Inspectorate of Mental Health Services

National Overview of Occupational Therapists Working in Mental Health Ireland 2012

Aim

As part of the Inspector of Mental Health Services' annual inspection of each of the 62 approved centres in Ireland and of community based mental health services nationwide, the inspectors routinely sought to meet with a representative group of clinicians, including health and social care professionals. All inspections were unannounced and as frontline staff were engaged in face-to-face service delivery, it was not always feasible to meet with a range of disciplines. To enhance the national overview of mental health services, the Inspectorate sought the views of the disciplines of occupational therapy, clinical psychology and social work in 2012.

The Inspector of Mental Health Services sought the views of occupational therapists (OTs) working in mental healthcare in relation to 1) their experience as practising OTs and 2) on how mental health service delivery might be improved. To this end: OTs working in mental health nationwide were asked to complete an online survey; were invited to participate in an open-forum discussion chaired by the Inspector; and those who were unable to attend the meeting were invited to make a written submission addressing the two topics above.

How views were sought and response rate

OTs were notified about the survey and the national overview meeting via email circulated to the Mental Health Advisory Group (MHAG) of the Association of Occupational Therapists Ireland (AOTI) and to the Health Service Executive (HSE) OT Managers with responsibility for mental health services. A total of 68 survey responses were received and it was estimated that this represented almost one in three OTs working in mental health in Ireland[1]. Thirty–two OTs attended the National Overview meeting on the 19th November 2012 in the Mental Health Commission offices. Several OT Managers informed the Inspectorate that they could not attend owing to the HSE embargo on travel with no funding for travel and in addition staff were not permitted to attend external meetings. Three written submissions were received also. The online survey asked ten questions:

1. What post do you hold?
2. In which Mental Health Service Catchment Area/independent Sector are you employed?

Boland, L. &[1]O'Reilly, A., AOTI MHAG Report on Occupational Therapy Staffing Levels in Mental Health Services in Ireland, October 2010.

3. Are OTs in your area members of multidisciplinary teams and if so what type of team?
4. In what way does OT contribute to the Individual Care Plan (ICP)?
5. Does an OT sit on the local or area health management team?
6. Do OTs receive regular supervision & training?
7. What unique skills does the OT bring to the multidisciplinary team (MDT)?
8. How are service users and carers included in your mental health service?
9. What contribution can OT make to the further development of a recovery approach to mental health services?
10. What are the particular challenges encountered by OTs working in mental health services now?

The response rate to each question varied as not every respondent answered each question.

Report Structure

This report 1) outlines the responses to the survey, 2) presents the key issues highlighted during the meeting and 3) the recommendations of the Inspectorate in relation to occupational therapists working in mental health in Ireland.

Survey Questionnaire Results

Q1. What post do you hold in mental health services?

