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Occupation-centred practice: perspectives of occupational therapists working in acute mental health care

by

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DECLARATION

I, Jenna d'Oliveira, student number 23046296 hereby declare that this dissertation, "Occupation-centred practice: perspectives of occupational therapists working in acute mental health care" is submitted in accordance with the requirements for the Magister Occupational Therapy degree at University of Pretoria, is my own original work and has not previously been submitted to any other institution of higher learning. All sources cited or quoted in this research paper are indicated and acknowledged with a comprehensive list of references.

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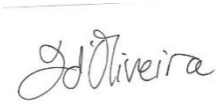
Jenna d'Oliveira

November 2020

ETHICS STATEMENT

The author, whose name appears on the title page of this dissertation, Jenna d'Oliveira has obtained, for the research described in this work, the applicable research ethics approval from the University of Pretoria Research Ethics Committee: Approval number 467/2019.

The author declares that he/she has observed the ethical standards required in terms of the University of Pretoria's Code of ethics for researchers and the policy guidelines for responsible research.



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Jenna d'Oliveira

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DEDICATION

I dedicate this research to all the occupational therapist working tirelessly in acute mental health care. Continuing to define and develop our profession around occupation, meaningful and purposeful engagement.

Thank you for sharing your perspectives with me so that we together could document a description of the practice that I hold so dear.

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To have achieved this milestone in my life, I would like to express my sincere gratitude to the following people:

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- Last, but not the least my family, especially my husband who loved and supported me in this journey and my children who constantly encouraged me to finish what I started.

ABSTRACT

Introduction

The prevalence of mental disorders is rising across the world and in South Africa driving the need for effective, occupation-centred practice in acute mental health care. In the acute setting, however, many occupational therapists experience challenges to practising in an occupation-centred manner. Occupation though remains the core construct of occupational therapy and occupational therapists everywhere are being urged to rediscover the power of occupation and embrace, develop, and maintain an occupation-centred practice.

Aim

This study aimed to describe occupation-centred practice from the perspective of occupational therapists working in acute mental health care, in and around the City of Tshwane, South Africa.

Methodology

A qualitative, explorative, descriptive design was used. Through maximum variance purposeful sampling nineteen participants were recruited to two focus groups. Transcriptions were analysed using the six steps of thematic analysis as described by Braun and Clarke to construct themes.

Results

Four themes were constructed namely, 1. The process of occupation-centred practice, 2. Activities enable occupation-centred practice, 3. The theoretical underpinnings of occupation-centred practice and 4. Influencers of occupation-centred practice.

Conclusion

Occupational therapists confirmed the centrality of occupation in their practice and further described occupation-centred practice as a process that entails the use of activities to facilitate experiences. Theoretical constructs that were helpful in guiding occupation-centred practice were highlighted. Influencers were experienced as either supporting or constraining occupation-centred practice.

Significance

This study contributes to the evidence base of the profession in South Africa, ensuring that Occupational Therapy maintains its unique role and contribution to acute mental health care.

Key terms / concepts: Occupation-centred practice, acute mental health care, perspectives, occupation

LIST OF ABBREVIATIONS

Abbreviation / Acronym	Meaning
ADL	Activities of Daily Living
AOTA	American Occupational Therapy Association
APOM	Activity Participation Outcome Measure
CINAHL	Cumulative Index to Nursing and Allied Health Literature
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders, 5th edition
HPCSA	Health Professions Council of South Africa
IADL	Instrumental Activities of Daily Living
MHCU	Mental Health Care User
OT	Occupational Therapy
OTPF	Occupational Therapy Practice Framework, 3rd edition
SASH	South African Stress and Health
UFS	University of the Free State
UP	University of Pretoria
VdTMoCA	Vona du Toit Model of Creative Ability
WFOT	World Federation of Occupational Therapists
WHO	World Health Organization

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CHAPTER 1
GENERAL ORIENTATION

1.1 INTRODUCTION AND BACKGROUND

Globally and in South Africa in particular, the burden of mental disorders is continually increasing, significantly impacting health, social and human rights as well as having adverse economic consequences.[1-4] The findings of the South African Stress and Health Study completed in 2009, the most recent study of its kind, indicates that almost a third of South Africans will experience a mental disorder in their lifetime.[5] More recent figures from private medical aids indicate substantial increases in pay-outs for mental disorders and hospitalisations for mental disorders year on year.[2,6] The South African Depression and Anxiety Group in their published Mental Health Fact Sheet report that mental health impairments are the third-largest contributor to the burden of disease in South Africa.[7]

Mental Health Care Users (MHCU) experiencing symptoms of acute mental disorders such as depression, bipolar disorder, schizophrenia, and other psychoses are admitted to mental health care facilities, where they are introduced to occupational therapy. [8-10] At these facilities the occupational therapist fulfils a unique role, to integrate the MHCU back to daily life and enhance occupational engagement and performance.[9-10] In this role, four important tasks are completed by an occupational therapist as suggested by Lloyd et al.[9]: individual assessment and intervention, therapeutic groups, and discharge planning. Throughout these tasks, an occupational therapists' focus is the occupational functioning and enablement of the MHCU with particular emphasis on the therapeutic use of meaningful, relevant occupations and/or activities to achieve health and well-being.[10-12]

Occupational therapists collaborate with MHCUs to enhance their performance skills in order for them to be more capable of performing their occupations, which include activities of daily living (ADLs), instrumental activities of daily living (IADLs), leisure pursuits, work, education, rest and sleep, and social participation as categorised by the Occupational Therapy Practice Framework (OTPF).[13-14] Ikiugu et al.[15] found that

occupational therapy based on occupation-centred theoretical frameworks may be effective in improving the occupational performance and well-being of MHCUs and should therefore be an integral part of rehabilitation services in mental health. Occupational therapy has a distinct value for people with, at-risk of, and without mental health challenges in promotion, prevention and intervention across the life span.[16]

Occupational therapy relies on occupational science, the scientific study of people as occupational beings, to develop the profession.[17] Occupational scientists are interested in how occupational therapists use occupation in practice and continue to encourage occupational therapy to adhere to its core belief of occupation as instrumental in the restoration and maintenance of health and well-being.[18-19] There are multiple defining features of occupation.[20] One such feature is that occupation is, in part, a subjectively determined experience, with meanings being subjectively attached by individuals to create their occupations.[20] Occupations are defined as the everyday activities that people want to, need to and are expected to do as individuals, in families and within communities to occupy time and bring meaning and purpose to life.[13,21] Occupation is inextricably linked to the four experiences of being, doing, becoming and belonging.[22]

The roots of occupational therapy are deeply embedded in the use of occupation to achieve health and well-being.[23] The OTPF[13] states that "achieving health, well-being and participation in life through engagement in occupation is the overarching statement that describes the domain and process of occupational therapy in its fullest". Fisher[24] quotes personal communication with Wood when referring to occupation:

"My image is of planets rotating around the sun, obviously with the sun being the ''occupation'' that keeps all else in its gravitational pull as a kind of inescapable relational centring force."

Fisher[24] uses the term occupation-centred practice to describe a core understanding of the centrality of occupation, viewing people as occupational beings foremost and using occupation as the framework for intervention.

Occupation-centred practice implies setting explicit occupation driven goals in a client-centred manner, to ensure the relevance of the intervention. Iwama[25] argues that occupation is required to be relevant to the MHCU and their occupational needs in their day to day lives for it to be of value to society and to fulfil its healing potential.

Occupation-centred practice is established using occupation-focused and occupation-based practice.[24] During occupation-focused practice engagement in occupation is clearly stated as the goal of the intervention or evaluation although the occupation itself is not included in the actual intervention session.[24,26] An example of such practice is the inclusion of a discussion regarding sleep routines to improve engagement in the occupation of rest and sleep. The goal of the intervention is focused on the occupation of sleep and rest, but the MHCU does not participate in the occupation that involves sleep and rest during the intervention. Occupation-based practice entails involving the MHCU directly in an occupation as the evaluation or intervention.[24]

Occupational therapists' world view or perspective is important as it will influence the way they professionally reason and thus practice.[27-28] Professional reasoning, as described by Schell, [29] refers to how therapists are actually thinking when they are engaged in practice. Hooper[28] and Aiken et al.[30] highlighted that the occupational therapist's own values, beliefs, experiences and assumptions have an impact on their understanding of occupation and its meaning and will influence their professional reasoning and therefore the implementation of the therapy process.

Undergraduate occupational therapy curriculum also influences the values, beliefs, experiences and assumptions of students regarding occupation as they progress towards graduation.[27] A curriculum centred around occupation, or an occupation-centred curriculum, where occupation is taught as a central organising concept is, therefore, a precursor to occupation-centred practice.[27-28,31]

1.2 PROBLEM STATEMENT

Occupation-centred practice is advocated for by various authors who propose that occupation-centred practice is what occupational therapists should be striving towards.[24,30,32-38] Fisher[24] in particular challenges occupational therapists to stay true to their mandate of being occupation-centred and implement evaluations and interventions that are occupation-based and or occupation-focused, thereby ensuring that occupation is at the centre of practice. If occupational therapy graduates are to aspire to occupation-centred practice, educational programmes are required to implement an occupation-centred curriculum.[17,27,31,39-40]

The Occupational Therapy Department of the University of Pretoria in their 2018 strategic plan resolved to implement an occupation-centred curriculum, thus rising to the challenge presented in the literature.[27,36] However, Kielhofner[41], and Vermaak and Nel,[42] cautions that a discrepancy between education and practice, specifically when education is occupation-centred yet practice still relies heavily on the medical, impairment focused models, may result in a theory-practice gap.[41-43] A theory-practice gap is described by Kielhofner[41] as a gap between the everyday practice of occupational therapy and the vision of occupation-centred practice as described in the literature.[24] International research, especially in Australia is continually being conducted into establishing occupation-centred theory to guide curriculum formation.[43] However, there is a need to explore and describe the practice, implementation or 'doing' element of occupation-centred practice. Thus, the perspectives of occupational therapists working as clinicians in the field, regarding occupation-centred practice are sought.

A 2017 study by Hess-April et al.[44] investigated the experiences and perceptions of occupational therapists working in a tertiary general hospital regarding occupation-centred practice and found that occupational therapists view occupation-centred practice as being effective in enhancing occupational engagement and participation. The authors note that their study findings may not apply to all settings, and fields of practice of occupational therapy.[44] They thus encourage research in specific fields of occupational therapy practice to broaden understanding of the use of occupation-centred practice. There appears to be a paucity of literature regarding the

application and description of occupation-centred practice in acute mental health care with only recent Australian studies readily available.[35,45-46]

Supervising students and having practised as an occupational therapist in the field of acute mental health care, it is the researcher's experience that all too often occupational therapists working in the field of acute mental health find themselves working removed from occupation. An occupational therapist in this particular field often relinquishes occupation and occupation-centred models of practice to adopt more psychological frames of reference and biomedical models, due to overwhelming pressure to do so because of the predominantly impairment focused setting.[35,45] These discourses, models and frames of references borrowed from other health care domains have different views of well-being and thus may challenge the occupational therapists use of occupation-centred practice.[35]

Furthermore, participants in one study reported feeling like less of an expert when not using psychological frames of reference and reported feeling inadequately trained and unable to defend their use of occupation.[45] When occupational therapists move away from occupation-centred practice, they lose sight of relevant and meaningful occupation, which is the core construct of the profession.[41]

Aiken et al.[30] reported that the occupational therapists in their study found themselves dealing with two realities, the first the way occupational therapy *was* practised in the hospital and the other the way they felt occupational therapy *should be* practised. The discrepancy and incongruence between the two realities Aiken et al.[30] termed the meaning gap'', where the participants, struggled to find meaning in their own occupation.[30] This gap leads to a decrease in job satisfaction as mentioned by Ashby et al.[35] when occupational therapists find themselves having to tap into their professional resilience and adopt a more assertive stance to defend occupation-centred practice in mental health, a field that was found to be dominated by biomedical and psychological knowledge discourses. There is thus a need to explore the perspectives of occupational therapists practising in acute mental health care, tapping into their wisdom and encouraging critical reflection of current practice with the aim of understanding and describing the practitioners' perspectives in order

to develop and maintain occupation-centred practice while informing undergraduate theoretical and practice education curriculum.[34-35,47]

1.3 RESEARCH QUESTION

What are the perspectives of occupational therapists working in acute mental health care on occupation-centred practice?

1.4 RESEARCH AIM

To explore and describe the perspectives of occupational therapists working in acute mental health care on occupation-centred practice.

1.5 DELINEATION

This study explores and describes the perspectives of occupational therapists practising in acute mental health care facilities in and around the City of Tshwane, Gauteng Province, South Africa. It will not include those working in chronic mental health care or those working elsewhere in the country. It will not include those occupational therapists that work exclusively with MHCUs with chronic mental disorders or those who are not actively involved in both the occupational therapy evaluation and intervention.

1.6 CLARIFICATION OF KEY CONCEPTS

Acute mental health care: According to the Mental Health Care Act No 17 of 2002 acute mental health care is sought at "a health establishment, facility, hospital, clinic or specialised ward that provides care, treatment and rehabilitation services for mental health care users acutely ill with a mental disorder".[48] In this study this definition will be applied.

Acute mental illness: "Acute mental illness is characterised by significant and distressing symptoms of a mental disorder requiring immediate treatment. This may be the person's first experience of mental illness, a repeat episode, or the worsening

of symptoms of an often-continuing mental illness. The onset is sudden or rapid and the symptoms usually respond to treatment''.[49]

Belief: "Is a feeling of certainty that something exists, is true or is good", also described as a strong opinion.[50]

Evaluation: In this study, evaluation will refer to any assessment of the mental health care user or users conducted by an occupational therapist. Evaluation, as defined by the Occupational Therapy Practice Framework[13], is an on-going process focused on discovering what the service user wants to and is required to do, can do and has done as well as identifying the barriers and supports to health, well-being and participation.[13]

Intervention: "Consists of the skilled services provided by occupational therapy practitioners in collaboration with clients to facilitate engagement in occupation related to health, well-being, and participation".[13] In this study intervention will refer to occupational therapy interventions that occur in both an individual and a group setting.

Medical model: A term devised by psychiatrist R.D. Laing[51] in The Politics of the Family and Other Essays, as a "set of procedures in which all doctors are trained". In this study, the medical model will refer to a school of thought that considers mental disorders a consequence of purely physiological factors.[52]

Mental disorders: There are many different mental disorders, which present differently. They are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others.[8] Mental disorders include: depression, bipolar affective disorder, schizophrenia and other psychoses, dementia, intellectual disabilities and developmental disorders including autism.[1]

Mental health care: Services devoted to the treatment of mental disorders and the improvement of mental health in people with mental disorders or problems.[50] In this study, mental health care will refer specifically to care provided by an occupational therapy practitioner.

Mental health care user: As defined by the Mental Health Care Act No17 of 2002[48] "A mental health care user is a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally ill". This definition will apply to this study.

Occupation: As defined by WFOT[21] occupation in this study will refer to the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include the activities people need to, want to and are expected to do.[21] The Occupational Therapy Practice Framework[13] specifically mentions the following seven occupations: Activities of Daily Living, Instrumental Activities of Daily Living, Education, Work, Leisure, Social Participation and Sleep and Rest.

Occupation-centred practice: All actions in occupation-centred practice are either based on occupation or have occupation as their focus.[24] This is the broad view the occupational therapist adopts, and it informs clinical practice. Occupation-centred practice is actioned through occupation-based practice and occupation-focused practice.[24] To adopt a world view of humans as occupational beings and therefore ensuring all aspects of the occupational therapy process, including evaluation and intervention, have at their centre occupation.[24]

Occupational engagement: is defined as the opportunity that occupation offers service users to fulfil their needs and wants.[53]

Performance skills: are considered a classification of actions, encompassing multiple capacities (body functions and body structures) and, when combined, underlie the ability to participate in desired occupations and activities.[13] Performance skills include motor skills, process skills and social interaction skills.[13]

Perspective: The Collins English Dictionary[50] defines perspective as "a particular way of considering something based on one's beliefs and experiences".[50] In this study this definition will be applied relative to the perspectives of occupational

therapists in terms of occupation-centred practice. These perspectives are ones considered views of occupation-centred practice which are influenced by one's understanding, beliefs, and experiences.

Practice: "The actual application or use of an idea, belief, or method, as opposed to theories relating to it" as defined by the English Oxford Dictionary[54] and applied in this study as the actual application of occupation-centred theories or models.

Theory practice gap: This term, as defined by Kielhofner,[41] will be used in this study, when referring to the gap between everyday occupational therapy practice and the vision of occupation-centred practice as articulated in the literature.

1.7 ASSUMPTIONS

1.7.1 Paradigm

This study develops from an interpretive paradigm.[55] The realities or perspectives of the participants are given meaning by the participants and then interpreted by the researcher and described as such.[56]

1.7.2 Ontological assumptions

Ontological assumptions are the assumptions made with reference to the nature of reality.[57] Reality is viewed as subjective, differing from person to person in its construction through lived experience and interactions with others.[58-59] Each occupational therapist practices in a particular context, has a unique background, specific training, knowledge and experiences. Reality is therefore multiple as experienced and reported by these unique individuals. Each participant's perspective is valuable and provides important insights regarding occupation-centred practice.[60] Meanings are conveyed through language and the actions of the participants.[56] For the participant's world of meaning to be understood, the researcher was required to make use of interpretation.[56]

1.7.3 Epistemological assumptions

Reality is shaped by individual experiences and interactions and is co-constructed by the participants and the researcher.[59] As knowledge is subjective, it is imperative for the researcher to understand the perspectives of the participants. The researcher immersed herself in the subject and context to understand and interpret the meanings the participants constructed as their reality.

1.7.4 Methodological assumptions

Data were gathered by asking the participants for descriptions about the meanings they attach to the phenomenon of occupation-centred practice as well as their experiences within the field of acute mental health care. Directing the enquiry to interpret the participants' perspectives regarding occupation-centred practice, the phenomenon under investigation, questions asked by the moderator of the focus group were broad, open-ended so as not to limit the participants' perspectives.[61] This contributed to ensuring that the process was inductive with themes and categories being identified from the data. Meaning was generated from the data collected, in a bottom-up manner.[60] These perspectives and descriptions were elicited and understood as well as interpreted through social interactions and language between the participants and the moderator.[56] The detail was understood in context; the data received from each participant was considered in context.[60] The researchers' own perspectives, background and experiences influenced the interpretation of the data and were closely monitored through reflexivity.[62]

1.8 SIGNIFICANCE OF THE RESEARCH

1.8.1 Theory practice gap

This study provides a description of the practice element of occupation-centred practice in acute mental health care indicating the possibility of an emergent theory-practice gap.[41] Active strategies in terms of curriculum development could be introduced if necessary, to reduce and eliminate this emergent gap.

1.8.2 Occupational Therapy practice

Occupational therapists practising in acute mental health are given a platform to share their perspectives, experiences, and wisdom. This contribution forms a valuable part in the development of the profession. Understanding current perspectives and descriptions of occupation-centred practice in acute mental health care assists researchers, academics and practising occupational therapists in understanding the present picture of practice and therefore assists in developing the profession of occupational therapy.

