**The Mental Health Act White Paper (England and Wales) 20/4/21**

The Royal College of Occupational Therapists (RCOT) is pleased to provide a response to this consultation. RCOT is the professional body for occupational therapists and represents over 34,000 occupational therapists, support workers and students from across the United Kingdom. Occupational therapists are regulated by the Health and Care Professions Council (HCPC), and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.Occupational therapy takes a “whole-person approach” to both mental and physical health and wellbeing and enables individuals to achieve their full potential. Because the Mental Act Health covers our members working in both England and Wales, any of the proposed changes will have to work in tandem with the Mental Health (Wales) Measure.

***Chapter 1- Guiding Principles*** *-* *We propose embedding the new guiding principles in the Mental Health Act (MHA) and the MHA Code of Practice.* *Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?*

These core underpinning values should frame the values and way whole organisations are structured, co-created, delivered and reported on. They should be explicit in organisational strategy, vision, mission, priorities, commitments and aims. Executive Boards and teams should know and understand how the organisation currently delivers and plans to improve on these principles.

The principles should form a framework to guide decision making at every level and in every part of the system including leadership, governance, regulation, inspection, research and education.

These principles must also be central to the individual professional response, and we would like to see them embedded more explicitly within the standards for all health and care professionals particularly via the regulatory bodies such as the General Medical Council, the Nursing and Midwifery Council and the Health and Care Professions Council. They need to be integral in the undergraduate training of new health and care professionals, and the ongoing mandatory training of current health and care professionals.

We feel that they are core to the values, ethics and philosophy of occupational therapy and would like to reiterate that three of the principles (people as individuals, choice and autonomy and least restriction) are non-medical and emphasise people and communities taking ownership of their own recovery and wellness.

Our members report multiple, real, everyday challenges in the system that

at worse, de-humanise both patients and staff. The principles here offer a solution by advocating quality relationships and sharing of responsibility which are not apparent enough in the current system.

The challenge therefore, is not **where** in the current system to apply these principles, but **how** to fundamentally drive meaningful change across complex systems with these values at the heart of care. Using them as a plaster across a system already under great strain will not bring the hope that is desperately needed at this time.

***Chapter 2 – Detention criteria*** *will be changed and strengthened to ensure it can only happen when there is clear therapeutic benefit to the individual. Do you agree or disagree with this proposal? Please give reasons for your answer.*

RCOT agree that the criteria should change in alignment with the principles. For example, there does need to be clear therapeutic benefit to individuals and the other three principles also need to be upheld during detention.

The therapeutic benefit should be specifically identified in the medical recommendations. Where non-medical Approved Clinicians (ACs) exist such as psychologists, nurses or occupational therapists, it should be acceptable for this professional to make one of the two recommendations for a Section 3. For example, the non-medical Responsible Clinician (RC) already evidences that the criteria for detention continue to be met at renewal without the support of a medical AC. In addition, in forensic settings a non-medical AC could make one of the recommendations to the court where the focus is on the therapeutic benefit of detention.

However, we also feel that a clear and widely understood definition of “therapeutic benefit” needs to be present. For example, detention to reduce acute risk to self or others forms much of the justification for detention presently. If a person is experiencing a significant risk of harm to themselves but the only therapeutic benefit is containment in a safe environment, would this be grounds to use the powers of detention? If not, RCOT believe that safe, alternative community interventions will have to available to keep people alive and free from harm.

The potential therapeutic benefit to the individual of detention needs to be balanced against the removal of the person from their normal environment, roles and routines. They lose the opportunity to take part in valued /activities occupations, maintain relationships, tenancies, employment. Detaining a person automatically means their access to health promoting activity is restricted.

***Chapter 4 – Patients’ rights to choose and refuse treatment*** *will be strengthened through Advanced Choice documents indicating what they would prefer and what they would refuse. The document can also include details of the patient's nominated person, crisis planning arrangements and early signs of relapse.* *Do you have any other suggestions for what should be included in a person's Advance Choice document?*

As many organisations do not have a similar document to the one described, one of our members has already shared Advanced Choice documents with the Independent Review and these could be disseminated wider by the Department of Health and Social Care/ Department of Health and Social Services (Wales).