Sixty-seven OTs answered this question: 11 were OT Managers (16.4%), 35 Senior OTs (52.2%), 21 Basic Grade OTs (31.3%) and 0 OT Aides/Assistants. As no OT assistants responded to the questionnaire there is no response included in Table 1. At the National Overview meeting four OT managers stated that there was an OT assistant post in their service and that the posts were very effective.
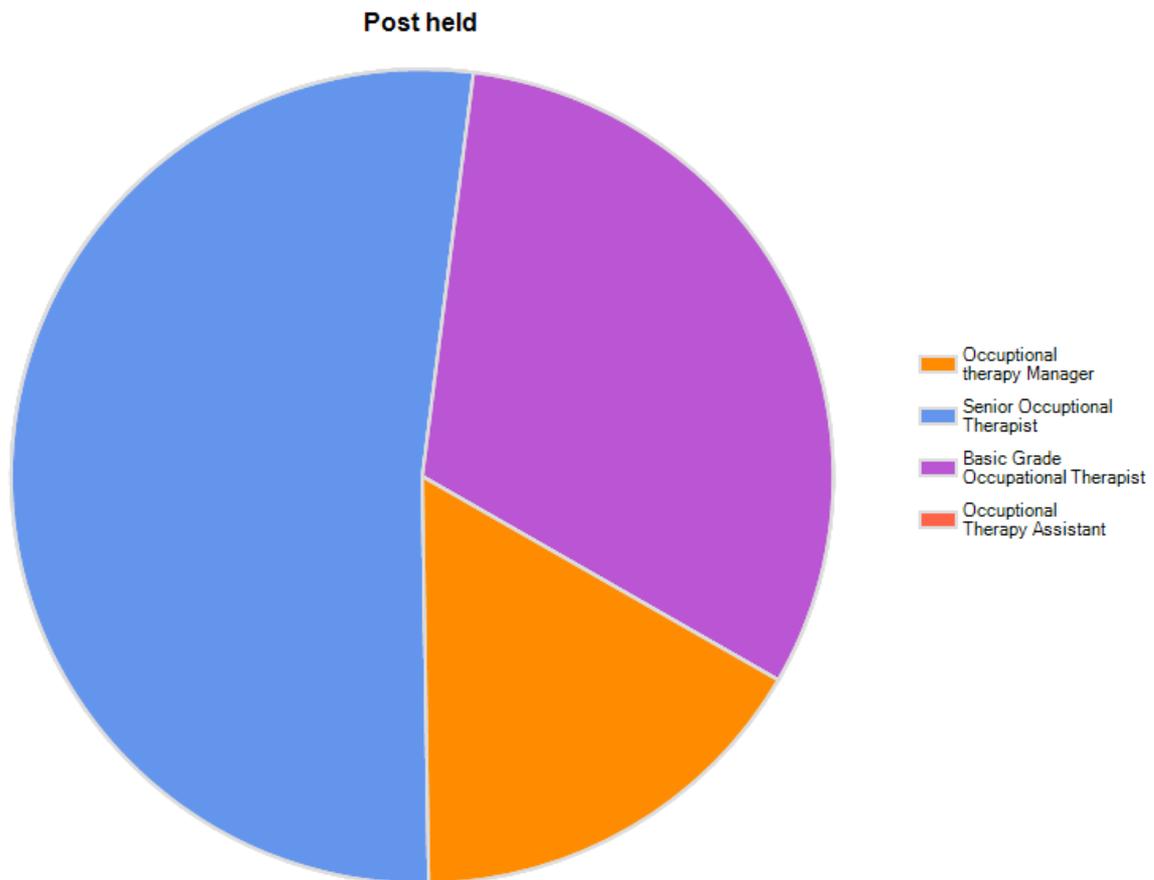
Post held

Legend:
- Occuptional therapy Manager
- Senior Occuptional Therapist
- Basic Grade Occupational Therapist
- Occuptional Therapy Assistant

Table 1: Post held.

Q2. What Mental Health Service Area do you work in?

Sixty-eight OTs answered this question and there was broad representation across all HSE areas.

Region	Number	Adult Mental Health Services	Child & Adolescent Mental Health Services	Other
HSE Dublin Mid Leinster	17	16 & 1 Forensic	0	0
HSE South	13	12	1	0
HSE West	13	12	1	0
HSE Dublin North East	18	16	1 & 1 Liaison	0
Independent Provider	7	5	1	1 TCD Unilink students' service
Total	68	62	5	1

Q3. Are OTs members of a multidisciplinary team? If yes, what team?