Awareness of occupation-centred practice is created through participation in the focus groups, the occupational therapists practising in acute mental health care will through the focus groups be encouraging to engage in critical reflection of current practice. Critical reflection may lead to improvements in occupation-centred practice by occupational therapists leading to a more occupation-centred experience of occupational therapy for MHCUs. Increasing occupation-centred practice may also have a positive effect on the occupational therapists, reducing what Aiken et al.[30] terms the meaning gap. If the occupational therapists find more meaning in their work it may lead to higher levels of job satisfaction which may in turn attract more occupational therapists to consider working in acute mental health care.[30]

This study contributes to the development of targeted continued professional development events that may assist occupational therapists in establishing, developing, and/or maintaining an occupation-centred practice in their place of work. Achieving these feats assists in ensuring occupational therapy retains its unique role and contribution to acute mental health care.[27]

1.8.3 Undergraduate curriculum

The results of this study may assist in the development of both the theoretical and the practice education components of the occupational therapy undergraduate curriculum, ensuring that the curriculum used in undergraduate education is relevant and results in the formation of competent graduates that can confidently use occupation as the core of practice in acute mental health care settings. Yerxa[27]

suggests that the strength of occupational therapy “is connected with the power of those it serves through the knowledge of occupation” thus reminding us that a relevant, well informed and useful curriculum in terms of occupation taught to undergraduate occupational therapy students is essential as the values, beliefs and traditions of the profession are transmitted through the curriculum.[27] Estes and Pierce,[34] as well as Khayatzadeh Mahani et al.[31] also conclude that the implementation of occupation-centred practice is advanced through education.

1.9 CHAPTER OVERVIEW

Chapter one has outlined the background and explained the justification for this study; introduced the research question and aims. The philosophical assumptions which underpin this study were discussed and lastly, the concepts and or terms used throughout the study were clarified.

Chapter two will discuss relevant literature concerning the topic, providing a foundation of knowledge regarding occupation-centred practice. Gaps, inconsistencies, contradictions, and recommendations from previous studies will be discussed. The following headings will be used: mental health, occupational therapy in acute mental health care, occupation and occupation-centred practice in occupational therapy, implementation of occupation-centred practice, implementation of occupation-centred practice in acute mental health care.

Chapter three will detail the methodology of the study. Discussing the research design, data collection and data analysis procedures in details. The measures taken to enhance the trustworthiness of the study are explained. Finally, the ethical considerations implemented in the study are detailed.

The research findings and discussion are explained in chapter four. The themes are presented together with a detailed discussion of each theme and the corresponding subthemes. The discussion includes a comparison with relevant literature.

To conclude the study chapter five presents the contribution of the study, with a detailed critique of the study and discussion regarding the recommendations resulting from the study.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

This literature review will initially outline the method undertaken to access relevant literature. The concept of acute mental health care will be discussed in broad terms and then in terms of the South African context. Occupational therapy's role in acute mental health will be described and then further emphasis will be placed on the significance of occupation as a core concept in occupational therapy. A discussion regarding the implementation of occupation-centred practice in different parts of the world and different fields of occupational therapy will precede the final discussion which will report on current literature regarding the use of occupation-centred practice in acute mental health care.

2.2 METHOD

Literature for this review was assembled through searches of the EBSCOhost database as well as making use of WorldCat Discovery, an online cloud-based application that allows one to search local libraries as well as those worldwide. These platforms include all the major allied health research databases such as Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PubMed and the Cochrane Collection. The search was completed intermittently over a period from June 2019 to April 2020. The following keywords were used to search; ('occupation' OR 'occupational therapy' OR 'occupation-centred practice" (all variations of the spelling of centred were used), OR 'occupation-based practice' OR 'occupation-focused practice') AND ('mental health' OR 'acute mental health' OR 'mental disorder'). All available literature over the last ten years was searched, older literature included was discovered through the reference lists of found articles.

2.3 ACUTE MENTAL HEALTH CARE

The World Health Organization[63] (WHO) states that “mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life”. The World Federation of Occupational Therapy[64] (WFOT) concurs stating that “mental health enables people to realise their potential, cope with life’s usual stresses, work productively, and contribute to their communities”. The World Health Organisation[65] establishes the significance of mental health care when it states ‘the promotion, protection and restoration of mental health is of utmost importance to all people worldwide”. However, severe disturbances in mental health or mental disorders are becoming ever more prevalent, with WHO reporting that mental disorders are amongst the leading causes of disability and ill-health worldwide, the latest estimates indicate that approximately 450 million people globally suffer from such disorders.[8]

Acute mental disorders are characterised by a sudden onset of significant and often distressing symptoms that require immediate intervention.[49] While acute mental health care involves active intervention aimed at the apparent symptoms of an acute episode of a mental disorder, such care also includes all the interventions, medications and therapies, required to maintain gains in function and prevent relapse.[66]

In South Africa, recent statistics of those with mental disorders who are cared for by government mental health care facilities are not readily available. Whilst private mental health care facilities that provide acute mental health care are seeing an annual increase in admissions and are overshooting medical insurers predictions year on year as reported by Discovery Medical Aid, a large South African medical insurer.[67] The South African Depression and Anxiety Group (SADAG) reports based on the South African Stress and Health (SASH) study that the lifetime prevalence of depression in South Africa is 9.7%, that is 4.5 million people will experience depression in their lifetime.[68] Mental disorders have a serious impact on the economy of South Africa, SADAG together with Discovery Health report that R218bn is lost in productivity annually due to depression alone.[5,67] This highlights the need for effective acute mental health care.

Provision of care, intervention and rehabilitation for people suffering from mental disorders in South Africa, is guided by the Mental Health Care Act 17 of 2002.[48] This Act stipulates that mental health facilities are designated to "provide any person requiring mental health care, treatment and rehabilitation services with the appropriate level of mental health care, treatment and rehabilitation services within their professional scope of practice".[48] Even though there is an international drive for mental health care to occur at a primary health care level within the general health care system, the acute mental health care facility remains an important part of holistic health care.[65,69]

A mental disorder has a negative impact on the occupational engagement (participation in every day) and performance (to be active and productive in their communities) of a person, which may result in admission to an acute mental health care facility.[10] The acute mental health care facility is where the MHCU may encounter an occupational therapist, a mental health care practitioner who has been "trained to provide prescribed mental health care, treatment and rehabilitation services" to the MHCU.[48]

2.4 OCCUPATIONAL THERAPY IN ACUTE MENTAL HEALTH CARE

Occupational therapy has since its inception contributed to mental health care.[69] The World Federation of Occupational Therapy[64] in 2019 released a position statement; Occupational Therapy and Mental Health, in which it states that the role of the occupational therapist includes the facilitation of recovery for those experiencing mental health difficulties.

Occupational therapists enable participation in everyday life (occupational engagement), empowering service users to be active and productive in their communities (occupational performance), influencing health, well-being and quality of life.[64] The impairment in occupational engagement and performance of the MHCU admitted to an acute mental health care facility is the basis for the work of the occupational therapist in such settings globally.[10]

Lloyd and Williams[69] supported by Fitzgerald[70] report that the primary tasks of an occupational therapist working in acute mental health care facilities include individual evaluation and intervention, therapeutic groups and discharge planning. In addition, WFOT[64] describes the work of the occupational therapist in mental health to include skills training, education, group work, self-management and the employment of strategies to encourage social inclusion and participation. In this context, though, the focus is very much on evaluating and reducing target symptoms with psychopharmacological agents.[71] This hints at a predominantly medical model approach with the reduction of symptoms as the emphasis. However Lloyd and Williams[69] state that "mental health is now understood to have a far greater emphasis on assisting people to engage in life, or occupational roles than simply symptom reduction." The idea that symptom reduction is insufficient is strengthened by WFOT[64] who highlight that the philosophy of occupational therapy acknowledges that symptom remission is insufficient for complete recovery from mental disorders.

It is the opinion of Crouch and Shorten[71] that during admission the occupational therapist should facilitate the engagement of the MHCUs in activity both individually and in groups to evaluate and contribute to the diagnosis and treatment of the user, as well as returning the user to normal daily life.[10] The main focus of the occupational therapist during evaluation is to understand the dynamics of health, illness and the occupational functioning of the user.[72] Standardised assessments may prove difficult to use with MHCUs acutely ill with a mental disorder, resulting in clinical observations being a preferred method of evaluation.[10]

Activity selection should always be guided by that which the user finds meaningful.[10] Creek[73] further explains that the main intervention modality of occupational therapists are "therapeutic activities which are selected because they are meaningful to the service user and can be used to develop or maintain skills and contribute to the user's health and wellbeing". The World Federation of Occupational Therapy[64] calls occupational therapists experts in occupation, ensuring that service users' occupational needs and potential are met through meaningful and purposeful activity.

A wide array of therapeutic activities used by occupational therapists in acute mental health care are described in the literature, examples include self-care, leisure, daily chores, work-related, exercise, art and craft and social activities.[10] These activities can all be classified as forming part of occupations as classified by the Occupational Therapy Practice Framework (OTPF).[13] The inclusion of occupations in practice contributes to the idea of occupation-centred practice. If activities are linked to the MHCU's occupations, the activities will be meaningful to the user thus enhancing engagement. There is evidence to suggest that engagement in meaningful activities provides a feeling of flow and or mindfulness which in turn has a positive impact on the health and well-being of the mental health of the user.[74]

2.5 OCCUPATION AND OCCUPATION-CENTRED-PRACTICE IN OCCUPATIONAL THERAPY

Joosten[75] suggests that ensuring occupation is at the centre of practice involves; checking the knowledge that occupational therapists use, the professional reasoning that is applied to the evidence, and the goals set with service users as well as the accurate reporting of occupation that emerges through occupational therapy practice. Occupation-centred practice as described by Fisher[24] involves ensuring all elements in the occupational therapy process, including evaluation and intervention, are centred around occupation, meaningful and purposeful engagement. Fisher[24] suggests occupation-centred practice is actioned through occupation-based and occupation-focused practice.

Occupation-based practice implies that the occupation forms part of the evaluation or intervention, for example using the activity of preparing a meal as an evaluation or part of an intervention. Meal preparation and clean-up is an activity classified as an Instrumental Activity of Daily Living (IADL) occupation in the OTPF[13].

Occupation-focused practice implies that the occupation may not be participated in directly during the session however it is explicit that the goal of the session is to improve engagement or performance in the occupation. Another example of such practice would be a session around establishing effective shopping habits but

participation in the Instrumental Activity of Daily Living (IADL) occupation of shopping will not form part of the session.

Fisher[24] as well as many others[30,32-37] advocates for the focus of evaluation and intervention in occupational therapy to be on the occupation. The minimum standards for the education of occupational therapists released in 2016, by WFOT[76] calls for curricula that is occupation-focused, including occupation, as a means and as an outcome. An understanding of people as occupational beings is the unique contribution that an occupational therapist brings to health care.[77]

Occupational science, the study of people as occupational beings[78] continues to develop the way occupational therapists understand and use occupation in practice, and provides the groundwork for the unique contribution of occupational therapists to health care.[33,79]

Kielhofner[80] describes the history of the position and use of occupation in occupational therapy. He asserts that the profession of occupational therapy began with the first paradigm; where occupation was the centre of practice, highlighting the uniqueness of the occupational therapists' contribution. Meyer[81] in a 1922 paper titled The Philosophy of Occupational Therapy, highlights the importance of occupation as in this first paradigm describing the proper use of time in a gratifying, and helpful activity as being fundamental to intervention for a user with a mental disorder. Nothing better sums up this paradigm that the famous quote of Mary Reilly[82] "Man, through the use of his hands as they are energized by the mind and will, can influence the state of his own health".

This initial paradigm was followed by a shift towards a biomechanical and impairment focus, where pressure was exerted for occupational therapy to align with the medical model.[80]

Kielhofner[80] as well as Whiteford et al.[83] however, suggest that there is a movement within occupational therapy to return occupation as the central organising concept, this movement Kielhofner[80] refers to as the contemporary paradigm. This paradigm aims to reclaim and promote occupation as the primary means and end of

occupational therapy intervention.[80,84] The contemporary paradigm is highlighted by Yerxa[27] who states that occupational therapy's concern is not the diagnosis but rather the skills that enable the service user "to achieve their purposes and connect with the routines of their culture". The contemporary paradigm is constituted of three main themes. Firstly, the idea that occupation is intimately linked to health and well-being, secondly, that people can experience dysfunction in their occupations and thirdly, occupational therapy practice centred around occupation.[85]

Gustafsson et al.[38] suggest that the use of practices that are evidence-based but not occupation centred may hinder the progress of the contemporary paradigm. Joosten[75] suggests that barriers to implementation of occupation-centred practice arise when occupational therapists do not adopt and adhere to principles of occupational therapy conceptual models. This she argues leads to four concerns, occupational therapists not knowing what service users want to, need to or are expected to do, not choosing occupation-based outcome measures and not doing this in collaboration with the service user as well as not documenting in such a way that reflects the occupational engagement gains of the service user.[75] Thus, we lose the opportunity to highlight the unique contribution of occupational therapy.[75]

It would appear that occupational therapists in practice may be struggling to implement the ideals of the contemporary paradigm.[85]

2.6 IMPLEMENTATION OF OCCUPATION-CENTRED PRACTICE

A 2019 study by Di Tommaso et al.[85] found that recently graduated occupational therapists working mostly in acute settings in Australia found it difficult to implement occupation-based practice, preferring instead to focus on remediating impairments. For these participants, the pressure to practice in a manner that was acceptable and expected by other more senior occupational therapists and team members often included a focus on a medical model of practice served as an insurmountable barrier to occupation-based practice.[85] Similarly, in Japan it appears that impairment-based occupational therapy is more evident than occupation-centred intervention as reported by Nakamura-Thomas[86] however she too notes the momentum towards occupation-centred practice. An Iranian study studied facilitators of occupation-

centred practice in the country in an attempt to promote occupation-based interventions.[31]

The struggle seems to resonate in all fields of practice in occupational therapy. Robinson[87] found that more occupational therapists working in the field of hand therapy need to be encouraged to embrace occupation-centred practice so that they incorporate an occupation-based intervention approach.

A study exploring the perspectives of occupational therapists working in the field of paediatrics found that although participants found occupation-centred practice to be more rewarding, effective and individualised they also experienced that it was difficult to implement in a medical-based facility.[34] This was because they found that contextual factors, competing discourses, and pragmatic considerations exerted strong influences.[34]

The context seems to play a role in the implementation of occupation-centred practice. A South African study found that in tertiary hospital settings the nature of the service context created several barriers to the implementation of occupation-based practice.[44] This is echoed by Aiken et al.[30] who identified that occupational therapists working in a general health science centre experienced environmental constraints to occupation-centred practice, these included job pressures, time, budgets, medical models, and systemic issues as well as the clashing expectations of other staff, constraints of the work environment, and hospital policies. But one of the major findings of this study was that occupational therapists seem to battle to fully implement the ideals of occupation-centred practice as described in the literature.[30] Britton et al.[88] appear to summarise this when saying that the challenge for occupational therapists working in acute settings is to provide interventions that stay true to the occupation-centred philosophy of occupational therapy whilst still demonstrating value to the service user. Britton et al.[88] further mention that when occupational therapists working in an acute setting are unable to practice in an occupation-centred manner they struggle to clearly articulate their contribution in this setting.

A study by Jewell et al.[89] in a skilled nursing facility for older adults found that the majority of occupational therapy intervention time was spent on approaches that did not centre around or focus on occupation.

There appears to be a common thread throughout the above-mentioned studies. They all appear to indicate that occupational therapists, although they acknowledge and strive toward embracing occupation as the central tenant of the practice of the profession, struggle with the implementation of this in the clinical setting, across different contexts.

A study by Ikiugu et al.[90] attempts to remedy this and aims to guide occupational therapist in selecting and combining occupations for intervention. Ikiugu et al.[90] recommend a combination of what they refer to as meaningful and psychologically rewarding occupations in occupational therapy interventions. This they hope will lead to more positive therapy outcomes. Both psychologically rewarding and meaningful occupations require physical engagement however psychologically rewarding occupations have the added element of fun, which stimulates neural reward pathways. Ikiugu et al.[90] argue that these kinds of occupations should be optimally combined by occupational therapists to redesign service user's lifestyles such that health and well-being are improved.

Although much literature speaks to the challenges that occupational therapists experience in the implementation of occupation-centred practice there is a paucity in the literature in the description of current occupation-centred practice from the occupational therapist's point of view.

2.7 IMPLEMENTATION OF OCCUPATION-CENTRED PRACTICE IN ACUTE MENTAL HEALTH CARE

The challenges to the implementation of occupation-centred practice in acute mental health care are reported in an Australian study by Ashby et al.[35] who report that the influence of the medical model on occupation-based practices is significant in acute inpatient mental health facilities. Participants in this study reported that the focus of interventions was often on the reduction of service user's symptoms

through pharmaceutical interventions relegating occupational interventions.[35] Another Australian study similarly found that in some mental health care facilities there is a risk that occupation-centred practice can become disregarded, as more prominent discourses take precedence, causing tension in the work-life of occupational therapists practising in mental health care.[35]

The use of psychological frames of reference is one such discourse in mental health care, as reported on by Ashby et al.[45] in 2017. This study found that occupation-centred practices in acute mental health care may be threatened by the pressure felt by occupational therapists to utilise psychological frames of reference in an intervention.[45]

Only limited Australian literature appears to be available regarding the use of occupation-centred practice in acute mental health care, highlighting the need for a South African occupational therapy perspective regarding occupation-centred practice in acute mental health care.

2.8 CONCLUSION

Initially, the method for obtaining literature used in this review was explained followed by a discussion of available literature regarding mental health and mental disorders globally as well as the prevalence and impact of these figures locally in South Africa. Once the importance of mental health intervention was established, literature detailing the role of occupational therapy in the context of acute mental health care was discussed. The core philosophical construct of occupational therapy, occupation and relevant literature regarding this tenant and its application in occupation-centred practice was then detailed. Relevant literature regarding the implementation of occupation-centred practice, especially in acute settings and in different fields of occupational therapy, was then detailed. In closing, literature dealing specifically with the use of occupation-centred practice in acute mental health care was then discussed. The literature included above builds a solid foundation for this study and clearly illustrates the gap in the literature that this study will contribute towards filling.

The following chapter will present the methodology used in this study. The study design and approach will be discussed, followed by a description of the population and the sample. The processes followed in data collection and analysis will then be detailed, after which trustworthiness and ethical considerations will be discussed.

CHAPTER 3
METHODOLOGY

3.1 INTRODUCTION

This chapter will detail and discuss the method undertaken in this study. The research approach and design, as underpinned by the assumptions of the study, will be discussed after which the population and sampling will be described. A detailed discussion regarding data collection, data analysis and the ethical considerations of this study will constitute the last half of the chapter.

3.2 RESEARCH APPROACH AND DESIGN

A qualitative research approach was used in this study. Creswell and Creswell[91] suggest that this approach is most suited for exploring and understanding the meaning that groups or individuals ascribe to a phenomenon.

Denzin and Lincoln[92] describe qualitative research as *a set of interpretive, material practices that make the world visible*. They go on to explain that qualitative research seeks to understand or interpret phenomena in terms of the meaning that it brings to people.[92]

This study used a qualitative approach, as it seeks to understand and describe through interpretation the perspectives of occupational therapists regarding the phenomenon of occupation-centred practice in the specific context of acute mental health care. Whilst doing so, this study brought to the fore in the minds of the participants the concept of occupation-centred practice. This cognisance may have influenced their practice thus transforming the care they provide, in a small way changing the world.