As formats for advanced decision (AD) making under the Mental Capacity Act currently exist and are supported by a NICE guideline and Quality Standard, we propose that this format is adopted and held on the proposed national database. This would support consistency in language and enable the documents to be used across health and social care, primary and secondary care and mental and physical health settings. In addition, this database will need to be accessible by the private sector as many detentions happened in private hospitals. Better still, people and their carers could own and carry them themselves, like a passport.

This is a sensitive area that needs careful consideration: people have the legal right to refuse clinically appropriate treatment but case law is clear that a person cannot demand a clinician give treatment as this is a clinical decision. However, the RCOT is supportive of the proposal that people’s views, wishes and preferences are identified and respected.

People who use services, their families and clinicians will need clear guidance, with practical everyday examples to help them uphold person centred principles within a legal framework often in emergency situations. Drawing on the principles could help decision making and the principles could be embedded in these documents.

People will need guidance about the possible alternatives to medication such as occupational therapy or types of talking therapies. People need to know about the full range of treatments available to them when making advanced decisions.

***Chapter 4 – All patients must have a detailed care and treatment plan*** *in place by day 7 of detention. It can include care and treatment provided, wishes and preferences, planning for discharge, plans to take account of protected characteristics.* *Do you have any other suggestions for what should be included in a person's care and treatment plans?*

RCOT support this proposal but are concerned about the idea and governance of having a medical director sign the care and treatment plan off, what this actually means and how it will operate in everyday practice.

For example, how will the medical director sign off a plan that involves the multiple input and interventions from a range of different clinicians? What does their signature mean? That they approve or endorse of what the occupational therapist, psychologist, nurse, social worker, peer support worker or advocate propose? If they are short of time, will the Responsible Clinician (RC) write the MDT plan on behalf of the MDT committing colleagues to a plan that they may not agree with? Will a part time occupational therapist come onto the ward on Thursday to find in the ward round on Wednesday, that the medical director has already prescribed the occupational therapy intervention for them? It is clearly unacceptable for a professional to prescribe treatment in an area outside their field of knowledge and skills. Clinicians such as occupational therapists are trained to be autonomous professionals, allied but not supplementary to medicine.

The content of the detailed care and treatment plan needs to be guided by the principles so must include people’s views and choices, least restrictive mechanisms that can be used during the detention, delivery of the full range of therapeutic interventions and key information about the person as an individual.

It is very easy for inpatient services that only see a person when they are very unwell to lose sight of how the person and their life exists when they are well. This would include what the person has achieved in their life, what they like doing, where they live, who and what is important to them. Information about the person’s typical day or week would be extremely useful, their usual habits, role, routines, including employment. The structure and content of the care and treatment plan could replicate that of the Liberty Protection Safeguards care and treatment plans.

This type of information should be at the very beginning of the document to help frame an appropriate and humanising response throughput the person’s recovery journey. It should also be co-owned by the person and with their consent with their family or carers, and the mental health team so that people who use the service can add detail about their real, everyday lives which can be more important to them than a brief inpatient stay.

***Chapter 8: Patients in the Criminal Justice System*** *who are conditionally discharged are generally supervised in the community by a psychiatrist and a social supervisor. Social supervision is an important role, balancing public protection with the care and support of conditionally discharged patients. It has traditionally been a local authority social worker, although other professionals can also take on this role. There is currently some confusion about which professionals should play this role and a lack of national guidance about how it should operate.* *How do you think that the role of social supervisor could be strengthened?*

At present conflicting advice exists regarding the identity of the social supervisor. The Ministry of Justice (MoJ) guidance refers to the social worker being the appropriate professional whilst the Mental Health Act (MHA) Code of Practice states that ‘The MoJ does not stipulate who can undertake the role’.

As the MHA identifies that the statutory role of the Approved Mental Health Professional (AMHP) can be undertaken by social workers, occupational therapists, psychologists, mental health and learning disability registered nurses, RCOT suggests that the role of the social supervisors should be open to the same professional groups.

The MHA Code of Practice identifies that the social supervisor should have received adequate professional development, however there is no clarity regarding what qualifies as ‘adequate professional development’.