Table 3: Membership of MDT.
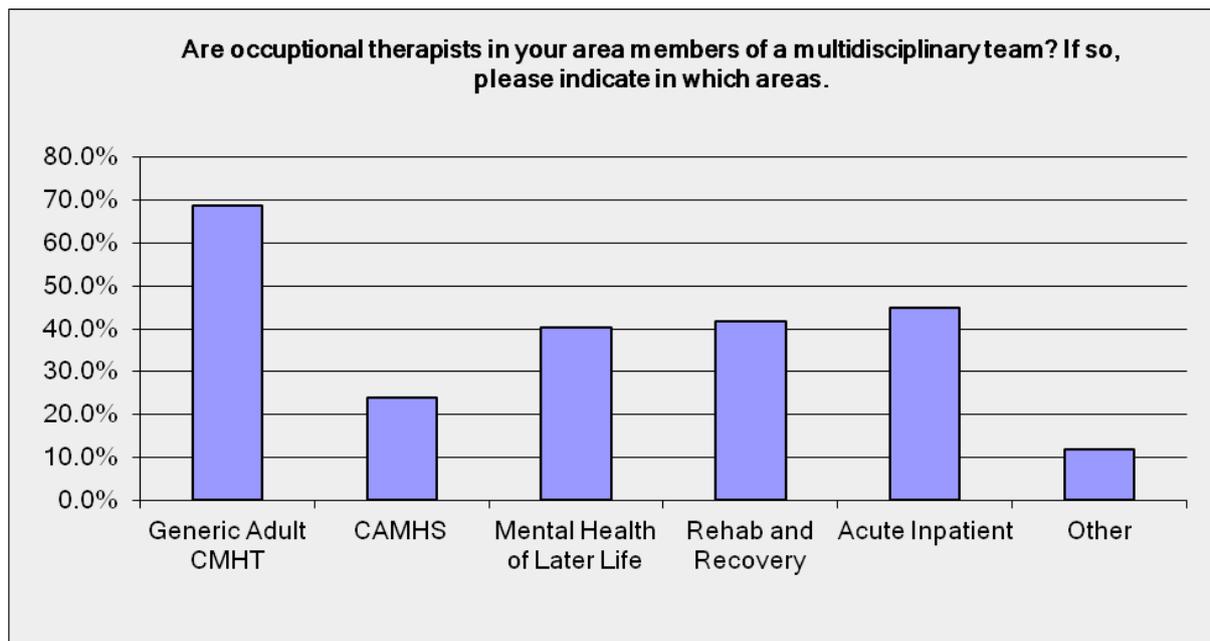
Sixty-seven OTs answered this question. Many OTs were members of more than one multidisciplinary team. Seventy per cent of respondents were members of community mental health teams (CMHTs). Seven OTs recorded "other" for team type, these included a university based student mental health service TCDs Unilink and the National Forensic Mental Health Service.

Q4. In what way does the OT contribute to the Individual Care Plan (ICP)?
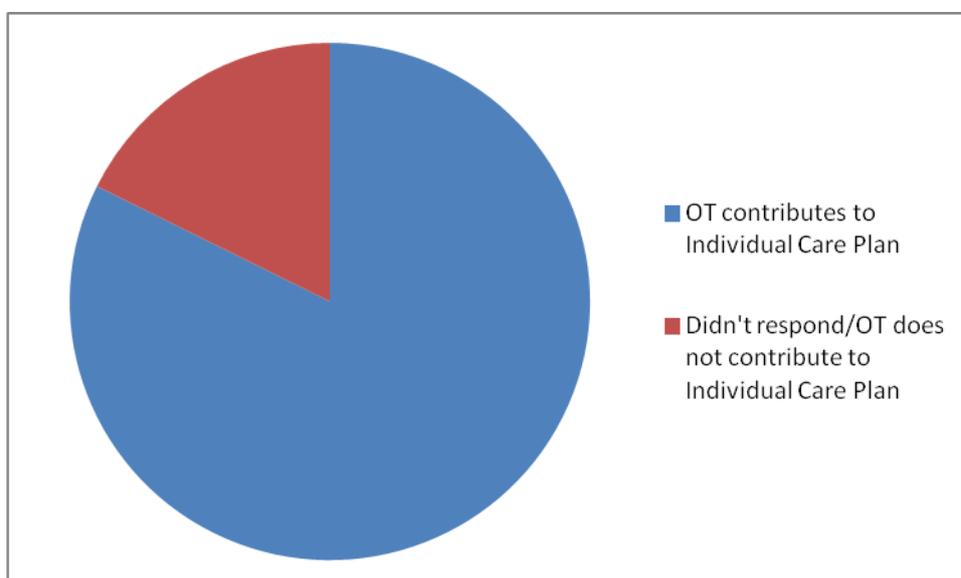

Table 4: Does OT contribute to Individual care Plan?

Sixty-two OTs answered this question and of these six said they were not involved in the ICP process. 6 OTs did not answer the question.

Answers from OTs not involved included: "ICPs not used by CMHT, just in approved centres. Not asked to contribute, seems to be a nurse led thing. Not used in our service yet". One OT stated "Fill in the plan if asked, always named on the plan" which may suggest that the MDT goes through the motions of engaging in the ICP process.