An explorative, descriptive research design was used in this study.[93-94] The design is descriptive in that it aims to describe occupation-centred practice in acute mental health care from the perspective of occupational therapists. This design facilitates

the exploration of the participants' perspectives regarding the phenomenon of occupation-centred practice in a definite context, acute mental health care in the City of Tshwane, Gauteng Province, South Africa. This results in a contextualized description of these perspectives of the phenomenon.[94-95]

3.3 RESEARCH SETTING

Mental health care users acutely ill with a mental disorder are admitted to mental health care facilities for intervention. Occupational therapy is provided to these mental health care users by occupational therapist working at the facilities, either employed by the facility, renting space at the facility, or contracted to provide services. These include both government and privately funded facilities. Occupational therapy is offered as both individual and group intervention sessions in most facilities.

3.4 POPULATION AND SAMPLE

3.4.1 Target Population

Occupational therapists that were practising at acute mental health care units', wards, or facilities in government hospitals and or clinics and at acute psychiatric hospitals and day clinics in the private sector in the City of Tshwane in 2019 constituted the population of the study. After an internet search the population was estimated to be approximately 35 occupational therapists at the time of the study.

3.4.2 Sampling strategy and sample size

Purposeful sampling allowed the researcher to ensure that the participants who could provide a great deal of rich information regarding the central phenomenon in the study were selected to ensure depth in the data.[96-97] Maximum variance purposeful sampling allowed the researcher to ensure a heterogeneous group composition, aimed at enhancing the richness of the data.[97] Maximum variance purposeful sampling was used to recruit occupational therapists working in acute mental health care facilities in the City of Tshwane at the time of recruitment in September 2019. Heterogeneity in terms of place of work, years of experience in

acute mental health care, overall years of experience and place of study were considered.

Snowball sampling was used to ensure that the private practitioners working at acute mental health care facilities were included, as there was no other way of formally contacting them.[98] Literature provides a wide range for the ideal number of participants in a focus group, indicating that three through to 15 participants may be possible but approximately eight participants were preferable, allowing time to hear from each participant.[98]

3.4.3 Inclusion criteria

Occupational therapists registered with the Health Professions Council of South Africa (HPCSA) as independent practitioners who were actively involved in the evaluation and intervention of MHCUs who require acute mental health care.

3.4.4 Exclusion criteria

Occupational therapists who were involved in only the evaluation of MHCUs acutely ill with a mental disorder were excluded from the study, as well as occupational therapists who worked exclusively with MHCUs who require chronic mental health care.

3.4.5 Recruitment and sampling

Potential participants were identified by the researcher through an internet search of all mental health care facilities that provide care to acute MHCUs in the City of Tshwane. Each facility was then contacted to obtain the contact details of the occupational therapists working there. These occupational therapists were contacted by the researcher and sent a brief explanatory letter (Annexure A: Invitation to participate in research) about the study via email as well as a demographic information form (Annexure B: Demographic information form). They were asked to reply by 6 September 2019 with the completed demographic information form should they be willing to participate. Once the completed

demographic information forms were received, the researcher was able to allocate participants to groups in such a way that heterogeneity was maximised within the limits of availability. Participants were notified via email regarding the date of the focus group that they were allocated to. The informed consent form (Annexure C: Informed consent form) was attached to the email for their perusal.

3.4.6 Informed consent

The participants had an opportunity to peruse the informed consent form (Annexure C: Informed consent form) as it was sent to them as an attachment to the email which notified them of the group they had been allocated to. Informed consent forms were made available on the day of the focus group and signed by the participants prior to the commencement of the focus groups. A copy of the signed consent form was provided to each participant who requested one. Before signing the informed consent form, special mention of the following was made: the focus group would be audio recorded, although confidentiality would be encouraged it could not be guaranteed and the participants would receive an email with the preliminary results for member checking purposes. They would be asked to comment on if they felt the preliminary results were a true reflection of the group discussion that they had been part of. Participants were reminded that their names and the names of their places of employment would not be included in any reporting of the study.

3.5 DATA COLLECTION

3.5.1 Data collection procedures

Two focus groups were conducted. The final number of focus groups held were determined by data saturation.[61,98] Data saturation was considered to be achieved when no more new ideas or themes were emerging from the data.[99] The participants were assigned to a focus group making use of the demographic information they provided to ensure a heterogeneous group composition. The focus groups took place at the University of Pretoria, Prinshof Campus as this provided a neutral setting. The focus groups were conducted on a Friday afternoon, as the occupational therapy programme of most facilities is more flexible on a Friday

afternoon resulting in less of a disruption to occupational therapy services at the facilities. Each group ran for approximately 90 minutes.

An occupational therapist trained and experienced in the facilitation of focus groups served as the moderator for the focus groups. The moderator was required to sign a confidentiality agreement as seen in Annexure D. The researcher acted as an observer during the focus group taking field notes, noting possible themes and subtleties in the discussion and interaction in an unobtrusive manner.[61] The researcher took responsibility for the preparation of the area used for the focus group as well as the audio recording of the group.

The venue was prepared well before the commencement of the focus group. Chairs were arranged in a circular pattern around a table to increase interaction and feelings of security.[61] The focus groups followed the process suggested by Liamputtong,[61] which included the following stages: arrival pre-discussion, introductory, questioning, ending the group and after the session.

During the arrival pre-discussion stage, the participants were required to sign the informed consent forms (Annexure C) that they were sent to peruse on accepting a place in the group. Participants were reminded that the group would be audio recorded, as described in the informed consent form. At this stage, participants received a name tag to build better rapport and cohesiveness as well as allowing the moderator to address questions directly at a specific person.[61]

The introductory stage started with the moderator introducing herself and then introducing the researcher as the note taker. Each participant then introduced themselves to build confidence and to allow the researcher to differentiate between the different voices in the recording when transcribing the audio recording.[100] Confidentiality was discussed and encouraged, highlighting that anything shared in the group should remain confidential. The topic and aim of the focus group were then explained to the participants with the reassurance that no answers given to the questions would be considered incorrect and that they should freely interact with each other and may respectfully disagree with each other.[61]

A list of guiding open-ended questions formed the focus group question guide (Annexure E), this list was used to guide the questioning stage of the focus group.[61] To ensure relevant data were collected the question guide was informed by the research question as well as relevant literature[24] and personal experience of the researcher working as a clinician in acute mental health care. The question guide was reviewed by an expert, an occupational therapist with over five years of experience in qualitative research. Suggestions for changes made by the reviewer resulted in adjustments to the focus groups question guide. Open-ended questions ensured that the participants' perspectives were shared and that participants could construct the meanings that they attach to the process being researched, in this case, their perspectives of occupation-centred practice in their own work setting.[60] Probing, follow-up, specifying, direct and indirect as well as structuring and interpreting questions were used by the moderator to gather more in-depth, detailed data and to direct the discussion.[61] Repetition and rephrasing of the question was also used as a means of enhancing the credibility of the study.[62]

The focus groups concluded with the moderator debriefing the participants, asking if they would like to add anything and/or comment on their experience of the group. The participants were thanked for their participation and contributions.[61] Refreshments were provided after the focus group. The participants were reminded that they would be sent the preliminary results of the data analysis by the researcher and would be kindly asked to provide comment on the accuracy of these, how closely they feel the results represent the discussion during the focus group. This member checking served to increase the credibility of the study.[62]

3.5.2 Data Organisation

The focus groups were audio-recorded on a digital voice recorder and then transcribed verbatim by the researcher for analysis. Pseudonyms were used in the transcription to protect the participants' confidentiality. Any mental health care facility mentioned was replaced with a numerical value such as Facility 1 in the transcription. A first language English speaking independent person checked the transcriptions against the audio recording to ensure the accuracy of the transcription. This person was required to complete a confidentiality agreement, to

protect the identities of the participants (Annexure G). The recordings, as well as the transcriptions, were saved on two separate password-protected hard drives that were kept in two secure locations at the University of Pretoria, Prinshof Campus. All documents and external hard drives were kept in a locked office at the University of Pretoria, Prinshof Campus when not in use. Transcriptions were typed in a landscape orientated table in a word document. The left column contained the typed transcription whilst the right-hand column was empty initially. These tables were printed. Words with meaning were highlighted manually. Hand-written notes were filed and stored in a secure office. Each note was dated. Data organisation and analysis commenced directly after the first focus group.

3.6 DATA ANALYSIS

Data analysis was inductive, in keeping within the interpretivist stance of the research.[101] An inductive approach facilitates an understanding of the meaning of complex raw data through interpretation and reduction to themes.[102] Creswell and Creswell[91] further suggest that in qualitative research data analysis happens inductively building from details to general broader themes, a bottom-up approach. Creswell and Creswell[91] further suggest that the researcher's interpretation of the meaning of the data forms part of the analysis.

Transcriptions were analysed by the researcher making use of reflexive thematic analysis as described by Braun and Clarke.[103-104] Data analysis commenced after the transcription of the first group.[98] A suggested guideline to analysing the data was followed by the researcher so that an increase in detailed knowledge of the phenomenon was gradually obtained. The six phases of thematic analysis used as a guide were: familiarisation, coding, searching for themes, reviewing themes, defining and naming themes and finally writing up.[105-106] The analysis process was however fluid, moving backwards and forwards as was necessary to gain an ever-deepening understanding of the data. The emphasis was on the active role of the researcher in interpreting the data to construct themes that serve as interpretive stories rather than domain summaries.[107]

The following definitions were used to guide data analysis:

- **Code:** A label assigned to text to capture the meaning and serves to reduce raw data such that its production is noted as the first level of abstraction.[104,108]
- **Subtheme:** A subtheme shares the same central organising concept as the overarching theme but, focuses on one noteworthy particular element that forms part of the theme.[108-109]
- **Theme:** An idea that captures something important about the data in relation to the research question, that represents a pattern in responses and serves as the highest level of abstraction.[104,108]

Phase 1 of the six phases of thematic analysis; familiarisation involved the researcher immersing herself in the data.[106] This process began whilst acting as an observer during the focus groups, taking detailed notes and creating an awareness of the general nuances of the conversation and the ideas discussed. Familiarisation was furthered when the researcher transcribed the audio recordings of the groups, listening and relistening to the audio recordings multiple times to ensure the accuracy of the transcriptions. Familiarisation was further deepened by reading and rereading the transcriptions multiple times and making notes on any interesting observations and reoccurring ideas.[103]

Coding, Phase 2, involved the generation of labels for significant features of the data, guided in a broad sense by the research question.[106] Codes were not only semantic representations of the data but also captured the underlying meanings of the data. Line by line, open coding was used by the researcher. This involved the researcher carefully going through the entire transcription of both groups line by line and labelling significant parts of the data with a code that captured the essence of that data. Open coding implies that codes were not predetermined but rather emanated from the data.[106] Data with similar features were given the same labels or codes. Codes were then collated in a word document together with the data extracts or direct quotes that related to that code. Recoding was done two weeks after the initial coding to check the consistency of the codes thereby increasing the credibility of the study.[62] At the end of this stage all codes were collated in a table in a word document with their relevant data extracts.[103]

Searching for themes then commenced. Themes were constructed by the researcher from coherent and meaningful patterns in the data that were relevant to the research question.[106] All relevant codes were grouped into themes, themes were then divided into parts to form subthemes. Subthemes were constructed to explain and describe parts of the themes.

Reviewing themes involved checking that the themes were congruent with both the coded data and the raw data. In this reflective stage, the researcher considered the developing story being told by the themes and established connections between the themes.[103]

Defining and naming themes required the researcher to write a comprehensive analysis of each theme, defining the core element of the theme and suitably naming the theme.[106] Feedback from member checking confirmed that the themes were an accurate representation of the focus group discussions. Seven of the 19 participants responded to the request for member checking via email. All seven agreed with the accuracy of the results and made no additions or corrections to the proposed theme summary.

Writing up was the final stage in the thematic analysis process and continued to involve analysis, with the researcher weaving the themes together to form a convincing, logical story and then using current literature to provide more context.[103]

Data were always seen in context and interpreted and described as such.[95] Multiple reviews of the coding and theme construction by the supervisors of the study was used to improve the confirmability of the data interpretation.[62] Member checking was used to confirm the results of the study.[62] The preliminary results (Annexure F) were sent via email to the participants on 1 June 2020 and they were asked to comment on the accuracy of the information, whether they felt the results were a true representation of the data gathered in the focus groups and suggest any changes they felt should be made. The researcher's background, experience and perspective on practice in acute mental health care impacted her interpretation of the data, thus

reflexivity was essential in becoming aware of any of the researchers own assumptions and biases and the changes in these over time.[62]

3.7 TRUSTWORTHINESS

Trustworthiness was established by the following strategies as developed by Lincoln and Guba[110] and suggested by Krefting.[62]

Credibility, truthfully representing the multiple perspectives of the participants as accurately as possible was ensured through reflexivity, peer debriefing, the reframing of questions during the focus groups, member checking and establishing the authority of the researcher.[62]

Reflexivity was ensured through the keeping of a research journal, kept by the researcher to track her own perspectives and attitudes to create an awareness of biases and preconceived assumptions.[62]

Peer debriefing, discussing the research and results with impartial peers who have experience in qualitative research, encouraged deeper reflective analysis.[110] Rephrasing and repetition of the questions during the focus groups enhanced the credibility by ensuring the participants understood what was being asked of them.[111]

Member checking involved asking the participants to confirm and or comment on and adjust the preliminary results of the study to ensure they are an accurate representation of the data.[62] The participants were sent an email summarizing the preliminary results of the study. They were requested to provide any commentary either directly in an email or using track changes in the word document on how accurately they felt that the results represented the discussion they were a part of. Seven of the 19 participants responded to this invitation and all seven agreed with the accuracy of the themes, having nothing further or different to add.

Lastly, credibility was increased by the researcher's familiarity with both the phenomenon and the context as well as a strong interest in the theoretical underpinnings of the constructs.[112]

Transferability was considered by ensuring that the focus groups were as heterogeneous as possible in terms of place of work, years of experience in acute mental health care, total years of experience and place of study and then providing detailed descriptions of the demographics of the participants so that those wishing to can make adequate conclusions on the transferability of the results.[110]

Dependability was enhanced through the code-recode procedure employed during the data analysis stage. The researcher coded a section of data and then waited for a period of two weeks after which she recoded the data and then compared the results.[62] A methodology expert and a departmental reviewer with more than five years of experience in qualitative research reviewed the research proposal and implementation of the research.[62]

Conformability, was enhanced by making use of an objective person or an expert/peer reviewer to act as an auditor at each of the following stages: i) focus group question guide development, ii) raw data transcriptions and iii) data analysis, to ensure that the interpretations made by the researcher were accurate.[110] An objective first language English speaking person checked the transcriptions for accuracy. An occupational therapist with over five years' experience in qualitative research and the field of acute mental health (peer reviewer) revised the focus group question guide and the themes and interpretations made by the researcher to ensure accuracy and adequate analysis. Member checking was used to confirm the results of the study and decrease the chances of misrepresentation.[62]

3.8 ETHICAL CONSIDERATIONS

The Faculty of Health Sciences Research Ethics Committee granted ethical clearance for this study to commence on the 6 August 2019, and a certificate with ethical clearance number 467/2019 was issued (Annexure H). No permission was sought from the Gauteng Department of Health as those participating in this study did so in their personal capacity.

3.8.1 Autonomy

Respect for human dignity was ensured through the protection of autonomy.[98] People and therefore participants are autonomous, they have the right to self-determination and are thus allowed to withdraw from the study at any time.[98] Autonomy was respected in this study in the following ways: Prospective participants received information regarding the study and an invitation to participate in the study from the researcher electronically. Their participation was voluntary. All those that agreed to participate were required to sign an informed consent form, found in Annexure C. Participants were informed that they were free to withdraw at any stage of the research and that their decision to do so would be respected and not questioned.

3.8.2 Confidentiality

The principle of justice, which protects the participant's right to fair selection and treatment, was adhered to by protecting the confidentiality of the participants.[98] Although confidentiality could not be guaranteed because of the nature of the focus groups, it was encouraged by including confidentiality as a guideline in the introductory stage of the focus groups. In the transcripts each participant was assigned a pseudonym, to protect their confidentiality in the data and the reporting of the results. Any mental health care facility mentioned during the focus groups was assigned a numerical value, and reported as such in the results, to ensure confidentiality and that no harm is done to the reputation of the facility. The moderator and the auditor of the transcriptions were required to sign a confidentiality agreement (Annexure D & G) to protect the identity of the participants and the mental health care facilities where they work. The recordings, as well as the transcriptions, were saved on two separate password-protected hard drives that were kept in two, secure locations at the University of Pretoria, Prinshof Campus.

3.8.3 Beneficence

Beneficence refers to a participant's right to be protected from discomfort and harm.[98] Although the participants may not have benefited directly from the study

contributed to the development of the profession of Occupational Therapy. The focus group process may have indirectly benefited the participants and the MHCUs they provide services to by allowing the participants time to critically reflect on current practice and think of possibilities for improvement of current practices. The article produced from the study will be shared with participants and with all acute mental health care facilities in the City of Tshwane to facilitate and encourage conversation regarding the use of occupation and occupation-centred practice in occupational therapy in acute mental health care, thus further developing the unique professional identity of occupational therapy.

Reputational risk is an important aspect of beneficence.[98] Reputational risk was dealt with in this study by ensuring the names of participants and of the facilities that they practice at were replaced with pseudonyms in all reporting regarding this study.

3.8.4 Non-maleficence

Non-maleficence, often coupled with beneficence, is an ethical principle that refers to the researcher's obligation to ensure that no harm is done to any of those involved in the study.[98] In this study, non-maleficence was ensured by conducting the focus groups on a Friday afternoon when the occupational therapy program of most mental health care facilities is quieter therefore reducing the impact on MHCUs. Focus groups ran for a period of 90 minutes to limit the inconvenience to participants. The names of the facilities from which participants were recruited were and will not be included in any formal reporting of the results so that no harm can come to the reputation of the facility.

3.8.5 Compensation

The University of Pretoria's Code of Ethics for Research document defines compensation as anything of value such as remuneration or any other item of significant financial value that is received for services rendered.[113] No compensation was provided to the participants and this was made clear to them in the informed consent form completed by the participants. Refreshments, appropriate for the time of day, were provided during the focus group.

3.8.6 Sponsors and contributions

No contributions from any sponsors were received. The supervisor, co-supervisor, focus group moderator as well all those that made any contributions towards the research are officially thanked in the research report.

3.9 CONCLUSION

This chapter detailed the research approach and design, then further described the population and the sample. The data collection procedures and instrument were described. Also included in this chapter is a detailed description of the process undertaken to analyse the data. An outline of the ethical principles and their application in the study concludes the chapter. Chapter 4, the findings of the study, will be discussed hereafter.

CHAPTER 4
FINDINGS AND DISCUSSION

4.1 INTRODUCTION

This chapter outlines the findings of this study and discusses relevant literature that serves to confirm, refute, or further explain the findings.[98] Firstly, the demographic information of the participants is summarised whilst providing a rich, thick description for transferability purposes.[110] Secondly, themes are reported, a tabulated overview of all the themes and subthemes is provided. Each theme and subtheme are then described using the quotes for the theme or subtheme followed by a discussion of the theme or subtheme in relation to relevant literature.