RCOT suggests that the social supervisor should be recognised as a distinct role, in the same way that the AMHP and AC/RC roles are also recognised by the MHA. To recognise the function and role of the social supervisor explicit training should be developed at Masters level, the same level as the AMHP training. This training could be run separately to that of the AMHP. It would require evidence of refresher training, set at every 5 years.

RCOT supports a clear delineation between the roles of the mental health care co-ordinator and that of the social supervisor and recommends that these roles cannot be filled concurrently by the same person to avoid potential conflict of interest between the roles and their purpose.

The allocation of the social supervisor is the responsibility of the Local Authority. To avoid the role remaining as the preserve of the social worker, as has happened with AMHP’s and as a consequence limits the activity of the social worker in mental health to statutory roles at the cost to the service users of their skills as social workers, RCOT suggests that steps be taken to ensure that Health (Health Boards in Wales) and Local Authorities are required to jointly commission training, review refresher/revalidation processes, have a single payment structure and agreed process for the allocation of social supervisors. RCOT would strongly urge a similar approach to be taken with the statutory AMHP role.

Prior to any person being conditionally discharged both the MoJ and where directing the conditional discharge the Mental Health Tribunal, must be provided with evidence of there being an identified social supervisor and clinical supervisor. Evidence should be sought from these professionals to ensure that the Tribunal or MoJ are satisfied that appropriate treatment can be provided for the person on their discharge and that the receiving team are able to manage risks associated with the person and have a process in place to support recall to hospital should this be required.

Before any transfer of care can be made the MoJ must be satisfied that there is a clinical supervisor and social supervisor ready to accept the person. Where there is a gap the MoJ should have the power to direct the appropriate NHS Trust to identify suitable professionals to these roles.

#### *Chapter 9: To ensuring an adequate supply of community services for people with a learning disability and autistic people, and prevent unnecessary inpatient stays, a duty will be placed on health and social care commissioners to collaborate to ensure provision of community-based support and treatment for this group.  Do you agree or disagree with this? Please explain your answer.*

#### RCOT agree that more community services that focus on early intervention, prevention and management should be available. Ideally, RCOT would like to see a duty placed on health and social care to collaborate to provide community-based support for everyone who needs it to avoid unnecessary inpatient stays.

#### However, we do understand the particular challenges faced by people with a learning disability and/or autism who regularly have their rights to participate in a full range of everyday activities curtailed, whether this might be developing social relationships, gaining paid employment or taking part in their communities.

#### This duty must centre on:

#### Supporting people to access and participate in education, work and mainstream community resources;

#### Providing clear access points for mainstream services to access specialist expertise and guidance

#### The creation of strong, working partnerships across all sectors to ensure people with learning disabilities and/or autism can maintain their health and wellbeing through healthy, meaningful occupations.

#### Occupational therapists can help ensure participation in communities is a core standard in service commissioning and delivery. Much of our role in this area considers how to support people to live fully integrated lives within communities and create packages of care that promote this. Occupational therapists are able to take an assets-based approach, balancing choice and risk which take account of the meaning and value of the occupation when assessing risk.

#### People with very complex needs and behaviours in particular need to be better supported in the community. RCOT believe that the health and social care system could make more effective use of occupational therapists to promote independence and avoid hospital admission. Additionally, occupational therapists can be key change agents as part of a positive behaviour support approach to cater for people’s needs; to train and advise formal carers to take up a personalised approach to care, to identify suitable housing including future proofed environmental adaptions and on-going support.

#### By advising on the therapeutic use of activity people can:

#### Become more active, addressing their wider health issues

#### Learn new skills for both independent and interdependent living

#### Set up environments around themselves to support inclusion and use activity to regulate emotion.

#### The consequence of this approach is greater self-determination, efficient use of limited resources and reduction of the need for psychotropic medication.

***Chapter 11: Experiences of people from Black, Asian and Minority Ethnic backgrounds -****The review found that parts of the current mental health workforce often fail to reflect the population which they serve. This is clear in professions such as clinical psychology and occupational therapy. Within the NHS, we want to increase the number of people of black African and Caribbean descent, who are particularly poorly represented in senior mental health professions, most significantly in the fields of psychology and occupational therapy.*

RCOT is committed to improving the diversity of its workforce. The principles of equality and diversity are core to the practice of occupational therapy. We believe that all people should be treated with dignity and respect, and have the right to be equal members of society with the same choices, rights and privileges. Discrimination and prejudice have no place in our practice and no place in society.