Comments from OTs who were engaged in the ICP process included, for example: "Taking role of Care Co-ordinator, contributing to discussion re content and problem identification of care plans with MDT. Advocating that care plan should be individualised for the person. Facilitating wellness group where care planning is one of the themes – encouraging service-users to be a part of care plan. Evaluating/auditing use of care plans as part of MDT working group"; "OTs focus on the service user's level of functioning at home and in their community, focusing on self care, productivity and leisure activities. They take a holistic approach to the person, taking in all aspects of their life outside of their diagnosis e.g., environmental impacts, social isolation etc. In this way they can offer a unique treatment approach incorporating individual assessment, goal planning, home visits, group programmes, community access etc"; "The OT provides important insights and support on the person's activities of daily living, education/vocational goals, independent living skills, leisure, communication skills

and social networks. The OT can help the person set achievable goals based on the assessment results and the care plans mark the progress the person is making with same".

Q5. Does an OT sit on the local and/or area mental health management team?

Sixty-seven OTs answered this question. Some OTs interpreted local to mean a mental health management team within a facility or sector as opposed to a local catchment or area management team. Many answers were qualified and these coupled with the ensuing discussion at the national overview meeting, would suggest that OT representation in management is not robust. Many OTs were not aware of their local mental health service governance structures and did not have representation into decision making as they do not have an OT manager. The "other" category represented a miscellany ranging from sitting on a national Child and Adolescent Mental Health Services (CAMHS) advisory group to project groups.
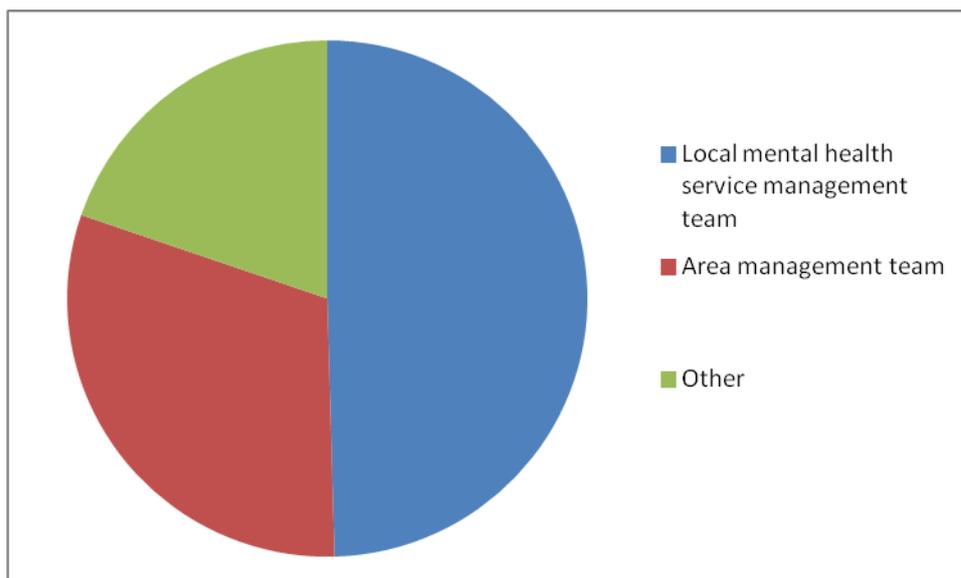

Table 5: OT representation on Management teams.

Q6. Do OTs receive regular supervision/training?

This question elicited the fewest responses with only 17 OTs answering this question. The clear picture presented was that there was no structured provision within the Health Service Executive for education and supervision of occupational therapists. This lack of supervision, combined with the national panel recruitment system and the current trend in recruiting entry grade OTs, had implications in terms of providing an effective quality service. OTs reported that they initiated supervision

themselves locally. Basic grade OTs appeared to fare better than other grades and some received supervision from senior colleagues. Very few senior grade OTs had access to supervision, and where it was available it was generally provided by the line manager which was seen as not always appropriate. Some OTs had been offered supervision by HSE administrative managers who would not have had the competence required to provide such supervision. Peer supervision was the most predominant model but was only three to four times a year. Training was severely limited and the embargo on travel within the HSE was in place at the time of the survey. Some OTs stated that they self-funded training and took personal leave to attend educational courses.

Q7. What unique skills does the OT bring to the multidisciplinary team?