4.2 DEMOGRAPHIC INFORMATION OF THE PARTICIPANTS

4.2.1 Description of the participants

Table 4.1 provides the demographic information of the participants for both focus groups, 1 and 2. The participants' names have been replaced with pseudonyms.

Table 4.1: Demographic information of all the focus group participants

Pseudonym	Age	Gender	Experience in acute mental health care	Total number of years practising OT	Postgraduate qualification	Current place of work
Focus group 1						
Jane	25	F	2	4	No	Government
Isabel	48	F	24	25	Yes, Masters OT (UFS)	Government
Annette	28	F	6	6	No	Private
Megan	25	F	1	2	No	Private
Colleen	32	F	9	10	No	Private
Diane	26	F	3	4	No	Private
Nelly	27	F	3.5	5	No	Private
Susan	26	F	2.5	2.5	No	Private

Candice	43	F	9	19	Yes, Postgraduate Diploma: Group intervention in OT (UP)	Private
Abigail	35	F	11	11	No	Private
Cynthia	28	F	2	5	Yes, Masters OT (UP)	Private
Average for Focus group 1	28.7	100% female	6.5 years	8.1 years	27.3% with a Postgraduate degree/diploma	18.2% work in government
Pseudonym	Age	Gender	Experience in acute mental health care	Total number of years practising OT	Postgraduate qualification	Current place of work
Focus group 2						
Ruth	38	F	13	16	No	Private
Stacy	38	F	9	12	No	Private
Anne	54	F	28	30	Yes, Masters in OT (UP)	Government
Maureen	31	F	8	8	No	Private
Louise	28	F	5.5	5.5	No	Private
Tessa	41	F	16	16	Yes, Masters in OT (UFS)	Private
Betty	54	F	13	28	Yes, Postgraduate diploma: hand therapy (UP)	Private
Jenny	26	F	1	2	No	Private
Average Focus group 2	38.8	100 % female	11.7 years	14.7 years	27.5% with PG	12.5% work in Government

UFS: University of the Free State UP: University of Pretoria

Table 4.2 provides a summary of the demographic information of the participants for the two focus groups.

Table 4.2: Summary of the demographic information of the participants in both focus groups

Demographic Information	Average
Number of participants	19
Average age	34.4 years
Gender percentage	100 % female
Average years' experience in acute mental health care	8.8 years
Average total years of practising occupational therapy	11.4 years
Percentage with a postgraduate qualification	31.6% have a postgraduate qualification
Percentage working in government/public sector and private sector	15.8% government/public sector 84.2% private sector

In summary, the average age of the participants was 34.4 years, but the ages ranged from 25 to 54 years of age with the participants in the second focus group averaging 10 years older than those in the first focus group. The average years practising occupational therapy was 11.4, ranging from 2 to 28 years. The average number of years practising occupational therapy in an acute mental health care setting was 8.8 years but ranged from 2 to 28 years. All 19 of the participants were female of which 31.6 % had a postgraduate qualification in occupational therapy. Of the participants, 15.8% worked in acute mental health care in the government/public sector whilst 84.2% worked in acute mental health in the private sector.

4.3 THEMES

This study aimed to explore and describe the perspectives of occupational therapist's working in acute mental health care regarding occupation-centred practice. Four themes were constructed from the data to meet the aim of the study.[107] These themes, together with the relevant subthemes, are reported and discussed below. Table 4.3 provides an overview of the themes and subthemes. Numbers allocated to themes are merely to provide structure for ease of referral and reading and are not indicative of the significance of the themes.

Following the table, each theme is reported on separately including (1) a table indicating the theme and subthemes, (2) the operational definition of the theme as

constructed by the researcher including appropriate quotes supporting the theme, and relevant literature, (3) the subthemes with operational definitions, (4) the quotes for each subtheme and (5) each subtheme is discussed and compared to literature.

Table 4.3: Overview of themes and subthemes

Theme 1	**The process of occupation-centred practice**
Subthemes 1.1 Enable experiences through doing 1.2 Facilitating reflection of the experience 1.3 Healing as the outcome	
Theme 2	**Activities enable occupation-centred practice**
Subthemes 2.1 Activities provide experiential opportunities 2.2 Activities reveal the authentic mental health care user 2.3 The metaphorical use of activities	
Theme 3	**Theoretical underpinnings of occupation-centred practice**
Subthemes 3.1 Vona du Toit's Model of Creative Ability 3.2 Model of Human Occupation 3.3 Client-centred approach 3.4 Yalom's psychosocial theory of group therapy 3.5 Kawa Model 3.6 Sensory Intelligence 3.7 Occupational Therapy Practice Framework	
Theme 4	**Influencers of occupation-centred practice**
Subthemes 4.1 Influencers that support occupation-centred practice 4.2 Influencers that constrain occupation-centred practice	

Themes will be reported and discussed below, first the theme as a whole and then the subthemes, with the relevant codes that contribute to the theme will be described and discussed.

4.3.1 Theme 1: The process of occupation-centred practice

Table 4.4: Theme 1 with subthemes

Theme	Subthemes
1.The process of occupation-centred practice	1.1 Enable experiences through doing
	1.2 Facilitating reflection of the experience
	1.3 Healing as the outcome

Theme 1: The process of occupation-centred practice

A process as defined by the Collins English Dictionary[50] is a series of actions which are carried out in order to achieve a particular result. The participants in this study referred to occupation-centred practice as being more than just an event or occurrence, making use of the word process.

"It's a process..." Stacy

"It's a journey." Ruth

The process of occupation-centred practice is depicted in Figure 4.1 below.

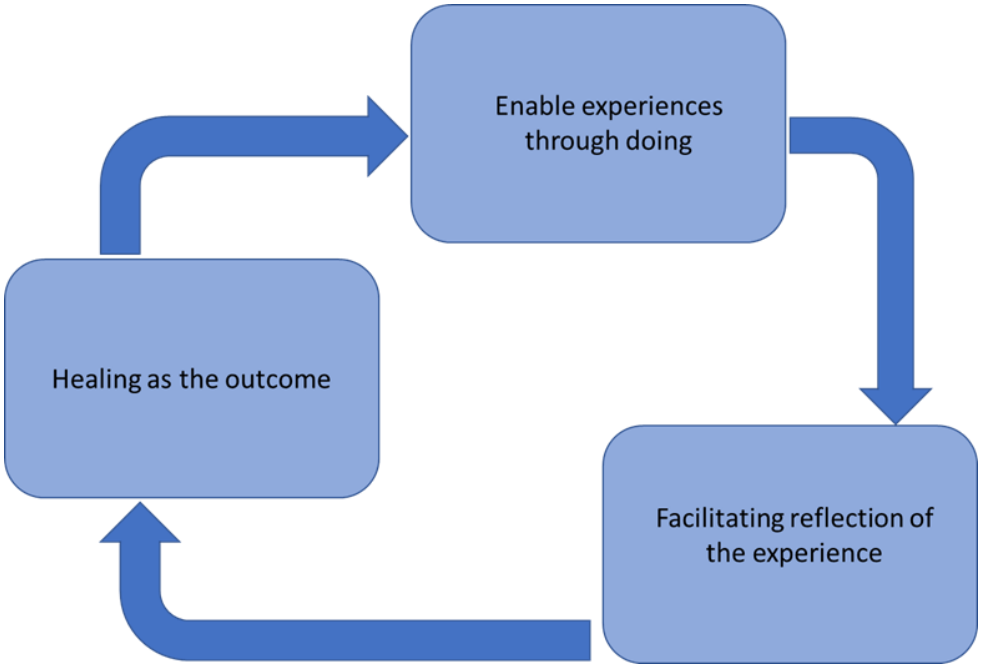

Figure 4.1: The process of occupation-centred practice

The process is described by one participant as the continual building of experiences, explaining the cyclical nature of the process as illustrated above. The same participant highlighted that it is indeed a process that builds over time. This is supported by the participant's statements below.

> *"It's building. Ja, it's building on top of one another um building experiences."* - Tessa

> *"Um, I think the pennies drop in an open group, in a closed group, it was building up towards that for maybe over the week or for maybe over years."* - Tessa

Figure 4.2 below illustrates how the process of occupation-centred practice continues, in a cyclical manner progressing from the starting point at the bottom towards recovery.[114]

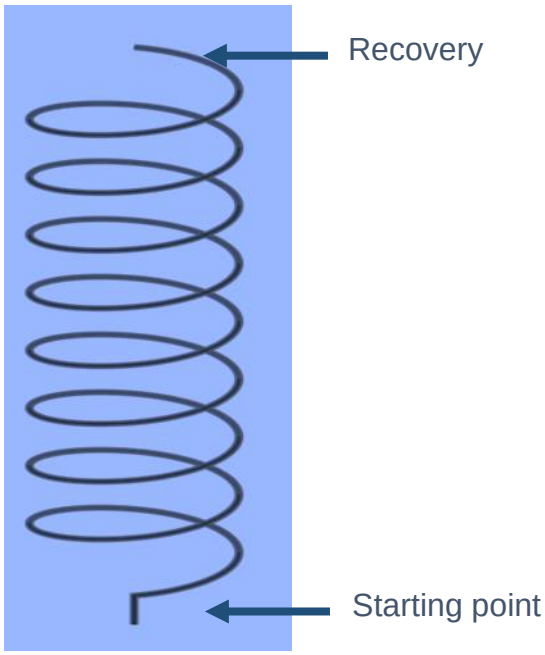

Figure 4.2: The cyclical process of occupation-centred practice

Discussion of Theme 1: The process of occupation-centred practice.

A 2018 scoping review by Doroud et al.[115] exploring the links between recovery and occupational engagement for people with enduring mental illness reports similar findings to this study; describing recovery as "an ongoing occupational process". It

appears that the description or idea of occupation-centred practice as a process has strong ties to the recovery model,[116] which is aligned with the Occupational Therapy Practice Framework (OTPF),[13] emphasising holistic and client-centred practice even in acute settings, as researched and reported by Synovec.[117] Hess-April et al.[44] concur that within the context of an acute hospital setting occupation-centred practice is seen as a process.

Synovec[117] refers to the Substance Abuse and Mental Health Services Administration's National Consensus Statement on Mental Health Recovery 2012[118] which describes recovery as ''a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential'' highlighting a link between occupation-centred practice and recovery, with the latter often being referred to as a process.[119] Lindström and Isakson[119] mention that recovery is seen as steps; encouraging people to move forward, rebuild identity, set new goals, perform activities and develop relationships. These steps described in the recovery process resonate with the subthemes of Theme 1, the process of occupation-centred practice. The subthemes reported below describe the actions or steps the participants believe contribute to recovery during the process of occupation-centred practice.

Subtheme 1.1: Enable experiences through doing

Table 4.5: Subtheme 1.1

Subtheme	Codes
1.1 Enable experiences through doing	1.1.1 Experience
	1.1.2 Doing

The participants suggest that the occupational therapist working in an occupation-centred manner enables the Mental Health Care User (MHCU) to experience through doing. The occupational therapist gives the MHCU the opportunity to do, which results in an experience. Experience is defined as "the fact or state of having been affected by or gained knowledge through direct observation or participation".[50] Participants commented on their belief in the power of doing, and the resultant experience:

"That's how people learn, is through um doing." - Susan

This participant further explained her experience:

"You can sit and tell a person to be more assertive and teach them how but if they not going to be able to practice it, they are not going to be able to do it…" - Susan

The participants commented on the end-product or result of doing which they termed an experience:

"So, for me, it's what comes out of the activity, the experience." - Colleen

Colleen further clarifies:

"…groups, it's always about the patients' experience this…" - Colleen

This participant explained her understanding of how the occupational therapist enables the MHCU to do and therefore experience:

"We give them the time and resources and space and um the tools just to experience it practically so that they can start doing it." - Maureen

Discussion of Subtheme 1.1: Enable experiences through doing

The first step of the process of occupation-centred practice is described by the participants as the occupational therapist enabling the MHCU to do which results in an experience. Doroud et al.[115] links doing and the resultant experiences to recovery, describing recovery as a process of occupational engagement or doing that involves experiences of gradual re-engagement with everyday occupational life. The term occupational experience coined by Wilcock and Hocking[120] to describe the states of doing, being, becoming and belonging, appears to capture the essence of what the participants described. The idea that doing, being, becoming, and belonging refer to four continuously interacting experiences that occur through occupation[120] links to what the participants shared regarding their beliefs of the starting point of occupation-centred practice which begins with enabling the MHCU's to do which results in an experience.

Hitch[121] comments on the Pan Occupational Paradigm which asserts that doing, being, becoming and belonging, the four occupational experiences interact with

each other constantly, but do not have an equal influence at all times. Doing is identified as the core dimension of occupation with being, becoming and belonging working alongside. Like the participants of this study Hitch[121] as a mental health clinician believes that the concepts of doing, being, becoming and belonging are representative of service users' experiences of occupational engagement. Doing, as described by the participants is highlighted and foregrounded during evaluation and intervention when working in an occupation-centred manner.[121] Krupa et al.[122] reports that "the actual doing of occupations is believed to be transformative as it promotes adaptation, creates identity both personal and social, connects people to their communities and enables ongoing personal growth and development".

Doroud et al.[123] add that the place or environment one is in also plays an integral role in enabling doing, this is supported by Krupa et al.[122] who mentions that experience is influenced by both the person and environmental level factors. Wimpenny et al.[53] too acknowledges the environment but goes a step further and describes the experience of service users when occupational therapists skilfully enable doing. The resultant experience, Wimpenny et al.[53] allude to, is one of empowerment, self-discovery and a greater means of expression.

Occupational engagement or doing can be described as having a component of subjective experience, although it should also be noted that to be a passive spectator and observe an occupation can generate a feeling of participation.[124-125] Experiences build, sustain, and damage the body, its structures and functions both physiologically and psychologically.[126] It is the occupational therapists function to enable experiences that contribute towards the healing outcome of the occupation-centred process.

Subtheme 1.2: Facilitating reflection of the experience

Table 4.6: Subtheme 1.2

Subtheme	Codes
1.2 Facilitating reflection of the experience	1.2.1 Making sense of experiences
	1.2.2 Discussing experiences

The participants suggested that once the experience has occurred, reflection by the MHCU upon that experience is essential. The participants understood it to be the role of the occupational therapists practising in an occupation-centred manner to facilitate that reflection. The participants expressed that in their experience discussions were an important part of reflection for the MHCU and assisted the MHCU to make sense of the experience. This is expressed in the statements by Betty and Tessa below:

> *"…and they [MHCUs] soundboard um to each other and when you start explaining it to someone else, 'I've just realised blah, blah, blah'. It's that it changes in that moment, that's where the change starts."* - Betty

> Tessa concurs: *"It, it's that here and now moment really reflecting. Figuring it out, in a safe space…"* - Tessa

Discussion of Subtheme 1.2: Facilitating reflection of the experience

Findings of the current study suggest that the participants believe that during occupation-centred practice, the occupational therapist is required to facilitate reflection of the MHCU's experiences. Reflection refers to the MHCU's making sense of the experiences, in the participants' experience this is often done through discussion.

Csikszentmihalyi[127] suggests that there is constant debate regarding the respective values of action and reflection. Proposing that at times it is action that is valued above reflection but as time passes reflection becomes the more important of the two.[127] Gailey[128] argues that reflection on contextual circumstances produces meaning which directs choice and outcome.

Wimpenny et al.[53] found that in studies where occupation-centred practice was implemented it provided service users with a means of reflecting on their progress which was seen as valuable by the service users. Lindström and Isaksson[119] also found that there is value in encouraging service users to express their experience of the ongoing process of change and argue that reflection has the potential to facilitate gains in insight, resourcefulness and personal agency, concluding that

being a reflective partner to the service user is helpful. Wimpenny et al.[53] report that effective occupation-centred intervention promotes reflection. These studies support the findings of this study and the participant's views that reflection on the experience is essential in reaching the next step in the process, healing. Reflection is therefore facilitated during the process of occupation-centred practice.

Subtheme 1.3: Healing as the outcome

Table 4.7: Subtheme 1.3

Subtheme	Codes
1.3 Healing as the outcome	1.3.1 Gains in insight
	1.3.2 Taking ownership
	1.3.3 Consolidation (moving forward)
	1.3.4 Discovering meaning and purpose
	1.3.5 Development of hope

Participants described the outcome of the process of occupation-centred practice as healing. Healing implies becoming healthy.[50] Gains in insight, taking ownership, consolidation (preparing to move forward), discovering meaning and purpose and the development of hope were all viewed by the participants as healing and were described as the outcomes of occupation-centred practice.

These participants highlighted gains in insight, which begin by gaining an awareness of myself and my behaviour:

> *"It just gives them more insight into themselves.''*- Ruth

> *"And it's about what I do everywhere else that makes the difference and for people to also to be able to become aware of what I do."*- Tessa

Taking ownership was described by the following two participants:

> *"And that's where patients really started feeling shifts, movements in their um drive, um in their…am I going to fight for my own life back now."* - Tessa

> *"This is now my dreams, my goals, my life…"*- Stacy

Participants described their understanding that consolidation of the learning from the experience is what allows the MHCU to move forward towards healing as shared below.

> *"They have these moments sometimes but they, they are not used to internalising it. We have to make sure that is actioned that the moments are actioned." - Stacy*

> *"…um, things get consolidated or reaffirmed um…"* - Betty

Discovery of meaning and purpose for the MHCU is viewed by the participants as healing and therefore an outcome of occupation-centred practice:

> *"…bring meaning and purpose to life, is where the psychiatric client battles most. They are busy with things but it's that meaning, that missing link that I feel disjointed from my own life; so, it's that bringing meaning and purpose back into life, that I think where we have a big role in that specific part."* - Stacy

Stacy later shared more of her experience:

> *"…everybody wants meaning, so everybody relates to that in that focus of we are here to sort of guide you and identify what is meaning again."* - Stacy

> *"…for me that's always important is, is roles, but I think it links strongly with the meaning and purpose, is what are the roles this person is expected to fulfil. And ja how do they fulfil that role, whether the way they do it is the same as prior to being admitted, but how do they go back and meaningfully occupy that role."* - Colleen

Finally, the development of hope is also associated with healing by the participants:

> *"So, I think from my point of view, it gives them also a lot of hope in terms of changing…"*- Ruth

> *"You know and how they can always link it back to you know, …, to be hopeful…"*- Stacy

The figure below illustrates healing as the outcome of occupation-centred practice as described by the participants

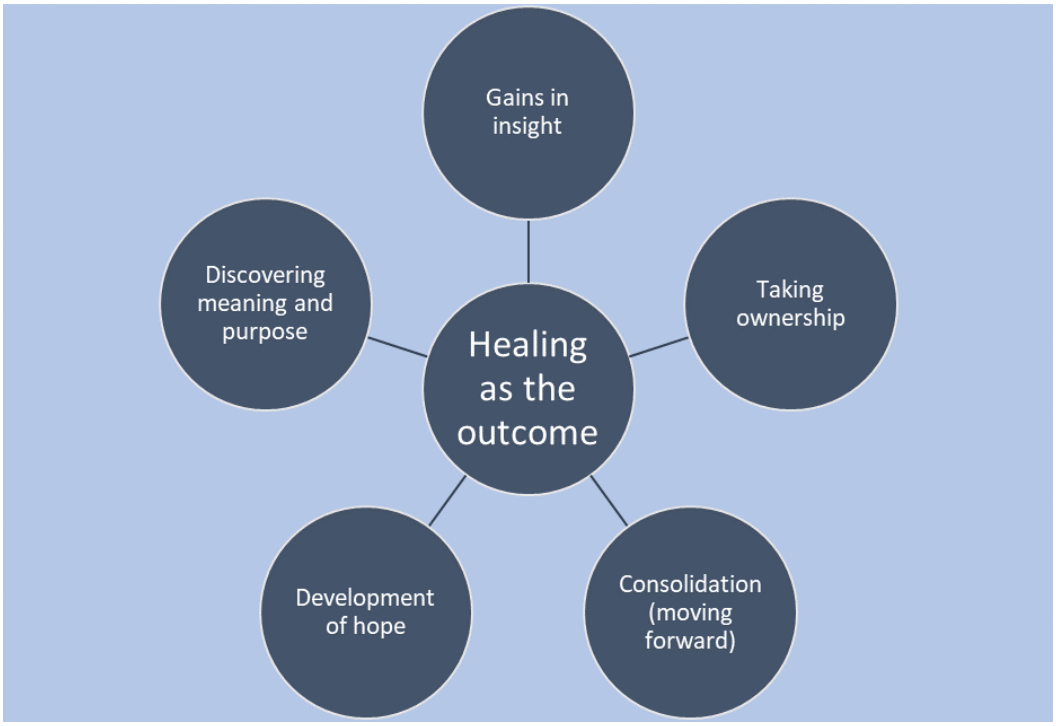

Figure 4.3: Healing as the outcome

Discussion of Subtheme 1.3: Healing as the outcome

Healing as the outcome of occupation-centred practice was described as having different components. Firstly, gaining insight into their disorder, behaviour, and themselves. Secondly, the MHCU taking ownership of their own lives, decisions, and journey towards healing. This is closely followed by the consolidation of what they learnt through the experience of doing and then reflecting or making sense of that experience so that they are ready to move forward. Lastly, the development of hope in the MHCU is viewed as an outcome, motivating them to go on to discover meaning and purpose. In doing the MHCU discovers that they can still have a purpose and may discover new meaning.

