT believe that the time for an Occupational Therapy campaign is right now.

RCOT have some concerns about the proposal to use of the Centre for Mental Health's 2017 workforce document. Not only it is several years old its Welsh input is unclear but it ignores the occupational therapy contribution. Basing any work on this will further minimise our contribution. We would suggest instead that you refer to and draw from the themes and actions in the Welsh AHP Framework instead.
allied-health-professions-framework-for-wales-looking-forward-together.pdf (gov.wales)

**Theme 4 Seamless Workforce Models**
Occupational therapists are dual trained equally across mental health and physical health. We feel

this model could be used more widely by other professional groups and could support development of training of this kind. While art organisations make a valuable contribution, occupational therapists and arts therapists use the arts to capture the lived experience of people in services. RCOT thinks that the work of occupational therapists and arts therapists needs to be included, as they are excellent at capturing meaningful narrative and quality of life story work. In addition, occupational therapists are already making a valuable contribution in primary care to support people with mental health needs. For example:

**Case study - Bwrdd Iechyd Prifysgol/Betsi Cadwaladr University Health Board I Can service**
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.

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. 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**.

The clinicians are acting as first point practitioners and seeing people instead of GPs reducing the GP burden. In addition, they give patients a much higher degree of direct, practical self-management advice than do GPs. They can support positive risk taking. They are great at providing bridges, pathways, and doorways to help people who don't need secondary care mental health services, but still experience a significant degree of disability and/or distress.

Finally, our members have expressed some concerns about whether proposed training from the workforce strategy will be delivered. Previously identified Making Every Contact Count (MECC) which was promised but not delivered. While there is potential for a strong, positive vision for the mental health workforce in Wales, actual implementation is key.

**Theme 5 Building a Digitally Ready Workforce**
Fragmentation of digital systems across Wales exists which restricts innovation and is compounded by a lack of digital training for staff. We need one digital system, not multiple different systems. We also need better data collection and sets of online tools most appropriate to occupational therapy so that our outcomes are more visible. Not only do electronic systems not ask if the person has access to occupational therapy, but they also generally contain nothing about occupational therapy metrics. All of us working in health and social care need to work together to increase the number of standardised outcome measures available on digital systems, including occupational therapy outcome measures. We also need to find ways for team capture online for co-created and produced plans.

We support the need for change and to improve data quality, but we are aware that some health boards still use paper notes and require a significant degree of support for change. The whole of the Mental Health Measure needs to be established on digital platforms alongside EMIS for example.

Finally, our members query the value of Digital Champions and request instead that more practical, hand on digital support is provided to individual teams. This is more likely to help teams embrace change, as it is frequently the practical/technical issues that need to be resolved, rather "winning hearts and minds".

**Theme 6 Excellent Education and Learning**
While we support multiagency training, occupational therapists have specific training needs in relation to our skills. Our concern about multiagency training is that it will become too medical. Our profession come from the social model of disability which emphasises the social determinants of health. The legislative directive in Wales has mandated a move towards the social model of disability. This needs to be a core factor in any proposed MDT training and occupational therapists could deliver training to the rest of the workforce on this. In addition, we believe that nurses and doctors should spend time with occupational therapists as part of their undergraduate and post graduate training to promote better understanding between the professions.

The development of a National Fund for post qualifying education needs to be open to all. As we have previously explained, some occupational therapy services in Wales are in the Therapy directorate of health boards and some in the Mental Health specialist directorates but both deliver specialist mental health services. If the proposed funding is not open across boundaries, occupational therapists may lose out. Also, for OTs in rural areas, while training in mid Wales can be equidistance for north and south Wales, it is still a two -three-hour drive to access the training. More development courses should be available online.

In addition to the proposed increased work on the psychological therapies' matrix, RCOT would like to work with the Welsh Government to develop an Occupational Matrix that would work across boundaries and tiers. This would help address workforce priorities, supervision and training needs across the whole workforce that deliver occupational interventions. It would also help differentiate where we need qualified occupational therapists and where other types of support are appropriate.

**Theme 7 Leadership and Succession**
All leadership roles need to go to the right person with the right skills rather than the professional

groups who have historically been appointed to these jobs, such as nurses and doctors. There is a link between leadership development and advanced practice development. Better linking across the clinical, leadership, education and research pillars of the professions could be promoted in the strategy.

Finally, there is a total absence of occupational therapy research posts in Wales which compounds many of the workforce problems described here. Consideration of the research role on the workforce needs more development in the strategy.

## Contact

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