Sixty-seven OTs answered this question and all reported clear role identity, confidence in professional practice, needs-led occupation focussed assessment and interventions, and a client-centred, outcome and recovery oriented practice. The aspects highlighted most by respondents were:

- A focus on health through occupation across the lifespan
- Only profession wholly focused on self-care, productivity and leisure
- A strengths based functional perspective to occupational performance
- A holistic approach not limited to diagnosis
- Practice underpinned by theoretical models e.g., Model of Human Occupation, Wellness Model
- May use standardised assessments to analyse occupational performance and outcomes
- A client-centred approach to "Recovering Ordinary Lives"
- Occupational assessment and intervention to facilitate participation
- Activity analysis to facilitate the "just right" challenge
- Ability to adapt the environment to promote access and engagement
- A focus on meaningful occupation and client valued roles
- Trained in group skills
- Collaborate with service user, carers, family and communities
- OT is provided to mental health service users in a variety of settings such as schools and colleges, at home, in hospitals and in community based health settings, in social settings in the community and in the workplace

Individual care planning process and a recovery perspective were reported to be long established in both occupational therapy undergraduate training and in professional practice. Responses to this question indicated that OTs were clear about what was the core role of OT within a multidisciplinary team, however, many

reported a conflict between the service demands to deliver a generic mental health role and maintaining an occupation therapy role.

Q8. How are service users and carers included in your service?

Sixty-seven OTs answered this question and gave a broad perspective in terms of how service user and carer voice is facilitated both in clinical and service development areas. The identified areas are listed in the table below. Some respondents focused on policy and committee input, others on individual care pathways. Those OTs who included the individual care planning process all stated that the service user was at the centre of the process.
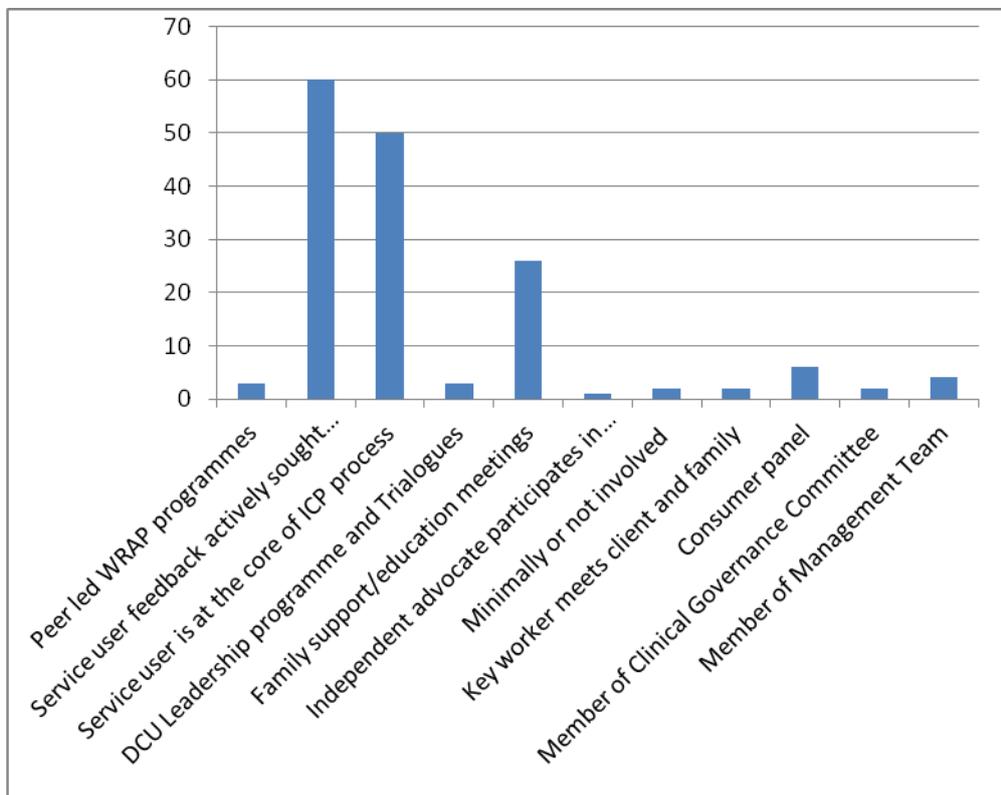

Table 6: Service User input to services

The respondents identified the following as examples of how service user voice is facilitated within their service.