Similarly, Krupa et al.[122] describe the components of the recovery process as renewing hope, moving beyond illness to construct a new self, expanding social roles, building social connections, learning to manage symptoms, being a citizen and overcoming stigma. These components echo those identified by the participants

of this study most notably the development of hope, discovering meaning and purpose, and gains in insight. Likewise, Rebeiro[129] identified that after engagement in an activity service users report feelings of hope and a sense of purpose. Wimpenny et al.[53] also describe occupation-centred practice as being effective in promoting personal meaning through reflection, creativity, exploration and challenge.

The findings of the current study and those presented above are contrasted by a Malaysian study which found that occupational therapists believed that the main outcome of occupation-centred practice is merely occupational performance, and should be recorded as such.[130]

The participants of the current study's description of healing included an aspect of consolidation or moving forward after reflection, this is affirmed by Wimpenny et al.[53] who too mentions that moving forward is important in the therapeutic process and managed by the therapist who sets the challenge and pace of therapy.

The MHCU taking ownership of their lives and their recovery is a component of the outcome of occupation-centred practice according to the findings of this study. Wimpenny et al.[53] again made similar findings that engaging in meaningful occupation led to service users regaining a sense of control and empowered them to make choices and accept responsibility for feeling better. Empowerment which is characterised by "hope" and "respect" in the working definition of recovery that is proposed by the Substance Abuse and Mental Health Services Administration's[118] 2012 document, increases a service user's ability to take control and make the necessary decisions regarding the steps required for their recovery.

Synovec[117] proposes that an increase in insight into a person's illness contributes to them developing a stronger internal locus of control and therefore a feeling of empowerment which all contributes positively to recovery, this is mirrored in the findings of the current study.

Theme 1, the process of occupation-centred practice is described through the subthemes of enabling experiences through doing, facilitating reflection of the

experience and healing as the outcome. This provides us with an illustration of the occupational therapists' understanding, beliefs and experience regarding the steps undertaken by the therapist in the process of occupation-centred practice in acute mental health care. Theme 2, which follows, describes the link between activities and occupation-centred practice.

4.3.2 Theme 2: Activities enable occupation-centred practice

Table 4.8: Theme 2 with subthemes

Theme	Subthemes
2. Activities enable occupation-centred practice	2.1 Activities provide experiential opportunities
	2.2 Activities reveal the authentic mental health care user
	2.3 The metaphorical use of activities

Theme 2: Activities enable occupation-centred practice

The participants in this study explained that occupation-centred practice is enabled or actioned through activities. They explained that in their experience, activities provide experiential opportunities, they reveal the authentic MHCU and activities are at times used metaphorically.

These two participants mentioned that activities are used to enable occupation-centred practice:

> *"But it's normally activities with lots of interaction and having to work together and those kinds of things…"* - Annette

> *"And with adults, we try to use um activities that are performance-based but within their role."* - Cynthia

Discussion of Theme 2: Activities enable occupation-centred practice

The findings indicate that the participants make use of activities as a channel through which they can ensure that MHCUs move through the process of occupation-centred practice. Activities enable occupation-centred practice by providing opportunities for the MHCU to do and therefore experience. Activities are often used metaphorically for reflection or making sense of the experience and the doing of activities was believed by the participants to reveal the authentic MHCU. This authenticity may result in gains in insight described as a component of healing that is believed to be the outcome of occupation-centred practice as described previously.

Creek[131] quotes Mosey[132] in describing the profession's legitimate tools or permissible means of carrying out occupational therapy as, the self, activities and the environment. The World Federation of Occupational Therapy[64] in their 2019 position statement on occupational therapy and mental health state that occupational therapists make use of meaningful activities that motivate and provide incentives for psychosocial rehabilitation and recovery. They further explain that occupational therapists, as experts in occupation "ensure that people's occupational needs and potential are met through engagement in meaningful and purposeful activity".[64]

Fortuna[133] likewise proposes that occupational therapy practitioners enable service users to participate in meaningful activities using occupation as therapy. Drew and Rugg[134] acknowledge the importance of activities to promote occupation-centred practice and suggests that activity is central to human existence. Activities are an inherent part of occupations, intertwined: embedded, directing, or otherwise entangled and therefore cannot be separated from a method of practice that is centred around occupation.[128]

Daud et al.[130] report that in occupation-centred intervention various intervention forms over and above activities and the service users' actual occupations, such as preparatory methods and simulated occupations could be used to achieve the goals set. In contrast to the findings of the current study Britton et al.[88] concluded that

although occupation is seen as the overall outcome of practice, it is rarely utilised as a treatment medium in Australian acute hospitals as it is often viewed as incompatible with the setting. The findings of the current study, however, indicate that in South Africa, in acute mental health care, activities and therefore occupations are considered central to practice by occupational therapists.

Subtheme 2.1: Activities provide experiential opportunities

Table 4.9: Subtheme 2.1

Subtheme	Codes
2.1 Activities provide experiential opportunities	2.1.1 To practice skills
	2.1.2 For connection
	2.1.3 For meaningful and purposeful engagement

Activities provide opportunities for MHCUs to practice skills, experience connection, and meaningful and purposeful engagement.

Abigail shared her experience of using an activity to practice skills; in this case, the activity assisted the MHCU to become more proficient in his telephonic skills:

> *"…she did with him telephone skills…, teaching him things like write down before the time exactly what you want to know so that you don't go rambling then you get more nervous, um you know, and remove yourself from the office if you are uncomfortable with the other people from the office listening to the conversation. It was things like that."* - Abigail

The experience of connection, to the self and others, was believed to be foundational by the participants. Connection creates a safe space in which improvements in other spheres can occur. Susan explained the connection to the self:

> *"So, then they make their own aroma dough with essential oils and things and you smell us before you see us, but it really works, and you often times see how a person is more connected when they are connected to their senses, they tend to be more connected in the here and now."* - Susan

Isabel described how the activities enable connection with the occupational therapist:

> *"We see that the patients form therapeutic relationships easier with the OTs because of the occupation focus..."* - Isabel

Whilst Louise explained how the activity provides the opportunity for the MHCUs to experience connection with others:

> *"Um ja, things like the human knot, or things where they actually have to work together, like where there is and sometimes, it's uncomfortable for them but like they have to be quite close, they have to move around they have to figure out a challenge, even making a poster. Things where they actually have to rely on one another."*- Louise

Louise also explained her belief that connection forms the foundation for work on other impairments:

> *"…usually something physical focusing a lot on cohesion because I think if the group is connected then you can work on some of the other things."*
> - Louise

The participants further described that activities provided opportunities for the MHCUs to experience occupation or being occupied which they defined as meaningful and purposeful engagement.

Stacy illustrated this below in a narrative that she recounted:

> *"…he battled with his meaning and purpose and that long term… eventually what he wanted, he just wanted to play the sax [saxophone]. He wanted to learn how to play saxophone, that's all he wanted to do...this man literally in one session did this (clicks fingers) … and then we started changing his family life and everything else was a lot easier to approach after the, just this one thing, I want to do something for me. Just my meaning and how I occupy my time."* - Stacy

She went on to describe the effects of not being meaningfully and purposefully engaged:

> *"… and if you don't get this then the impact of not being constructively occupied, meaningful and purposeful, this actually leads to, and make you vulnerable to, a bunch of other things…"* - Stacy

Discussion of Subtheme 2.1: Activities provide experiential opportunities

Practising skills, providing opportunities to connect with others and for the MHCUs to experience meaningful and purposeful engagement are the experiences that were found in this study to be provided by activities.

Csikszentmihalyi[135] developed the theory of flow, which explains how participation in activities can lead to experiences of flow. Flow is used to describe the holistic sensation present when a person acts with total involvement in an activity. Flow theory predicts that the person's experience will be positive when a person perceives that the challenges posed by the activity are matched with their skills. The possibility of new skills being learnt occurs when both the challenge presented by the activity and the person's skills are considered high.[135] The therapist's task is then to match the activity to the skill level of the service user such that skill development can take place.[127]

Acquisition of new skills, as well as the development of skills through practice, was also mentioned by MHCU's as an important aspect of occupational therapy as reported by Lim et al.[136] and Griffiths.[137] Hess-April[44] further explains that in occupation-centred practice, the activity in the appropriate context if relevant presents the service user with the opportunity to acquire skills that will assist them in returning to their everyday life. Wimpenny et al.[53] too found that an occupation-centred intervention program was effective in promoting skill development. Skill development is linked to the outcome of occupation-centred practice, healing by providing an increase in self-confidence and therefore the possibility of enhanced participation in a greater variety of activities which feeds back into the process of occupation-centred practice.[53,136] Synovec[117] reports that MHCUs would like an intervention to focus more on communication skills, which they felt would facilitate

their integration back into the community. Integration back into the community implies the formation of a connection with those in the community, which is the next experience participants of the current study mentioned as being facilitated by activities.

Krupa et al.[122] report that participating in occupations and activities transforms people by connecting them with their communities. Support from fellow MHCUs in an inpatient setting, in the ward or occupational therapy groups, was positively highlighted in a study by Casteleijn and Graham.[138] Ikiugu[90] clarifies what he terms meaningful occupations, as being goal-directed and voluntarily chosen, he further indicates that people perceive such occupations as contributing to their unique identity and connecting them with others. Participating successfully in meaningful occupations fosters a sense of belonging, meaning and purpose and these he suggests should therefore be included in occupation-centred practice.[90]

Mental health care users value being occupied, meaningfully and purposely engaged through participation in activities.[138] This is in agreement with the beliefs of the participants in this study who expressed that meaningful and purposeful engagement was facilitated through activities. Capra and Luisi[139] express that there is a “particular need to act with a purpose or goal in mind… and it is in this acting with intention and purpose that we experience human freedom”.[139] Wilcock and Hocking[120] add that occupations promote wellbeing and Gailey[128] further suggests that occupations that promote wellbeing as well as create possible varieties of experience are meaningful and therefore provide the experience of being occupied.

Literature, mentioned above, therefore supports and further explains the findings of this study. Occupational therapists working in acute mental health use activities to facilitate skill development, connection, and the experience of being meaningfully and purposefully engaged or occupied. The use of activities therefore assists the MHCU to move through the process of occupation-centred practice towards healing.

Subtheme 2.2: Activities reveal the authentic mental health care user

Table 4.10: Subtheme 2.2

Subtheme	Codes
2.2 Activities reveal the authentic mental health care user	2.2.1 Doing reveals the impairments
	2.2.2 Social environment in which activity takes place

Authenticity refers to the quality of being real or genuine.[50] Participants mentioned that in their experience *doing* revealed the genuine or real struggles or impairments that the MHCU was experiencing. The participants also believed that the social environment in which the activity takes place in has an impact on the MHCU's participation in the activity:

> *"…it's a lot easier for them to put up a mask when they are in an individual session with a psychologist or psychiatrist and say, but I don't have an issue here but in the activity, that occupation, it's almost like it's, their mind gets lost and they forget that they need to be holding up this mask and then it gives us the opportunity to engage, I almost want to say more with the authentic client then that with the image that they are trying to give the world."*
> - Colleen

> *''Um, I either see clients who say I'm so depressed I can't do anything or I'm so anxious I can't do anything, and then when you do engage in occupation then maybe I can do something. Or you get clients that say, there is nothing wrong with me I just had one little panic attack and actually I'm fine, and then they later on realise ok that maybe I struggle with this or I struggle with that."*
> - Cynthia

Anne highlighted the impact of the social environment in which the activity takes place, commenting on the changes in the MHCU's participation in a more social setting:

> *"You see a whole different picture in a far more social setting."* - Anne

Discussion of Subtheme 2.2: Activities reveal the authentic mental health care user

The participants explain their belief that whilst the MHCU is engaged in an activity it is more likely that they are being authentic and are less able to mask their true self consciously or unconsciously. Wimpenny et al.[53] similarly report that occupational engagement or activity participation validates a service user's interpretation of him or herself. However, the findings of the current study indicate that participation in the activity may also contradict and therefore challenge a service user's interpretation of themselves.

The social environment in which the activity takes place is also highlighted by Wimpenny et al.[53] as influencing the occupational engagement of service users, as described by the current participants.

Subtheme 2.3: The metaphorical use of activities

Table 4.11: Subtheme 2.3

Subtheme	Codes
2.3 The metaphorical use of activities	2.3.1 Mosaic
	2.3.2 Drawing

Participants referred to how they would use activities in a metaphorical way, where the product of the activity or the action of doing would be representative of the MHCU or their lives and circumstances. The two activities described as being used in this way were mosaic and drawing.

Both Betty and Stacy described the power of using the mosaic metaphorically:

> *"…it's become the whole abstract um sort of metaphor for healing. You know, it looks like my life is a mess and feels like it's never going to be whole again, I'll never be myself again but afterwards, I can be just as pretty and even prettier with my pieces and it doesn't take away from my self-confidence or where I'm going in my life, it's just a better me now, with more knowledge. So, it definitely does become a little bit of a metaphor…"* - Stacy

"…that last day and the symbolism out of that um grout that is covering everything and then when you wipe it all clean and those tiles start sparkling, the eyes start sparking you see the teeth sparkle…" - Betty

Tessa explained how drawing is used in the same way:

"…she said with that in her mind she drew this tree, that now represents her…" - Tessa

Discussion of Subtheme 2.3: The metaphorical use of activities

The participants described how they use activities especially those of mosaic and drawing in a metaphorical way to assist the MHCU to reflect on themselves and their lives and circumstances. The art forms: mosaic and drawing, are used as a comparison to the MHCU's own lives and provide a different perspective of themselves and their circumstances.

According to Coppola et al.[140] visual arts of which drawing and mosaic form part, offer nonverbal ways of communicating information about the human condition that may offer insights about values, beliefs, and the lived experiences of service users. Perruzza and Kinsella[141] also report on the value of arts-based occupations, that evoke a creative process in a person and found that these activities provided the opportunity for expression of emotion through symbolism.

Art-based occupations are often sensory experiences, like the experience of doing mosaic for example. Gailey[128] proposes that sensory experiences are universally understood and are therefore often used as a basis for the communication of more abstract ideas and suggests that metaphors are often used as a strategy for translating bodily experience into abstract concepts.

Theme 2, activities enable occupation-centred practice, dealt with the participants' perspectives regarding the mode through which occupation-centred practice is actioned, activities. Theme 3 which follows details the theoretical underpinnings of occupation-centred practice continually referred to by the participants.

4.3.3. Theme 3: Theoretical underpinnings of occupation-centred practice

Table 4.12: Theme 3 with subthemes

Theme	Subthemes
3. Theoretical underpinnings of occupation-centred practice	3.1 Vona du Toit's Model of Creative Ability (VdTMoCA)
	3.2 Model of Human Occupation (MOHO)
	3.3 Client-centred approach
	3.4 Yalom's psychosocial theory of group therapy
	3.5 Kawa Model
	3.6 Sensory Intelligence
	3.7 Occupational Therapy Practice Framework (OTPF)

Theme 3: Theoretical underpinnings of occupation-centred practice

The participants in the focus groups mentioned approaches, models, frames of reference and frameworks that they use and combine to support and guide their occupation-centred practice. Vona du Toit's Model of Creative Ability,[142] the Model of Human Occupation,[143] a Client-centred approach,[144] Yalom's psychosocial theory of group therapy,[145] the Kawa model,[146] Sensory Intelligence,[147] and the Occupational Therapy Practice Framework[13] were all mentioned as guiding occupation-centred practice.

Discussion of Theme 3: Theoretical underpinnings of occupation-centred practice

The occupational therapist's choice of theory influences the way they conceptualise the service user and the intervention process and therefore the way they practice, occupation-centred models of practice are thus assumed to encourage and inspire occupation-centred practice.[43,130,148] Creek[131] suggests that occupational therapists use theory as a guide to practice, to encourage coherent and systematic intervention as well as to provide a rationale for practice. Wimpenny et al.[53] found that although occupation-centred models of practice supported occupation-centred practice they

were unable to comprehensively guide the delivery of client-centred care. This contrasts the findings of this study as participants expressed their experience of a client-centred approach guiding occupation-centred practice.

Subtheme 3.1: Vona du Toit's Model of Creative Ability

Table 4.13: Subtheme 3.1

Subtheme	Codes
3.1 Vona du Toit's Model of Creative Ability	3.1.1 Guides choice of activities used to evaluate the MHCU
	3.1.2 Used to group MHCUs

Participants mentioned this model mostly in guiding them with regards to the choice of activities used for evaluation of MHCUs:

> *"We use Level of Creative Ability, so we do an individual assessment, usually informal assessments with a craft activity or something where they follow instructions to assess task concept."* - Jane

> *"I can agree that we've also used the APOM [Activity Participation Outcome Measure] because Creative Ability is the main assessment tool that we use, the APOM is beautiful for that."* - Annette

Participants also reported using Vona du Toit's model of Creative Ability to group MHCUs according to their level of Creative Ability, so that intervention could be provided for those functioning on a similar level together:

> *"…um, and then our groups are according to levels of Creative Ability."*
> - Isabel

> *"All our groups are sort of based on the thing we got taught, the whole Vona theory."* - Betty

Discussion of Subtheme 3.1: Vona du Toit's Model of Creative Ability

Casteleijn and Graham[138] provide a succinct description of The Vona du Toit Model of Creative Ability (VdTMoCA). The VdTMoCA was developed in South Africa and is based on creative participation or doing and thus occupations and activities form a central component of the model.[142] This model is used to guide occupational therapy practice in all settings but mostly in mental health care settings in South Africa and the United Kingdom.[138] Embedded in this model is the assumption that participation in activities and occupations occurs according to a person's level of motivation and action.[142] Once an occupational therapist has determined a person's level of motivation and action, activities and intervention are implemented and presented according to the person's specific level of Creative Ability.[138]

The Activity Participation Outcome Measure or APOM that the participants refer to, is a valid and reliable outcome measure developed by Casteleijn[149] and is used to assist in determining and measuring changes in the service users' Level of Creative Ability.[142]

As the VdTMoCA[142] was developed in South African at the University of Pretoria, which is geographically the same area in which this research study was conducted, many participants were very familiar with the model and clearly implement it in practice. As the model is taught in most South African universities offering a degree in occupational therapy most participants appeared to consider the model as a central part of their practice of occupational therapy. The model's strong emphasis on doing and activity[142] may influence the participant's perspectives on practice, resulting in the participants finding it difficult to image occupational therapy without the use of occupation. It thus appears that the VdTMoCA[142] serves as a propelling agent for occupation-centred practice, by ensuring that doing and activity are central to practice.