RCOT is in the process of both identifying the steps that we can take now, and developing our long-term strategy for the future. We are committed to addressing inequality and to leading the way to improve diversity, equality and inclusion for our profession. To support this approach a new careers brochure has been developed as an opportunity to ‘speak’ to more diverse populations through imagery and storytelling. Our aim will be to target wider audiences for careers promotion, for example, families.

RCOT will also review and improve the robustness of equality, diversity and inclusion in RCOT policies and practices for members and for staff, for example, recruitment, career development, training. We have reviewed our ethnicity monitoring for our new member content management system so that we can accurately capture Equality, Diversity and Inclusion data from our members.

RCOT would welcome inclusion in national workforce development projects. We are keen to proactively address the workforce inequalities identified in the White Paper. RCOT wishes to support the development of a workforce that is reflective of the health and social care community served.

***The Physical Ward Environment:*** *Inpatient settings should offer rehabilitative environments that enable the delivery of therapeutic care, and support patient recovery. They should also facilitate social interactions and activities, which help patients regain their independence.*

RCOT has long recognised and advocated the vital need for rehabilitation environments. This aspect needs stronger recommendations so that this key component to treatment and recovery is structured, prioritised and adequately resourced. We believe that rehabilitation should be the central ethos of every inpatient service and every member of staff. Occupational therapists have expert skills in rehabilitation and feel that this approach needs to be shared with other professions so every single contact is an opportunity for skills development and learning. Inpatient services could then become true places for positive change.

This vision of the centrality of rehabilitation in inpatient care should be needs-led, joined up, holistic and based on what matters to the person so that rehabilitation, recovery, and readjustment can happen together.

***Supporting people in the community:*** *The*[*NHS Mental Health Implementation Plan 2019/20 to 2023/24*](https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/)*sets out the detail behind these commitments and how they will be implemented over the next four years, with information about how funding will be spent. We are currently testing the new models of integrated primary and community care for people with severe mental illnesses ahead of national roll-out from April 2021.*

RCOT support the testing of new models many of which already benefit from occupational therapy input and there are many opportunities for occupational therapists to influence service redesign, new packages of care and lead innovation at early stages of design and implementation.

Being able to access support that is local and community facing is crucial. Interventions offered by occupational therapists have to be multi-layered, flexible and led by the person’s occupational needs rather than their diagnosis. Support should be multi-disciplinary, multi -agency, wrapping around a person to offer step up/down, on/off with excellent links with all wider services that ensure occupational participation.

The occupational therapy offer should centre around and support the wider system offering advice and consultation to all. This should include bespoke clinical intervention where required and acute in-reach for crisis support to enable the person to develop strategies and skills to manage their care and situation. This empowering approach would represent a significant change of focus from the current medical model.

A key aim of reducing reliance on inpatient care and beds will need a greater number of occupational therapists focused on habilitation and rehabilitation pathways which are co-produced and co-delivered with people who have used services. Barriers to having needs met such as referral forms and drawn-out processes should be eliminated.

Community services will need close links with housing specialists, to support and up -skill providers, ensure that care plans have a rehabilitation focus and people can maintain tenancies, and continue to move to more independent living. This will free up the supported living resource for people that most need it. Early intervention by occupational therapists is required when placements are deteriorating. This approach will help manage the environment and be key to working alongside substance misuse, domestic violence and homeless services.

Community services will need access to specialists for example for people with neurodevelopmental conditions. Their advice will help to upskill staff working with people with co-occurring autism or ADHD to live successfully in the community and only come into hospital if and when absolutely necessary. A dedicated occupational therapy focus will be required for those who have become stranded in acute care.