Peer led WRAP programmes	3
Service user feedback actively sought (questionnaires, groups)	60
Service user is at the core of ICP process	50
DCU Leadership programme and Trialogues	3
Family support/education meetings	26
Independent advocate participates in groups with OT	1
Minimally or not involved	2
Key worker meets client and family	2
Consumer panel	6
Member of Clinical Governance Committee	2
Member of Management Team	4

Q9. What contribution can OT make to further the development of a Recovery approach in mental health services?

Sixty-seven OTs answered this question. All stated that the recovery approach was integral to the occupational therapy process, often described as "doing, being, becoming", and where the service user is seen as being the expert in their own recovery journey. Several OTs used the Recovery Star (A recovery based psychosocial assessment tool) to facilitate hope, responsibility and the setting of goals that are meaningful to the service user. Many expressed the view that incorporating a recovery perspective presented a challenge to professionals using a medical model of care and thus the OT could advocate on behalf of a service user in the MDT. Some OTs expressed the view that they worked in a risk aversive culture and this presented difficulties in facilitating recovery. Many OTs emphasised their role in providing information to service users to enable informed choices and decision making. Several OTs considered the availability of supervision and reflection on their practice as important to ensuring their faithfulness to recovery principles. Comments made included:

- "OTs need to be represented at a management level to advocate, advocate for service user values and hopes in care planning. Be involved in making /challenging service delivery to ensure it represents recovery principles, e.g., hope, responsibility, meaningful recovery oriented service – not paying lip services".

- "OT is one of the most influential health professions in pushing for a recovery approach to care in the service I work in. OT promotes the use of the Recovery Star to highlight that recovery is not just about symptom reduction/control, encouragement of group programmes to be needs led,

service user meetings with a clear line of communication with the service so that change is observable".

- "Providing accessible information on Recovery, written/pictorial information, education, groups, OTs are strong on facilitating people to make links between their everyday functioning/activities and how this is linked to recovery ".

- "OT can play a vital role in maintaining existing abilities and facilitating service users to achieve their full potential by encouraging and supporting engagement in meaningful activity and promoting independence in daily living skills. During a mental health crisis, service users can become de-motivated and inactive which if allowed to continue can become a persistent state. In line with the Early Intervention ethos, OT is uniquely placed to intervene and provide streamlined service from acute to community settings. At present, our staffing levels do not enable us to make the impact on recovery we would hope to achieve".

Q10. What are the particular challenges encountered by OTs working in mental health services now?

Sixty-five OTs answered this question. The most commonly identified challenges reported by OTs included:

- No resources or budget for OT interventions, no facilities/rooms for OT individual work, groups and functional assessments, no travel allowance for home visits, and no administrative support.

- No career path in OT, lack of OT manager posts and no supervision, no Continuing Professional Development (CPD).

- The lack of OT posts with OTs frequently spread across three sector teams was identified as a major challenge: this skewed service to be assessment focussed with little capacity for intervention and follow up, and there would be three MDT meetings to attend weekly, all of which created waiting lists.

- Respondents stated that the same low numbers did not apply in medical and nursing posts, and OTs were often single-handed and isolated, with OTs being members of team in name rather than reality, and MDTs were not functioning as such.

- Low numbers of OTs employed at senior level.

- Some OTs stated that there was a demand from management at a national level and from medical consultant led teams to see more numbers, so the service is more about quantity than quality. There was pressure to deliver more generic type groups and programmes. OTs expressed the view that key performance indicators were numerically focused and that there was no meaningful quality outcome focus within services. The view was expressed that service users should have input into identifying meaningful quality outcome measures.

- Working in a culture that is not Recovery oriented was deemed a challenge and consultant psychiatrists were perceived by OTs to be the most resistant to change in this regard. OTs considered that this increased the need for OTs to advocate on behalf of service users and their personal goals or preferences. A risk aversive culture and a high level of institutionalisation operating in some services was identified as a barrier to service user responsibility and hope.

- Challenge of balancing generic work (key working) versus core OT role, leading to dilution of skills, especially on poorly resourced teams.