Subtheme 3.2: Model of Human Occupation

Table 4.14: Subtheme 3.2

Subtheme	Codes
3.2 Model of Human Occupation	3.2.1 Habituation: routines
	3.2.2 Personal causation

Aspects of the person as described by The Model of Human Occupation[143] appear to be used by the participants in providing occupation-centred intervention. The participants reported that habituation, the establishment of routines as well as personal causation were concepts and considerations included in their occupation-centred intervention practice:

> *"I use routine as treatment."* - Ruth

> *"But I can agree with routines, … starting new habits and working on that ja."* - Anne

Personal causation refers to one's own perception of one's effectiveness or ability to perform an activity.[143] Participants referred to the MHCU's perception of the challenges that they experienced which impacted on their perception of their (the MHCU's) effectiveness:

> *"What is their perception on their challenges?"* - Betty

> *"And to see what the person's perception of that is…"* - Tessa

Discussion of Subtheme 3.2: The Model of Human Occupation

Although the participants in this study mentioned aspects of the Model of Human Occupation (MOHO), they did not overtly link those concepts to the model or mention the model by name. The use of habituation, roles, habits and routines in intervention is validated and confirmed by the American Occupational Therapy Association[16] (AOTA) in their 2019 document titled Occupational therapy's distinct value, promotion, prevention and intervention across the lifespan in which they

indicate that the focus of occupational therapy services includes the identification and implementation of healthy habits, rituals, and routines to support wellness.

Gillen and Greber[36] propose that by understanding how interventions enhance occupational performance, practitioners can work with the service user to re-establish occupational roles, habits, and routines. They further postulate that doing so assists the occupational therapist in implementing occupation-centred practice even in medically orientated contexts.[39] Ikiugu[90] also supports lifestyle design through review and reconstruction of routines and habits as an occupation-centred intervention to improve health.

The MOHO conceptual practice model is used by therapists internationally and is recognised as an occupation-centred model.[80,150] The MOHO attempts to explain how occupations are chosen, performed and patterned.[80] One of the components of motivation for occupation is personal causation, how effective one sees oneself as being.[80] Roles, habits and routines form part of the pattern of occupation and assist occupational therapists in understanding the service user as an occupational being.[150] A recent study by Lee et al.[151] who surveyed mental health practitioners on the perceived impact of the MOHO found that using the model increased service user satisfaction and the professional stature of the occupational therapists it also resulted in higher quality services.[151]

Subtheme 3.3: Client-centred approach

Table 4.15: Subtheme 3.3

Subtheme	Codes
3.3 Client-centred approach	3.3.1 Non-directive
	3.3.2 Motivates the MHCU

Participants explained how a client-centred approach assisted them in being non-directive, working collaboratively with the MHCU to guide therapy according to their own needs, expectations, and goals.[138,144,152]

"It's their expectations, what would they like to change…" **-** Ruth

"Not looking for a specific answer or the right answer but what is your answer, your connection, your need for now." - Tessa

"I work very much client-centred; whatever the patient needs then I will do that…" - Isabel

Participants also explained how they believed this approach motivated the MHCU to do or engage in the activities that they use in practice. When the therapist collaborated with the MHCU to include aspects, activities and or occupations that were important to the MHCU they were more motivated to participate in therapy.

"And that is also because of the motivation thing, the fact that there is, it is motivating. It makes me feel like you are working on what is important to me." - Annette

Discussion of Subtheme 3.3: Client-centred Approach

The Client-centred Approach is ascribed to Carl Rodgers and results in the philosophy of respect and collaboration with the service user, a non-directive approach where the service users articulated needs are prioritised.[138] Occupational therapists who embrace a client-centred approach involve service users in the evaluation and intervention planning process; they take the time to understand the service user's values, needs, priorities, interests, daily occupations, and preferences; and then use that information to guide their clinical decisions throughout the occupation-centred process.[152]

Lim et al.[136] and others report that despite a commitment to client-centred practice, involving service users in their own evaluation and intervention has made slow progress, especially among service users having a mental illness.[138] The findings of this study seem to indicate that the participants of this study have embraced a client-centred approach and may even rely on to ensure occupation-centred practice. This finding is supported by Daud et al.[130] who in a Delphi study aiming to define occupation-based practice found that a client-centred approach was used to prioritise the services users' goals to ensure the meaningfulness of the intervention thus motivating participation, other studies concur.[44]

A study by Di Tommaso et al.[77] found on the contrary that most of their participants, occupational therapist working in traditional occupational therapy settings such as hospitals and community centres, felt that they could not use occupation-based interventions as they felt that they should and as a secondary measure they focused on maintaining their client-centred role.

Subtheme 3.4: Yalom's psychosocial theory of group therapy

Table 4.16: Subtheme 3.4

Subtheme	Codes
3.4 Yalom's psychosocial theory of group therapy	3.4.1 Working in the here and now
	3.4.2 Curative factors

Participants explained the use of the "here and now" as well as the curative factors as described by Yalom[145] in his psychosocial theory of group therapy as contributing to occupation-centred practice.

> *"For me, the biggest, biggest thing is the here and now, and connecting now and doing now and feeling now and reflecting on that now. Because that is where the changes happen."* - Tessa

> *"… so, it's greatly focused on social participation, your Yalom curative factors."* - Colleen

Discussion of Subtheme 3.4: Yalom's psychosocial theory of group therapy

Lloyd and William's[69] suggestion that therapeutic groups are among the main tasks of an occupational therapist working in acute mental health care is supported by Fitzgerald[70]. According to the participants in this study therapeutic groups form part of the occupation-centred practice they provide in acute mental health care facilities. Guiding their practice in this regard the participants refer to Yalom's psychosocial theory of group therapy[145] as having been adopted and given an occupational slant. Participants explained some of their thoughts regarding therapeutic groups and how they relate to occupation-centred practice, mentioning accurately that social participation is classified as an occupation in the OTPF.[13] It appears that not only

the occupational therapists view groups as beneficial, a study by Lim et al.[136] reporting on the perspectives of acute MHCUs indicates that groups with an occupational focus that is meaningful and relevant are seen as most beneficial by service users.

Wimpenny et al.[53] report that occupational therapists appear to be particularly effective in facilitating inclusive and nurturing spaces within therapeutic groups, accepting people as they are, allowing service users space to express themselves and ask for help but also providing the opportunity for service users to provide help and support to others. The ability to effectively facilitate therapeutic groups may be due to the occupational therapist's knowledge and ability to incorporate curative factors into the group. The curative factors include cohesion, universality, imparting of information, interpersonal learning, reconstructing of the primary family, catharsis, altruism, installation of hope, development of socialising techniques, imitating behaviours and existential factors.[145] The curative factor, interpersonal learning which involves learning about relationship and intimacy, has as an essential idea that of the social microcosm which was mentioned by the participants.[145] The group as a social microcosm is best described as the notion that a person's interpersonal behaviours in the context of therapy reflect their interpersonal behaviours in the outside world.[153] Occupational therapists may use this concept in terms of social participation in the group being indicative of social participation in the outside world, and using the tools of the "here and now" as well as the other curative factors to implement occupation-centred practice.

The use of the "here and now" was mentioned by participants as being effective in encouraging MHCUs through the process of occupation-centred practice. This concept is championed by Yalom[145] as a powerful tool. The use of the "here and now" involves facilitating the sharing of raw, honest thoughts and feeling about what one is experiencing or what is happening in the group in the present moment.[145] The use of these practices is described by the participants as contributing to the process of occupation-centred practice previously described.

Subtheme 3.5: Kawa Model

Table 4.17: Subtheme 3.5

Subtheme	Codes
3.5 Kawa Model	3.5.1 Evaluation tool

Tessa described the Kawa Model as a tool used for evaluation.

"Kawa, Kawa is a nice assessment tool actually." - Tessa

Discussion of Subtheme 3.5: Kawa Model

Iwama[154] suggested the use of the Kawa Model in an attempt to incorporate a more eastern understanding of life or philosophy in occupational therapy. The Kawa Model suggests that a person picture one's life as a river. In the picture, the following are included: water which represents the life force or energy of the person, rocks representing challenges or limitations, driftwood, significant attributes that can influence the person's life, river banks and bed symbolise the environment.[146]

How Iwama[146] describes using the Kawa Model does appear to be as an evaluation, which is in agreement with the findings of this study. Wada[155] comments that although the protocol is in alignment with client-centred practice, links to occupation are harder to make, some concepts appear missing such as the meaning attributed to and the effects of occupation. This makes it difficult to see the link this model has to occupation-centred practice. Chan[156] provides some insight in terms of how the application of the model can be used to support occupation-centred practice. Chan[156] illustrates the application of the Kawa Model as a culturally relevant model which serves as a media to help service users re-create meaning in their lives and hence promote positive experience and thinking. Considering the previous descriptions of the process of occupation-centred practice, it becomes clearer that meaning and experience are aspects of the Kawa model that link to the perspectives of the participants regarding occupation-centred practice.

Subtheme 3.6: Sensory Intelligence

Table 4.18: Subtheme 3.6

Subtheme	Codes
3.6 Sensory Intelligence	3.6.1 Sensory Profiling

The Adult Sensory Profile[157] which forms part of the theory of Sensory Intelligence[147] was described by participants as a tool that they frequently used in practice.

> *''I think the one thing that we use very regularly as well though, I don't know if it's really assessment, slash treatment tool, that would definitely be the sensory profile* - Ruth

> *"… do very practical with them in terms of wherever they are activating and calming activities and how do they need to use it in their own system or in their own environment…"* - Ruth

Discussion of Subtheme 3.6: Sensory Intelligence

The American Occupational Therapy Association[16] in their 2019 document titled Occupational therapy's Distinct Value in Mental Health, indicate that sensory strategies can form part of the focus of occupational therapy services in acute mental health care.[16] Krupa et al.[122] suggest that occupational therapy services of this sort can take the form of adaptation or modification of performance. As described by the participants in the current study, an occupational therapist may use the findings from the Adult Sensory Profile,[157] to collaborate with the MHCU to develop ways to incorporate the findings in everyday occupations and routines to enhance performance.[122] Lombard[147] advocates for the use of these strategies in everyday life and in participation in occupations, most specifically in the occupation of work.

Subtheme 3.7: Occupational Therapy Practice Framework

Table 4.19: Subtheme 3.7

Subtheme	Codes
3.7 Occupational Therapy Practice Framework	3.7.1 Occupational profile

The Occupational Profile that forms part of the OTPF[13] was described by participants as being useful when working in an occupation-centred manner.

> *"…activity profile is used… to understand how this person functions with their daily activities."* - Tessa

Discussion of Subtheme 3.7: Occupational Therapy Practice Framework

The participants from this study referred to the activity profile which in the more recent third edition of the OTPF[13] is referred to as the occupational profile. The occupational profile is a summary of the service user's occupational history and experiences, everyday routines, interests, values and needs.[13] The occupational profile is essentially a tool to view occupations from the service users' perspective, in a top-down manner, and thus is considered a component of a client-centred approach.[13,158] The findings of the current study illustrate this to be true but go a step further, indicating that the occupational profile is seen as being especially helpful when practicing in an occupation-centred manner. This sentiment is echoed by the findings of a studies by Hess-April[44] and Wong et al.[159] where the occupational profile was deemed essential to occupation-centred practice.

Ikiugu et al.[90] in their published guidelines for therapists in incorporating both meaningful and psychologically rewarding occupations suggest that an occupational profile should be the starting point.

Theme 3 detailed the theoretical underpinnings of occupation-centred practice from the perspective of the occupational therapists working in acute mental health care. Theme 4 will describe and discuss those influencers that are experienced and

believed to have either a supporting or a constraining impact on occupation-centred practice.

4.3.4 Theme 4: Influencers of occupation-centred practice

Table 4.20: Theme 4 with subthemes

Theme	Subthemes
4. Influencers of occupation-centred practice	4.1 Influencers that support occupation-centred practice
	4.2 Influencers that constrain occupation-centred practice

Theme 4: Influencers of occupation-centred practice

The findings of this study indicate that the participants felt that in their experience there were different influences, some of which made it easier or supported occupation-centred practice. Other influencers they believed had more of a negative impact in their experience, constraining occupation-centred practice.

'Easier' was used by the participants to explain positive influencers:

> *"…that in itself is easy, makes it (occupation-centred practice) easier."*
> - Stacy

> *"So, I think what makes it (occupation-centred practice) easier also is…"*
> - Annette

Whilst words like 'hard' and 'difficult' were used by the participants to explain and describe those influencers which constrained occupation-centred practice.

> *"…that is hard, that makes it (occupation-centred practice) difficult."* - Stacy

> *"I think it's difficult (occupation-centred practice), I think it could be even more, it could be even more (occupation-centred)."* - Amanda

Discussion of Theme 4: Influencers of occupation-centred practice

The participants of the current study unanimously reported that they considered their practice to be occupation centred, though one did mention she felt it could be even more occupation centred. The findings also indicate that although they reported practising in an occupation-centred manner they did not always find it easy to do so. The participants mentioned that they experienced certain influencers that facilitated occupation-centred practice and those that constrained occupation-centred practice.

A paper by Ashby et al.[35] suggests that in some mental health care facilities there is a danger that occupational perspectives and occupation-centred practice can become marginalised by competing dominant practice knowledge discourses. Ashby et al.[45] further highlight the pressures felt by occupational therapists to adopt psychological frames of reference in practice and the tension that this creates for occupational therapists. Daud et al.[158] in a Malaysian study made similar findings indicating that it is challenging to practice occupation-centred intervention in a healthcare system that is dominated by the medical model. In Mulligan et al.[152] it was found that although participants valued occupation-based, client centred, and evidence-based practices, the tools, materials, and activities they most often used tended to focus more on the evaluation and remediation of body functions and performance skills than on occupational performance.[152]

The findings of this study indicate that occupational therapists working in acute mental health care in South Africa do not struggle to implement occupation-centred practice due to the emergence and predominance of other discourses as suggested by Ashby et al.[35,45] in Australian studies and Daud et al.[158] in a Malaysian study.

Subtheme 4.1: Influencers that support occupation-centred practice

Table 4.21: Subtheme 4.1

Subtheme	Codes
4.1 Influencers that support occupation-centred practice	4.1.1 Achieving the outcome, strengthens the occupation-centred process
	4.1.2 Being authentic
	4.1.3 Teamwork
	4.1.4 Having experience

The participants reported that in their experience the following had a positive effect on their ability to be able to practice in an occupation centred manner: achieving the outcome was believed to strengthen the occupation-centred process, the occupational therapist being authentic, teamwork and the occupational therapist having experience in acute mental health care.

Jane explained how meeting the outcome of meaningful and purposeful engagement strengthened the occupational therapists' resolve to practice in an occupation-centred manner:

> *"…it actually gives you (the OT) meaning and purpose to see the patient is engaged in meaningful and purposeful tasks… It motivates you to actually do your occupations and to practice."* - Jane

The occupational therapist being authentic is described by Stacy as facilitating occupation-centred practice:

> *"…how we try to make it (groups) more occupation-centred is almost by being real and being true, you know occupation-centred, so the examples you will use is almost your own personal, it's almost like setting the norm like you are the norm."* - Stacy

Working as a team, in terms of referral and other occupational therapists was believed to positively influence occupation-centred practice.

> *"The doctors, that gives our referrals gives a very detailed referral ja and that helps."* - Ruth

"I mean we are six (6) OT's in our practice, just to be able to bounce ideas off each other. I don't think I would like to do it alone…" - Candice

The occupational therapist having experience in acute mental health care as well as having a range of real-life experiences was also seen as having a positive influence on occupation-centred practice.

"…because it's more just thinking about the group and facilitating it in the here and now and having a lot of experience already then you can just first see what the group comes up with so the preparation is also not that much anymore, as in the beginning of my career." - Tessa

"I think to a certain level, going through stuff yourself, I do think because then it's a relating kind of thing but just um cause its real, um, but the fact that we all have to do things. We have to balance things ourselves." **-** Ruth

Discussion of Subtheme 4.1: Influencers that support occupation-centred practice

The findings of this study indicate that participants experienced that in achieving the outcomes of the occupation-centred process, their resolve and motivation to practice in an occupation-centred manner was strengthened. Limited literature is available regarding this phenomenon in this context, however, it appears that the success of the process, when healing is achieved, serves as an intrinsic motivator to the therapist which then positively reinforces the implementation of the occupation-centred process.[160]

The occupational therapist being authentic or real was also described in the findings as facilitating the occupation-centred process. Wimpenny et al.[53] report similar findings; for occupational therapy intervention to be successful, occupational therapists need to demonstrate an authentic therapeutic relationship that is built upon care, trust, and respect. Service users also emphasise the significance of occupational therapists demonstrating authenticity and genuineness in terms of the therapeutic relationship.[53]

Teamwork in terms of the multi-disciplinary team referring timeously and providing a detailed referral as well as working in a team of occupational therapists was found to have a positive influence on the implementation of occupation-centred practice. These findings are supported by Gillen and Gerber[39] who suggest that occupational therapists can support each other in adopting the contemporary occupation-centred paradigm.

The participants believed that an occupational therapist with a wide variety of life experiences and extended working experience in acute mental health care would find practising in an occupation-centred manner less challenging. They commented on the ability of the occupational therapist to relate to what the MHCU was experiencing and mentioned having additional life experiences, increased the likelihood of being able to relate to the MHCU's experience. Participants did however also mention that occupation is something that is they believe is universally understood as it is part of the human condition and therefore is easy to understand and relate to. Krupa[122] confirms that the strength of the construct of occupation is that it is easily understood in lay terms and relevant to most people.

A study by Di Tommaso et al.[85] found that participants felt that with more experience they would be able to become more occupation-based in practice, this appears to be confirmed by the findings of the current study. A study to determine facilitators of implementing occupation-based practise among Iranian occupational therapists by Khayatzadeh Mahani et al.[31] found that the education programs of occupational therapy departments, the public information about occupation-based practice and working in a clinical setting that was compatible with occupation-based practice were all contextual factors facilitating occupation-based practice. Other facilitators reported were related to the therapist, having a positive attitude regarding the effectiveness of occupation-based practice, emphasis on client-centred and family-centred practice and convincing the service users to utilize occupation-based practice.[31] Although in the current study it appears that the participants have a positive attitude towards occupation-centred practice because they have experienced and therefore believe that it is effective and report making use of a client-centred approach, none of the other facilitators described in the Iranian study correspond to the findings of this study.