***The Mental Health Workforce:*** *We have already committed to increasing both the level and staff skill mix on acute inpatient mental health wards. We will seek to help minimise unnecessary time spent in hospital, and at the same time improve outcomes, through the development of new roles and by increasing access to multi-disciplinary staff groups such as peer support workers, psychologists, social workers, occupational therapists and other allied healthcare professionals.*

RCOT agree that a correlation exists between access to occupational therapy input and decreasing length of stay in acute mental health units. We would be keen to work with the Department of Health and Social Care /Department of Health and Social Services (Wales) to explore the different models for increasing this access to help achieve the White Paper’s ambition in this area.

In addition to this, we would welcome further exploration of how to expand the non-medical AC/RC role which has grown among non-medical professional groups at an extremely modest rate. We believe further opportunities could be developed by working more closely with Health Education England (HEE) and Health Education and Improvement Wales who could promote the development of courses for non-medical ACs at Masters level, in keeping with the HEE Centre for Advancing Practice. This would help to embed HEE’s “Multi-professional Approved/Responsible Clinician Implementation guidance” which has an occupational therapy case study on page 42:

<https://www.hee.nhs.uk/sites/default/files/documents/Multi%20Professional%20Approved%20Responsible%20Clinician%20Implementation%20Guide.pdf>

It would also build on the work carried out by HEE’s “New Roles in Mental Health Allied Health Professionals Task and Finish Group”. This project had RCOT input and contains many occupational therapy case examples in Appendix 10 including occupational therapists:

* Working with City of London Police and other emergency services to help those where there is immediate threat to life and those who are high intensity service users due to mental distress
* Leading eating disorder intensive day services as an alternative to inpatient care
* Leading implementation of Safewards Calm Down Methods to reduce arousal during inpatient care

<https://www.hee.nhs.uk/sites/default/files/documents/AHP%20Report%20March%202019.pdf>

**Impact Assessment:** *Please send any numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on different professional groups and their workloads; ability to return to work or effects on any other daily activity for patients under the Act.*

Occupational Therapy Workforce

It is estimated that a third of the 40 000 strong occupational therapy workforce work in NHS mental health services and occupational therapy has been identified as one of the five key professions in mental health. The workforce grows by approximately 1000 new therapists every year and the number of training providers delivering occupational therapy courses is expanding.

Mental health occupational therapists are in high demand. Many mental health services and teams include and rely on the valuable contribution of occupational therapists. As a significant part of the workforce, occupational therapists are committed to moving away from traditional models of medicalised practice to one which focuses more on the everyday concerns of people. These are frequently about the most important determinants of health and life expectancy such as education, housing, employment and social support.

The consideration of daily activity is core to the profession and could be shared by whole teams, services and systems. For example, while occupational therapy posts should have employment as a key responsibility within their job specifications and can lead vocational services, everyone in the team should be able to intervene to some degree to address employment because it is one of the most important determinants of health.

Occupational therapists are moving out of traditional services and offering therapy in new, innovative, cost effective ways that reduce mental health stigma and give people speedier access to services. RCOT believe that by using our workforce for earlier intervention and prevention, we can focus interventions on outcomes that really matter to people, their families and carers.

For more information, please see “Getting my life back: occupational therapy promoting mental health and wellbeing in England/Wales”:

<https://www.rcot.co.uk/promoting-occupational-therapy/occupational-therapy-improving-lives-saving-money>

Case studies

RCOT believe that our members have responded positively and creatively as many parts of the health and care system have during the pandemic to ensure safe service delivery and for example, speedy discharge from inpatient care. The following are some case studies with different ways of working that could be scaled in other parts of the system:

# Ruth Hambling

Occupational Therapist

**The Challenge**

Shielding and subsequent home working meant I was unable to experience the changing ward dynamics due to the application of COVID regs and the impact this had on OT service delivery, yet being expected to respond to increased discharge pressures.

**The Change**

New admissions were screened by me via electronic records to predict the need for OT and prioritise allocation to a ward OT within 72hrs. A weekly meeting via video with the OTs from the 3 acute wards reviewed prioritisation and outstanding OT input.

**The Impact**

Quicker allocation of patients and targeted assessments expedited the OT process. Background information collected during screening reinforced patient centred care. Improved communication across the wards ensured better handover of care.

[**https://www.rcot.co.uk/node/3686**](https://www.rcot.co.uk/node/3686)

# Michelle a Foody

Mental health occupational therapist

**The Challenge**

To complete OT groups in the service (recovery through activity and decider) in a safe environment with clients, despite covid-19.