- Lack of understanding of multidisciplinary roles from those who work in a medical model hierarchy, where psychotropic drug prescribing took precedence, often affecting the course of other team members' interventions, such as team members who do not work from that paradigm, e.g., OT, social work. Some OTs mentioned that they were only being referred a narrow range of clients. One OT cited a clinical director who did not see any need for OT on a Rehabilitation team.

- Panel recruitment system was deemed unsatisfactory to the delivery of a quality service. The absence of any clinical specialist roles within MH OT was considered a disadvantage to professional and service development.

- Tripartite decision making was identified as a re-emerging trend at management level.

National Overview Meeting of OTs Working in Mental Health

The Inspector of Mental Health Services invited OTs to meet and discuss a) issues arising from the survey, b) OT perspectives on current mental health services and c) to identify practical ways in which mental health services might be improved. Thirty-two OTs participated in this meeting on the 19th November 2012 in the Inspectorate offices. Many OTs had taken leave and self-funded their attendance as the HSE embargo on travel was in place. Three OT Managers who did not attend the meeting made submissions addressing the above issues. There was representation from General Adult Sector services, Psychiatry of Old Age services, Child and Adolescent Mental Health services, Adult Forensic Mental Health services, Rehabilitation services, Early Intervention Psychosis programmes and DETECT, Unilink student mental health service, Trinity College Dublin. The discussions arising are summarised below.

Discussion on issues identified in survey

Resources: The highest number of comments related to: OT resources being generally stretched with OTs covering more than one MDT, which then diluted the OT service; no monies being provided for OT interventions and materials; in a resource stretched mental health service OT posts were often dropped to divert funding to nursing posts. OT posts in mental health nationally were estimated to be 191 whole-time equivalent posts which fell well short of the recommendations of *A Vision for Change*. The number of OTs providing services was stated to have reduced since July 2011 when the HSE embargo on recruitment was applied, including the non filling of maternity leave posts. The view was expressed that there were as many OT posts in mental health in Northern Ireland as in the Republic of Ireland.

MDT functioning: Many OTs considered that their MDTs were not functioning in an effective multidisciplinary manner; team members often had poor knowledge of the role of OT and referrals for OT might be inappropriate or late in the care process; clash of values; risk aversive culture and focus on symptom alleviation rather than the context of illness and living. OT needs to maintain an occupational focus on functional performance in everyday living and not be diluted with more generic activities.

 Recovery: Views were expressed that the focus in many services is the reduction of symptoms of illness in the service users, OT's focus on wellness rather than the disease model, health is more than the absence of disease. Many felt that services did not have a recovery culture and that renaming of a program or service as "Recovery" was misleading and did not foster a culture or awareness of recovery values and practice.

Services not equitable: Some OTs stated that in their experience mental health services were not delivered on an equitable basis in Ireland and that access to care and quality of care was often dictated by geographical location rather than agreed clinical care pathways. The establishment of the National Group for Clinical Care Pathways in Mental Health was broadly welcomed and the need for adequate resourcing and education was noted to support effective service delivery.

Governance: There was a view that decision making had become more centralised and traditionally tripartite, comprising management, nursing and medical. The implementation of the ECD posts was considered to have reverted management practice into a tripartite system. The lack of OT managers in place was a concern. Clearer and more transparent management processes and structures were needed with adequate representation from all allied health professions, including OT. Many OTs were of the view that quality was not on the agenda in service delivery and that there was a skewing of focus onto reducing acute bed numbers without enhancing and delivering needs led and evidence based care pathways in the community. Current audit practices and key performance indicators were perceived to be predominantly numbers based with no meaningful outcomes focus. Some OTs reported that risk management was not used within their service and that this contributed to a risk aversive culture.

OTs also expressed the view that governance had become more centralised within the HSE with the result that monies scheduled for mental health services were siphoned off or redirected elsewhere in the health system.