Subtheme 4.2: Influencers that constrain occupation-centred practice.

Table 4.22: Subtheme 4.2

Subtheme	Codes
4.2 Influencers that constrain occupation-centred practice	4.2.1 Heavy workload
	4.2.2 Lack of resources
	4.2.3 Limited admission period
	4.2.4 Rigidity of the mental health care facility
	4.2.5 Consequences of mental disorders
	4.2.6 Use of meaningless/routine activities
	4.2.7 The multidisciplinary team's confusion regarding the scope and practice of occupational therapy

The participants reported that they experienced occupation-centred practice as being time-consuming and hard work.

Occupation-centred practice: "It's hard work, time-consuming." - Colleen

"…it is very time consuming and it is difficult…" – Annette

The participants believed that the following influencers place limitation or constraints on practising in an occupation-centred manner, making it more challenging to do so.

A heavy workload, lack of resources, a limited admission period, rigidity in terms of the mental health care facility, the consequences of mental disorders, the use of meaningless activities and the multidisciplinary team's confusion regarding the scope and practice of occupational therapy were all experienced by the participants as having a negative impact on occupation-centred practice.

A heavy workload as described by the participants included their experience of all the tasks they were required to do, how time-consuming they found occupation-centred practice to be, as well as the vast scope of occupation.

"We for argument's sake have an hour session but there is no consideration for the half an hour in advance that it took you to prep and then even if your

patient is part of the clean-up in terms of therapy, there is still stuff that needs to be sorted, packed away, whatever afterwards…" - Colleen

"It (occupation) is so vast." - Betty

"It's (occupation) a lot of different things." - Anne

This participant commented on the amount of administration work that she was required to do:

"Um well, my day will start with coffee and then admin, admin, admin and more admin…" - Maureen

A lack of resources was reported in terms of financial resources, especially those of the MHCU, space, materials, and the time the occupational therapist has available. Anne referred to the lack of resources of the MHCU when she said:

"I think if you also work in a fairly deprived environment, it is very difficult getting there (to occupation-centred practice). And most of our users come from a really deprived environment where they literally have nothing." - Anne

Abigail commented on a lack of space:

"So, your resources are almost limited in a sense that the actual space and um, you know you can't bring a whole kitchen in your boot, it's just not possible." - Anne

These participants commented on the lack of time the occupational therapist has available:

"The task team are currently working on the ratio of patient to um staff to OT and we not getting there. We, way too few OT's to address all the needs and for that reason um in a government hospital you a lot of times have to focus on groups to try and get to the majority of patients. You don't have time to work individually client-centred and occupation-centred as you would like to because there is just no time to do that". - Isabel

"It does help you a lot if you, that time if you have the time and the resources." - Susan

A limited admission period was also experienced as providing a challenge to occupation-centred practice.

> *"And I think also sometimes if you think of a limited stay of an acute patient, sometimes it takes up so much of that admission time just for the diagnosis to be um…, and to stabilise the patient that by the time we get to work with the patient we don't have ten days. We have maybe three..."* - Betty

The rigidity in the structure and set up of the mental health care facility in terms of the daily programs made it difficult to ensure that there were enough occupational therapy groups.

> *"…that's how the hospital program is set up and how it has been structured. And OTs only do a small number of groups in the hospital."* - Candice

The consequences of mental disorders that are experienced by the MHCUs are also experienced as challenges to occupation-centred practice:

> *"To set goals about what is meaningful is hard because they (MHCUs) don't know."* - Annette

The participants experienced that the use of meaningless activities by occupational therapists hindered occupation-centred practice. These activities are comfortable for the occupational therapist to use as they are known and easy to use but not necessarily experienced as meaningful by the MHCUs.

> *"I think we run the risk of falling into our comfortable activities and our comfortable games and using it over and over and not really re-evaluating the meaningfulness of it."* - Cynthia

The participants believed that there was confusion amongst the multidisciplinary team regarding the scope and practice of occupational therapy which negatively influenced the speed of the referral process and therefore occupation-centred practice and the outcome that could be achieved.

> *"…um, so I do feel that sometimes the ignorance of other people and our role and things, um I do feel we can sometimes make more of an impact in an*

acute setting if people actually, well the referring people, will actually wake up sooner." - Betty

Discussion of Subtheme 4.2: Influencers have a negative impact on occupation-centred practice.

The findings of this study indicate that occupation-centred practice is experienced as being a lot of hard work. The participants working in the private sector who rely on a billing system to received payment reported that they experienced that this time was also not reimbursed, which they found frustrating and limiting. The participants found it time-consuming to practice in an occupation centred manner. This finding is supported by Estes and Pierce[34] as well as Aiken et al.[30] who found that occupation-centred practice takes more time and that this time is not provided for in the occupational therapist's daily schedule.

The participants found that other tasks including administration limited the time they had available to implement occupation-centred practice. The pressure to complete paperwork and coordinate the MHCU's care, can limit face-to-face contact with the service user and distract occupational therapists from their core purpose.[72]

A lack of other resources was cited by the participants, especially those working in the government sector these include available finances, space, and materials. The mental health care facilities in the government sector cater for most of the population and these facilities are often limited in terms of financial resources. Working in a low socio-economic or deprived community posed challenges in terms of what materials and activities the participants could ethically introduce into intervention. The occupational therapist would want to expose the MHCU to sustainable activities during evaluation and intervention but if the MHCU is an individual who is homeless and thus has no access to resources then the use of activities becomes difficult. This appears to have created a possible ethical dilemma for the participants. The ethical dilemma experienced may be somewhat unique to the South African context where extreme poverty is a serious yet common condition.

Participants also noted that environmental constraints included not having enough space or the appropriate physical environment like a kitchen with the necessary equipment to do activities in. Estes and Pierce[34] report similar findings, that barriers to occupation-centred practice include equipment and space availability limitations, and reimbursement issues. In a South African study by Hess-April[44] a lack of resources was also reported as limiting occupation-centred practice. The resources detailed included a lack of time, funds, and materials as well as a lack of human resources or occupational therapists to carry out occupation-centred practice.

The time that the occupational therapist has available is not the only time constraint experienced as a limitation; the time the MHCU is admitted for also limits occupation-centred practice. The participants found that once the MHCU was stable and able to participate in occupational therapy they were only admitted for a few more days, essentially giving them limited time to work with the MHCU. The concerns of the participants are echoed by the findings of a study by Casteleijn and Graham[138] who state that clinicians in their study were concerned that the admission period did not allow enough time for them to form adequate therapeutic relationships with the MHCUs. Participants in Britton's[88] study also identified time constraints and the referral-based nature of their work as limitations to occupation-centred practice resulting in an inability to adequately use all of their skills.

Acharya and D'souza[161] comment that acute mental health settings pose specific challenges due to the varied nature of client diagnoses, short duration of stay in the hospital and fluctuating symptoms.[161] The consequences of mental disorders such as the fluctuation in symptoms as well as an inability to voice what they find meaningful because they lack motivation, energy and themselves are unsure about what they find meaningful.

Di Tommaso et al.[77] note that occupational therapists may base their practice decisions on what pragmatically and historically had been offered at that facility previously. Some participants in their study felt they had no choice but to accept and continue with the historical way of practising.[77] This was experienced by the participants in the current study too, they felt limited in terms of what they could and

couldn't do by the predetermined historical program of the facility, and their resistance to change.

Findings of the current study indicate that the participants were wary of getting comfortable in using the same routine activities and believed that although this may be easier on them that would be a move away from occupation-centred practice. Burley et al.[162] found that an occupational perspective was sometimes seen as being on autopilot and including a regular script of routine activities.

The multidisciplinary team's confusion regarding the scope and practice of occupational therapy affected the speed at which referrals are made to the occupational therapist which has a direct impact on the time that is available for intervention. The participants mentioned this as a source of frustration as they felt if the referral had come through sooner, they would be able to do more with the MHCU. This frustration is well-founded with Britton et al.[88] highlighting the importance of early referrals in order for occupational therapists to work quickly towards service user discharge but also mention as do Gerber and Gillen[36] and Duffy[163] that a lack of clarity regarding the occupational therapists roles and purpose is not new in acute care.

It must be noted however that even though many limitations or constraints to occupation-centred practice are detailed, the participants still reported that they believed that they are practising in an occupation-centred manner and are overcoming or working around these barriers effectively.

4.4 CONCLUSION

This chapter reported the findings of this study which aimed to explore and describe the perspectives of occupational therapists working in acute mental health care regarding occupation-centred practice. Perspectives were earlier defined as the participants' beliefs, understanding and experience. Four themes and relevant subthemes were constructed and discussed in detail to provide a clear description of the perspectives of the participants on occupation-centred practice. Each theme and subtheme were compared to the applicable literature to provide context and

balance. Most of the views of participants were supported by the literature. The following chapter will conclude and critique the study, as well as make relevant recommendations.

CHAPTER 5
CONCLUSION

5.1 INTRODUCTION

This chapter serves as a conclusion to the study. Initially, the findings of the study as discussed in Chapter 4 will be linked to the aim of the study. The contribution of the completed research is then discussed. This is followed by a critique of the study after which recommendations, based on the findings, will be suggested for education and training programmes, occupational therapists in clinical practice, and further research.

5.2 THE AIM OF THE STUDY

This study aimed to explore and describe occupation-centred practice from the perspective of occupational therapists working in acute mental health care. To achieve this, occupational therapists working in acute mental health care in the City of Tshwane, South Africa shared their perspectives of occupation-centred practice during two focus groups. These shared perspectives were transcribed verbatim and analysed by the researcher. Guided by the interpretive paradigm,[55] thematic analysis as described by Braun and Clark[103] was employed by the researcher to inductively construct four themes, considered the findings of the study.

The findings of the study provided a detailed description of occupation-centred practice in acute mental health from the view of the occupational therapist. The four themes namely, (1) the process of occupation-centred practice, (2) activities enable occupation-centred practice, (3) theoretical underpinnings of occupation-centred practice and (4) influencers of occupation-centred practice all served to describe occupation-centred practice from the participants perspective. The aim of the study was therefore accomplished.

5.3 THE CONTRIBUTION OF THE STUDY

Brink et al.[98] suggests that research findings should ultimately contribute to building the profession's body of knowledge in a meaningful way. The description of occupation-centred practice provided by this study contributes to the development of occupational therapy as a profession in several ways. These will be discussed under the following subheadings: occupational therapy profession, theoretical contribution (occupational science), and education and training.

5.3.1 Occupational therapy profession

The findings of the study paint a clear picture of what occupation-centred practice entails from the perspective of the occupational therapists working in acute mental health care. Separating occupation-centred practice into the fundamental components of which it is comprised is essential in developing an understanding of the practice. The findings describe occupational-centred practice, the process, which entails the occupational therapist enabling the MHCU to experience through doing, then facilitating reflection of the experience resulting in healing which is viewed as the outcome. Activities were described as the avenue through which occupation-centred practice is achieved. These findings from the perspective of occupational therapists working in acute mental health care and the clarity that they provide are required to further study, maintain, replicate, and advance occupation-centred practice.

Burley et al.[162] and Molineux and Baptiste[164] suggest that a clear description of the unique contribution of occupational therapy in all the practice areas may result from critical reflection within the profession of occupational therapy. This study provided the opportunity for critical reflection of current occupational therapy practice in the acute mental health care setting, allowing articulation of occupational therapy's unique contribution in this setting.

The findings suggested that challenges to occupation-centred practice do exist and although occupational therapists in this study saw themselves as being able to overcome these barriers, this may over time become tiresome and if not addressed

may threaten or result in a decline in occupation-centred practice in the future. Identifying those influencers that are perceived and experienced as having a constraining impact on occupation-centred practice allows them to be addressed proactively. Those influencers that have a positive and supportive impact can once identified, be strengthened and or employed to support occupation-centred practice.

5.3.2 Theoretical contribution (occupational science)

The findings of this study, the description of current practice, support the idea of occupation as the core construct of occupational therapy and indicate that this idea as suggested by the contemporary paradigm[80] may have been embraced and implemented by occupational therapists in the Southern African context in acute mental health care. This is encouraging and may be significant as theories developed by occupational scientists are not always accepted and implemented in practice, often due to a lack of consultation with practitioners.[121] The likely acceptance of the contemporary paradigm[80] by occupational therapists in acute mental health care in South Africa reduces the chances of the emergence of a theory-practice gap.[41] Thus, reaffirming the Occupational Therapy Department of the University of Pretoria's decision to implement an occupation-centred undergraduate curriculum in acute mental health care centred.

5.3.3 Education and training

Occupational therapy education and training programmes are often where a link between occupational science and occupational therapy practice is established, where theory and research meet practice.[19,34] A description of the practice element of occupation-centred practice as provided by this study provides input to educators regarding current practice. With a clear picture of current occupation-centred practice in acute mental health care available to them, educators are better able to prepare and support students for work in that context.[35]

Ashby and Chandler[148] report that occupation-focused models of practice are included in curricula based on how prevalent their use in practice is perceived to be.[148] The findings of this study indicate which theories occupational therapists

implement in acute mental health care to support and guide occupation-centred practice. The theories perceived by the participants as being useful in the implementation of occupation-centred practice should be considered by occupational therapy education and training programmes for inclusion in curricula at an undergraduate level to promote occupation-centred practice.

In summary, the findings of this study describe occupation-centred practice in acute mental health care, which serves as a foundation for further enquiry into and advancement of occupation-centred practice. The findings of this study articulate occupational therapy's unique contribution to acute mental health care. This study contributes to education and training, as the findings suggest that theory and practice may concur, as well as by providing clarification of the theoretical base used to guide occupation-centred practice. Occupation-centred practice can be enhanced by the provision of a description of those influencers that challenge the implementation of occupation-centred practice and those that support it, this too is viewed as a contribution.

5.4 CRITIQUE OF THE STUDY

Critiquing a study provides a systematic evaluation of the strengths and limitations of the research study to determine the value it adds.[165]

5.4.1 Strengths of the study

Since the link between occupational science and occupational therapy is strengthened through consultation and collaboration, researchers are encouraged to engage and consult with practitioners to ensure occupational science and occupational therapy work collaboratively to develop knowledge and understanding of occupation and its' role in wellbeing.[121] In this study, the voices of occupational therapists' practice in acute mental health care were heard, their perspectives were acknowledged and reported. This consultation and therefore the findings of this study strengthen the connection between occupational science and occupational therapy by further developing knowledge and understanding of the use of occupation in practice.

Transferability of study findings is often noted as a concern in qualitative research.[166] This study, with a qualitative design, took place in a small area of South Africa, the City of Tshwane. All participants recruited were working in acute mental health care in and around the City of Tshwane during the time of the study. The thick description of the participants reported in Chapter 4 provides detailed information for comparison to other samples upon which the transferability of the findings can be determined.[110] Thus addressing any concern regarding transferability.

The qualitative approach to this research with an explorative, descriptive design resulted in the gathering of rich data, which was interpreted by the researcher as guided by the interpretive paradigm to answer the research question.[92,94]

5.4.2 Limitations of the study

Limitations of a study refer to any inherent characteristics in the design or methodology of the study that weaken the validity of the findings.[98] In this study, the composition of the focus groups may be seen as a limitation. While every effort was made to optimise the heterogeneity of the focus groups through maximum variance purposive sampling, the researcher was unable to ensure that there was an equal number of participants from the private and public sectors in each group as only a limited number of occupational therapists working in the public sector showed an interest in participating in the study. The prevalence of occupational therapists working in the private sector may have influenced the findings of the study.

5.5 RECOMMENDATIONS

5.5.1 Recommendations for undergraduate education and training

It is recommended that undergraduate occupational therapy students are educated in occupation-centred practice.[30,76,167] The description of occupation-centred practice provided by the findings of this study may be used in education and training programmes to assist in educating occupational therapy students regarding occupation-centred practice in acute mental health care. Providing a clear description of what the unique contribution of occupational therapy is in this setting

may assist students in understanding the role and contribution of occupational therapy in acute mental health care, which may aid them in implementing occupation-centred practice when required to do so.

Furthermore, an area of learning that occurs in education and training is the imparting of knowledge based on the theoretical models of practice upon which the practice of the profession is based.[76,167] The findings of this study indicated which theoretical models, frames of reference and frameworks occupational therapists implemented to direct occupation-centred practice. These theoretical constructs, which were found to uphold and support occupation-centred practice, may be considered for inclusion in education and training programmes. The Vona du Toit Model of Creative Ability,[142] the Model of Human Occupation,[143] the Client-centred Approach,[144] Yalom's psychosocial theory of group therapy,[145] Kawa Model,[146] Sensory Intelligence,[147] and the Occupational Therapy Practice Framework[13] were found by this study to support and guide occupation-centred practice in acute mental health care and it is therefore recommended that these theoretical constructs are considered for inclusion in undergraduate education and training programmes. The application of these theoretical constructs to the field of acute mental health care can be explained making use of the findings of this study to ensure that occupation-centred practice continues to triumph in acute mental health care.

Educators have a responsibility to prepare students adequately to work in the different areas of occupational therapy practice and to encourage occupation-centred practice.[76,167] The findings of this study provide detailed descriptions of those influences that proved to challenge occupation-centred practice, allowing educators to fully prepare and equip students to overcome these once in practice. If students are adequately prepared for and taught to manage the heavy workload and the limited resources they may encounter, students may feel better equipped and therefore better able to overcome these challenges. Students should be informed about the effects of meaningless or routine activities, as highlighted by the participants, and should be encouraged to think creatively to compensate for a lack of resources.

The multidisciplinary team's confusion regarding the scope and practice of occupational therapy can also be addressed at an education and training

programme level. Occupational therapy departments at educational institutions should be encouraged to engage those in other health care departments with the aim of ensuring that students of other health care professions are adequately trained and educated as to the role, scope, and unique contribution of occupational therapy, especially in acute mental health care.

Implementing these recommendations in undergraduate education and training programmes may ensure that occupational therapy continues to make a unique contribution to acute mental health care through occupation-centred practice, therefore strengthening the profession.

5.5.2 Recommendations for occupational therapists in clinical practice

Britton et al.[88] suggests that occupational therapist practising in acute care "need support to embrace and articulate the professional artistry that has evolved" in this context. The researcher too recommends that support is offered to those practising not only in acute mental health care but also to those who advocate for and implement occupation-centred practice. This can be done practically in groups that are set up virtually on a social media platform such as WhatsApp, where support can be offered to therapists by therapists in similar settings. On this platform, therapists can share experiences and connect with others who can provide support and guidance in the implementation of occupation-centred practice.

Teamwork was highlighted by the participants as having a positive influence on occupation-centred practice. Whilst many occupational therapists do work in teams there are those who practice as individuals. Those individuals should be encouraged to pair up with mentors or peer-supporters who could assist, guide, and support them in implementing occupation-centred practice.

Reflective practice is encouraged to guide occupational therapists in making sense of their own occupation-centred practice.[30,168] Further opportunities could be provided for occupational therapists to spend time appreciating and developing occupation-centred practice through the sharing of success stories, and learning together.[30] Participating in conversations with fellow occupational therapists about

occupation-centred practices, lessons learnt, experiences, tips and strategies used is a recommended strategy for supporting the use of occupation in practice.[36,77] Similarly, Di Tommaso et al.[77] highlights the need for continued professional development opportunities that focus on implementing occupation-centred practice and the occupation for health message, to ensure the advancement of the use of occupation in practice.