**The Change**

Requested to use video calling system attend anywhere for use with clients to be able to attend these groups virtually.

**The Impact**

Interventions were able to be completed safely via the groups, waiting lists dramatically reduced, clients mood improved and clients who were shielding could have social contact once again.

[**https://www.rcot.co.uk/node/3664**](https://www.rcot.co.uk/node/3664)

# Gemma Wormald

Occupational Therapist

**The Challenge**

Scoping a role for OT in a newly created Older Peoples Mental Health Covid-19 Gate Keeping ward, where average length of stay is less than 72hours. Assessing functional ability & occupational identity within the constraints of isolating in bedrooms.

**The Change**

Function & occupation are quickly assessed on admission, positively impacting on the Inpatient Occupational Therapy pathway. Personalised care is paramount from the start.

**The Impact**

Individuals have timely OT assessment, leading to strength based, personalised care plans. Ward based OT colleagues have a foundation for further assessment. MDT colleagues see OT working in a new rapid, responsive way.

[**https://www.rcot.co.uk/node/3626**](https://www.rcot.co.uk/node/3626)

# Tanya Stewart

Occupational therapy assistant practitioner

**The Challenge**

Leo was due for discharge from a mental health ward; in the community he would use boxing as a way of coping with his emotions. Due to COVID restrictions he would be unable to attend his local boxing club.

**The Change**

A standardised assessment (interest checklist) made staff aware of Leo’s interest in boxing. Staff helped Leo to apply for madCOVID charitable funds and to purchase a punch bag and other equipment to use on discharge.

**The Impact**

COVID will not deprive Leo of this occupation upon discharge. He will be able to continue with boxing and use it as a means to cope with his negative emotions/thoughts, reducing risk of relapse.

**The Challenge**

Hazel was admitted to an acute mental health ward following deterioration in mood. Her ruminative thoughts were consuming and although she sought reassurance consistently, this fed into her low mood. She was unable to engage in anything meaningful.

**The Change**

OT staff used personal information to write positive affirmations and Hazels important values on coloured stars to place on the wall in her room e.g.” I love and care for my animals, therefore I am a caring person” and “I am human not perfect”.

**The Impact**

Hazel used the cards to aid in challenging her ruminative thoughts. She was able to do this independently, rather than seeking reassurance from staff. This helped break the cycle of her thoughts; allowing her to engage in meaningful activity.

**Share your story:**

[**https://www.rcot.co.uk/node/3620**](https://www.rcot.co.uk/node/3620)

[**https://www.rcot.co.uk/node/3599**](https://www.rcot.co.uk/node/3599)

# Kirsty Thomas

Occupational Therapist

**The Challenge**

At the start of lockdown many patients wanted to be discharged or treated at home due to Covid-19. The patients that remained started experiencing occupational deprivation having limited meaningful activity, especially for those having to isolate.

**The Change**

The Occupational therapy team created personalised isolation kits for those we knew & created #stayathomekits booklets that included advice on how to keep occupied & how to structure the day on the ward & at home. These were sent home with patients.

**The Impact**

Patients who were isolated could occupy themselves productively e.g. making & writing a card to keep connected with family. Feedback from the home treated patients included that the kits were a 'lifeline'. As such CMHT patients were offered a kit.

[**https://www.rcot.co.uk/node/3595**](https://www.rcot.co.uk/node/3595)

# Sarah Fairham

Occupational Therapist Perinatal MBU

**The Challenge**

I work on an impatient perinatal mental health ward and the mums, babies and families receive a lot of practical and emotional support on the ward. The challenge was to make sure that the skills that were learnt of the ward transferred home.

**The Change**

I developed a full Occupational Therapy home assessment which enabled me to accompany mums and their babies home, to assess functioning at home, to support the transfer of skills and to enable simple problem solving at home.

**The Impact**

The impact is that mums get to practice being at home with their babies and partners before they are discharged from hospital, and to plan out their routines at home, practice going out to local activities and amenities, and to gain confidence.

[**https://www.rcot.co.uk/node/3002**](https://www.rcot.co.uk/node/3002)

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