Recruitment, Supervision and Continuing Professional Development: There was unanimous and strong agreement amongst attendees that the panel system of recruitment within the HSE was not fit for purpose from an OT perspective. Countries such as New Zealand and Canada were cited as having well regarded OT mental health services and national panels for recruitment were not used. The lack of provision of supervision and education was of serious concern, especially with the focus on employing basic grade OTs into systems with poor governance structures. Educational resource structures were in place for some professions such as medical and nursing but not for health and social care professionals. Basic grade OTs reported being asked to implement services, especially in the community, that do not match the HSE/Therapy Project Office professional competencies for OTs guidelines[2] . The lack of a career structure, including clinical specialist roles was a concern.

Needs Led and Evidence Based Service: Many attendees expressed the view that: services were not being delivered according to identified needs and in keeping

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[2]Therapy Project Office, 2008, *Occupational Therapy Competencies*, HSE, AOTI, ISCP ,IASLT.

with evidence informed practice; there was increasing demand on OTs to deliver generic style groups to larger numbers of service users.

Suggestions from OTs for an improved mental health service

The suggestions for an improved mental health service made by OTs included:

- The establishment of a National Mental Health Directorate with budget for mental health services.

- Investment in early intervention and prevention programmes.

- The prioritisation of community based services with sufficient OT posts on CMHTs as per AVFC.

- Governance structures to be developed to include: OT membership of management teams; OT manager post for every mental health catchment area; quality assurance programmes that are based on quality outcomes; adequate risk management processes to support recovery programmes and community based services; evaluation and education in relation to effective MDT functioning; increased consumer representation at all levels.

- The development of evidence based programme and care pathways: e.g., DETECT, recognition of the value of productivity/work in mental well-being, roles developed to meet need, e.g., job coaches, rather than based on traditional roles; increase service user input to developing meaningful outcome measures; service delivery evidence based and equitable rather than geographically driven.

- Supervision and continuing professional education should be provided by the employing agency.

- The abolishment of the current national panelling system of recruitment and replacement with a system that allows services to get the best available person for each post and enables clinicians to have a reasonable degree of choice of post and the potential for career pathway development, including clinical specialist roles.

- Provision of budget and resources to provide core/essential OT services.

In addition to the national overview meeting, three OT managers made submissions on OT services and challenges within their area. The views expressed and issues identified by them were reflected in the discussion at the overview meeting.

Conclusion:

There were an estimated 191 occupational therapists working in mental health services in Ireland in 2012. This figure fell well short of the government's own policy on the number of OTs required to provide a modern community based mental health service. In 2010, the Inspectorate estimated that just under a half of OT posts recommended in *AVFC* were in place. There had been a marked decline in the number of OT posts filled in the HSE since July 2011, posts falling vacant were generally not filled. The additional posts promised and allocated, via a Department of Health and Children €35 million ring-fenced in 2012 for the staffing of community mental health teams, had not been realised. Resources were identified as a key challenge by OTs. The OT participants, articulated a clear professional role identity within the MDT; had service users at the centre of their practice and concern; conveyed an ethically driven commitment to human rights based and recovery oriented care and treatment; and a desire to develop and provide evidence based therapies based on assessed needs. The key service issues identified included: inadequate resourcing to provide basic services and an increasing demand to provide generic type programmes; ineffective recruitment process; lack of career development structures and processes, including supervision, CPD and clinical specialist roles; poor level of needs based service provision with geographical location being the main driver; variation in MDT functioning and locus of decision making from team to team; the need for meaningful outcome measures that are service user led and not limited to numerically valued key performance indicators such as bed reduction days; need for more service user voice and representation; a need for robust governance processes and representation, including management teams, risk management and a National Mental Health Directorate.

Recommendations:

1. The number of OTs working on mental health teams should be in line with A Vision for Change recommendations.

2. There should be an OT Manager in each catchment area mental health service.

3. The current national panel recruitment system is deemed unsuitable by OTs and should be replaced with a more effective system which seeks to match candidates' skills and interests with specific roles or areas of work.

4. Supervision and continuing professional development should be provided for OTs.

5. Governance structures should be enhanced to ensure more representative management teams, including OT representation and consumer representation.

6. Services should be needs led and based on meaningful outcomes with agreed care pathways.

7. Access to services and advocacy should be equitable and not based on geographical location.

8. OT services should be resourced with allocated budget provision.

9. Multidisciplinary team functioning should be enhanced through open dialogue, team building and education.

10. Recovery principles should underpin all service delivery and not be reduced to a rebranding of traditional services.