The multidisciplinary team's confusion regarding the scope and practice of occupational therapy is a constant concern for the profession especially in the field of mental health.[169] Although attempts are continuously made at a university level through interprofessional education and collaboration, to clarify the scope and practice of occupational therapy, it appears that little is changing.[170] This confusion has a real and felt negative impact on health care for the MHCU and should be addressed. Occupational therapists should be encouraged to take an active role in educating those they encounter regarding occupational therapy's scope and role.

5.5.3 Recommendations for future research

The findings of this study present additional topics that may warrant inquiry.

Numerous accounts of the use of the Vona du Toit Model of Creative Ability[142] (VdTMoCA) were described by the participants of this study. This warrants further study into the possible relationship of this model to the implementation and support of occupation-centred practice.

The picture portrayed by this study in terms of what occupation-centred practice looks like in acute mental health care from the perspective of the occupational therapist assists in understanding occupational therapy practice in this context. Similar research in different contexts such as chronic mental health care, or acute physical or neurological rehabilitation may broaden and deepen our understanding of occupation-centred practice and provide a picture of what current practice looks like in these areas. A description of the practice in all contexts may assist in education and training, continuing to drive and support occupation-centred practice in all areas of practice.

Research investigating the service user's experience of occupation-centred practice in acute mental health care could be conducted to provide a different perspective on the findings of this study. A comparison could be done to detail the similarities and the differences in these two perspectives and highlight any possible contradictions or misunderstandings. It may also be of value to explore educators' perspectives of occupation-centred practice in acute mental health care to provide yet another perspective with which to compare the current findings.

Finally, a more detailed description of the activities that are used in acute mental health care to establish and facilitate occupation-centred practice could be attained. This information could be used to inform education and training programmes regarding the kind of activities that should be included in curricula. The inclusion of these activities at an undergraduate level may assist students with the transition from university to clinical practice and may facilitate and support the continuation of occupation-centred practice.

In conclusion, all the above-suggested recommendations may serve to stimulate the conversation regarding occupation-centred practice. Continuing to deepen our understanding of the application of occupation as the central tenant of the profession and thereby continuing to drive occupation-centred practice forward. All this in a bid to hold fast and encourage occupational therapy's true and unique contribution to health care, thereby strengthening the profession.

5.6 THE RESEARCHER'S PERSONAL REFLECTION

Reflexivity required of the researcher to keep a research journal, keeping track of changes in thoughts, perspectives and attitudes throughout the research process.[62]

I, the researcher, am an occupational therapy lecturer with a special interest in acute mental health care. I strongly believe that the value of occupational therapy lies in its uniqueness which stems from its view of the person as an occupational being. This is how I experience myself, as an occupational being who derives meaning

through doing, being, becoming and belonging. Occupation is therefore central to my view of the person and the profession.

At the beginning of this research process, I was concerned that in acute mental health care occupational therapists were losing sight of their unique contribution and were practising with a different view of the person in mind. My perspective was informed by what I observed when I visited acute mental health care facilities that served as service-learning placements for students. It appeared to me that occupation had been replaced by meaningless routine activities and a focus on the cognitive behavioural frame of reference.

However, having reached the end of this research journey I see now that my fears were unfounded and that indeed occupational therapists are practising in an occupation-centred manner. This research has informed my ability to conceptualise what this means in acute mental health and has deepened my understanding and appreciation for the complexities of occupation-centred practice in acute mental health care. Strengthened by this understanding I feel better able to articulate and teach occupation-centred practice to the next generation of occupational therapists.

I am forever grateful for and humbled by the opportunity to challenge and alter my perspective. I am encouraged by the findings of this study and energised by the common belief in the power of occupation. I have learnt the importance of questioning one's perspective and the humility to grow.

5.7 FINAL CONCLUSION

Chapter 5, the final chapter in this dissertation, has linked the findings of this study to the aims, detailed the contribution of the study, critiqued the study and then provided recommendations in terms of undergraduate education and training, occupational therapists in clinical practise as well as made suggestions of further research. The chapter ended with the researcher's own personal reflection on the study.

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ANNEXURES

LIST OF ANNEXURES

Annexure A

Invitation to participate in the study

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Department of Occupational Therapy

Faculty of Healthcare Sciences

August 2019

Invitation to participate in research

Dear Occupational Therapist working in acute mental health care,

This is an invitation to participate in a research study as part of my master's degree in occupational therapy titled: "**Occupation-centred practice: perspectives of occupational therapists working in acute mental health care**" with ethical clearance number 467/2019.

This study aims to explore the understanding, beliefs and experiences of occupational therapists working in acute mental health care regarding the use of occupation in practice. Your voice as a practitioner is valuable in ensuring practice and research inform each other.

To be included in this study you should:

- Be an occupational therapist registered with the Health Professions Council of South Africa (HPCSA) as an independent practitioner

  AND

- Be actively involved in the assessment and intervention of mental health care users who require **acute** mental health care

Contributing to this research will involve participating in **one** of the two focus groups that will run for approximately 90 min on a Friday afternoon. The proposed dates are 27/09/2019 and 11/10/2019. The focus groups will be held at the Department of Occupational Therapy, 5th floor HW Snyman Building South, Prinshof Campus. Refreshments will be served after the group. CPD points will be awarded.

If you meet this criteria and are interested in participating please complete the attached demographic information form and email it to me (dol.jenna@gmail.com) by 06/09/2019. Please mention in your email if you are willing to participate but unable to attend on any of the above-mentioned dates. This information will be used to allocate you to a focus group in such a way as to increase the diversity of the group (in terms of years of experience, work setting etc).

If you know of any other occupational therapist working in acute mental health care who may be interested in participating, please feel free to share this email with them.

Please contact me with any queries.

Kind regards

Jenna d'Oliveira
dol.jenna@gmail.com
0828511426

Annexure B

Demographic information form

Demographic information form

Please complete the following information about yourself. This information will not be used to identify you. It will be used to allocate you to a focus group and to communicate with you regarding the date of the group.

1. Name:_____
2. Please indicate your preferred contact method:

   ☐ Email:_____

   ☐ Cellphone:_____
3. Age:_____
4. Gender *(please tick the appropriate box)*:

   Female ☐ Male ☐
5. Total number of years practicing occupational therapy: _____
6. University where you obtained your undergraduate degree:_____
7. In which year did you obtain your undergraduate degree?_____
8. Do you have a post graduate qualification? *(please tick the appropriate box)*

   Yes ☐ No ☐
9. If yes, please specify the qualification, the year it was completed and the institution through which it was obtained:_____
10. How many years of experience do you have practicing in the field of acute mental health care?_____
11. I work in the *(please tick the appropriate box)*

    Private sector ☐ Government sector ☐
12. Number of years working for current employer:_____

Thank you.

Annexure C

Informed consent form

PARTICIPANT'S INFORMATION AND INFORMED CONSENT DOCUMENT FOR A

FOCUS GROUP INTERVIEW RESEARCH STUDY

Study title: Occupation-centred practice: perspectives of occupational therapists working in acute mental health care

Principal Investigator: Jenna d'Oliveira

Supervisor: Tania Buys and Enos Ramano

Institution: University of Pretoria

DAYTIME AND AFTERHOURS TELEPHONE NUMBER(S):

Daytime number: 082 851 1426

Afterhours number: 0828511426

Date and time of informed consent discussion:

			:
date	**month**	**year**	**Time**

Dear Occupational Therapist/ Prospective Participant

1) INTRODUCTION

You are invited to volunteer for a research study. I am doing this research for a Master of Occupational Therapy degree purposes at the University of Pretoria. The information in this document is provided to help you decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this document, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about what we will be discussing during the focus group discussion.

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore and describe the perspectives of occupational therapists working in acute mental health regarding occupation-centred practice.

Part of the study will be a focus group discussion. A focus group is where a few people – usually about 8 or 10 – get together with the researcher to discuss a specific topic.

3) EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPECTED FROM PARTICIPANTS

If you agree to participate, you will be asked to participate in a focus group discussion which will take about 60-90 minutes. The discussion will be arranged on a Friday afternoon and will take place at the University of Pretoria Prinshof campus, at the Department of Occupational Therapy on the 5th floor HW Snyman Building South. You and the other participants will be asked some questions about your opinion about occupation-centred practice in acute mental health.

With your permission, the discussions will be recorded on a recording device to ensure that no information is missed. You will also be asked to comment electronically on the preliminary results of the study a few months later.

4) RISKS AND DISCOMFORTS INVOLVED

We do not think that taking part in the study will cause any physical or emotional discomfort or risk.

You do not have to share any knowledge you are not comfortable with.

If questions feel too personal or make you uncomfortable, you do not have to answer them.

5) POSSIBLE BENEFITS OF THIS STUDY

You will not benefit directly by being part of this study. But your participation is important for us to better understand the actual doing or practice element of occupation-centred practice. The information you give may help the researcher make suggestions in terms of undergraduate occupational therapy curriculum.

6) COMPENSATION

You will not be paid to take part in the study. There are no costs involved for you to be part of the study.

7) VOLUNTARY PARTICIPATION

The decision to take part in the study is yours and yours alone. You do not have to take part if you do not want to. You can also stop at any time during the interview without giving a reason. If you refuse to take part in the study, this will not affect you in any way. You will still receive standard care and treatment for your illness.

8) ETHICAL APPROVAL

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee. The study will follow the Declaration of Helsinki (last update: October 2013), which guides doctors on how to do research in people. The researcher can give you a copy of the Declaration if you wish to read it.

9) INFORMATION ON WHO TO CONTACT

If you have any questions concerning this study, you should contact:

Jenna d'Oliveira 0825811426

Tania Buys 0834078463

Enos Ramano 0825742720

10) CONFIDENTIALITY

We will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious pseudonym (another name) and we will refer to you in this way in the data, any publication, report or other research output. Similarly, any mental health care facilities mentioned in the data will be assigned a numerical value and will be referred to as such in the data, results, reports or any research output.

All records from this study will be regarded as confidential. Results will be published in medical journals or presented at conferences in such a way that it will not possible for people to know that you were part of the study.

The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Research Ethics Committee. All these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

All hard copy information will be kept in a locked facility at the Department of Occupational Therapy at the University of Pretoria, for a minimum of 15 years and only the research team will have access to this information.

Although all participants of the focus group discussion will be requested to keep the discussion confidential, the researcher cannot guarantee that they will do so. I, therefore, request that you do not disclose any information of a very personal or sensitive nature.

11) CONSENT TO PARTICIPATE IN THIS STUDY

- I confirm that the person requesting my consent to take part in this study has told me about nature and process, any risks or discomforts, and the benefits of the study.
- I have also received, read and understood the above-written information about the study.
- I have had adequate time to ask questions and I have no objections to participating in this study.
- I am aware that the information obtained in the study, including personal details that I disclosed by completing the demographic information form, will be anonymously processed and presented in the reporting of results.
- I understand that I will not be penalised in any way should I wish to discontinue with the study and my withdrawal will not have any negative consequences.
- If photos are taken it may only be used after I have seen it and agreed that it may be used.
- I am participating willingly.
- I have received a signed copy of this informed consent agreement.

_____ _____

Participant's name (Please print) Date

_____	_____
Participant's signature	Date
_____	_____
Researcher's name (Please print)	Date
_____	_____
Researcher's signature	Date

I understand that the focus group discussion will be audiotaped.

I give consent that it may be audio recorded.

YES

NO

Annexure D

Moderator confidentiality agreement

Confidentiality Agreement

Mrs J d'Oliveira
142 Paprika Avenue
Newlands
Pretoria
0181
0828511426
dol.jenna@gmail.com

Date September 27, 2019.

Confidentiality agreement

I am participating in this research study, Occupation-centred practice: perspectives of occupational therapists working in acute mental health care, as:

- [X] the moderator for the focus group interviews, which are being used to collect data for this study.
- [ ] first language English speaking independent person reviewing the transcriptions, checking for accuracy.
- [ ] a peer reviewer assisting in the data analysis, coding and theme construction of this study.

I agree to treat all information that is made known to me through this study as confidential, including the names of the participants and the mental health care facilities at which they work. I will protect the study participants by never revealing or discussing any of the information obtained through the study with anyone except the researcher, J d'Oliveira and the supervisors of the study, Dr E Ramano and Mrs T Buys.

Signed by: Jodie de Bruyn
Date: 27/9/2019.

Signed by: J d'Oliveira
Date: 27/9/2019

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Annexure E

Focus group question guide

Occupation-centred practice: perspectives of occupational therapists working in acute mental health care

Focus group question guide

The framework used for this focus group question guide is described by Liamputtong (2011)[61]. The questions are informed by literature, the Occupational Therapy Practice Framework Domain and Process 3rd edition (2014) and a publication by Fisher (2013) as well as the research question.[13,24]

Introductory question	What does a day of being an occupational therapist in your setting look like? What do you use to evaluate service users? What do you use in treatment with service users? What do you understand by the term occupation? What do you understand by the term occupation-centred practice? Do you have any specific definition or description for occupation-centred practice? How would you define it? How would you describe it?
Definition	Give study definitions (Attached after table)
Transition question	How central/important is occupation to what you do on a daily basis as a therapist? Would you describe your current practice of occupational therapy as occupation-centred? Please explain why you say so. . . Please give us an example of occupation-centred practice in your setting? How do you use occupation in your practice? Besides occupation what else do you use in practice? Do you believe occupation-centred practice is applicable in your setting? Will you consider it?
Focus questions	Should occupation be central to occupational therapy practice in acute mental health care? Do you identify occupation as being central to occupational therapy practice? [77] What is your understanding of occupation-centred practice in acute mental health?

	What are your beliefs regarding occupation-centred practice in acute mental health? (What are the benefits of using occupation centred practice?) (What are the disadvantages of using occupation centred practice) What are your experiences regarding occupation centred practise in acute mental health? (Are there any negatives to using it?)
Summarising question	What should occupation-centred practice look like in acute mental health care? In summary, when do you use occupation in the practice where you work? What makes it easier to use occupation in practice where you work? What makes it harder to use occupation in practice where you work? Is there anything else that you think is important, I missed about occupation-centred practice, and you would like to share with us?
Concluding question	We have discussed occupation-centred practice in acute mental health today, is there anything else that you think is relevant to this topic that we should have discussed?

Aim:

To explore the perspectives of occupational therapists working in acute mental health care on occupation-centred practice.

Occupation: the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include the activities people need to, want to and are expected to do. (WFOT, 2012)

Occupation-centred practice: ensuring all aspects of the occupational therapy process, including evaluation and intervention, have at their centre occupation. All actions in occupation-centred practice are either based on occupation or have occupation as their focus. (Fisher AG, 2013)

Annexure F

Summary of results sent to participants for member checking

Title: Occupation-centred practice: perspectives of occupational therapists working in acute mental health care
Aim: To explore the perspectives of occupational therapists working in acute mental health care on occupation-centred practice. Perspectives include understanding, beliefs, and experiences.

Theme A theme is the highest level of abstraction, an idea that captures latent meaning in the data in relation to the research question and represents a pattern in responses. (Braun and Clarke, 2006). Meaningful essence that runs throughout the data, the basic topic that is evident throughout the narrative (Morse, 2008)	**Subtheme** A subtheme shares the same central organising concept as the overarching theme but, focuses on one noteworthy particular element that forms part of the theme. (Terry et al., 2017) Shares the same central organising concept as the theme but focuses on one specific element (Vaismordi, 2016).	**Code** A name or label given to extracts of data to summarise their content/meaning. (Braun and Clarke, 2006)
1. The process of occupation-centred practice	1.1 Enable experiences through doing	1.1.1 Experiencing
		1.1.2 Doing
	1.2 Facilitating reflection of the experience	1.2.1 Making sense of experiences
		1.2.2 Discussing experiences
	1.3 Healing as the outcome	1.3.1 Gains in insight
		1.3.2 Taking ownership
		1.3.3 Consolidation (moving forward)
		1.3.4 Discovering meaning and purpose
		1.3.5 Development of hope
2. Activities enable occupation-centred practice	2.1 Activities provide experiential opportunities	2.1.1 To practice skills
		2.1.2 For connection
		2.1.3 For meaningful and purposeful engagement
	2.2 Activities reveal the authentic mental health care user	2.2.1 Doing reveals the impairments
		2.2.2 Social environment of the activity
	2.3 The metaphorical use of activities	2.3.1 Mosaic
		2.3.2 Drawing
3. Theoretical underpinnings of occupation-centred practice	3.1 Vona du Toit's Model of Creative Ability	3.1.1 Guides choice of activities used to evaluate the MHCU
		3.1.2 Used to group MHCUs
	3.2 Model of Human Occupation	3.2.1 Habituation: routines
		3.2.2 Personal causation
	3.3 Client-centred approach	3.3.1 Non-directive
		3.3.2 Motivating
	3.4 Yalom's psychosocial theory of group therapy	3.4.1 Use of the here and now

Theme A theme is the highest level of abstraction, an idea that captures latent meaning in the data in relation to the research question and represents a pattern in responses. (Braun and Clarke, 2006). Meaningful essence that runs throughout the data, the basic topic that is evident throughout the narrative (Morse, 2008)	**Subtheme** A subtheme shares the same central organising concept as the overarching theme but, focuses on one noteworthy particular element that forms part of the theme. (Terry et al., 2017) Shares the same central organising concept as the theme but focuses on one specific element (Vaismordi, 2016).	**Code** A name or label given to extracts of data to summarise their content/meaning. (Braun and Clarke, 2006)
		3.4.2 Curative factors
		3.4.3 The group as a social microcosm
	3.5 Kawa Model	3.5.1 Evaluation tool
	3.6 Sensory Intelligence	3.6.1 Sensory Profiling
	3.7 Occupational Therapy Practice Framework	3.7.1 Occupational profile
4. Influencers of occupation-centred practice	4.1 Influencers that have a positive impact on occupation-centred practice	4.1.1 Achieving the outcome, strengthens the occupation-centred process.
		4.1.2 Being authentic
		4.1.3 Teamwork
		4.1.4 Having experience
	4.2 Influencers that have a negative impact on occupation-centred practice	4.2.1 Heavy workload
		4.2.2 Lack of resources These include finances, space, materials, and time the occupational therapist has available
		4.2.3 Limited admission period
		4.2.4 Rigidity of the mental health care facility
		4.2.5 Consequences of mental disorders
		4.2.6 Use of meaningless activities
		4.2.7 The multidisciplinary team's confusion regarding the scope and practice of occupational therapy

Annexure G

Confidentiality agreement with the transcription auditor

Confidentiality Agreement

Mrs J d'Oliveira
142 Paprika Avenue
Newlands
Pretoria
0181
0828511426
dol.jenna@gmail.com

Date: December 2019

Confidentiality agreement

I am participating in this research study, Occupation-centred practice: perspectives of occupational therapists working in acute mental health care, as:

- o the moderator for the focus group interviews, which are being used to collect data for this study.
- A first language English speaking independent person reviewing the transcriptions, checking for accuracy.

I agree to treat all information that is made known to me through this study as confidential, including the names of the participants and the mental health care facilities at which they work. I will protect the study participants by never revealing or discussing any of the information obtained through the study with anyone except the researcher, J d'Oliveira and the supervisors of the study, Dr E Ramano and Mrs T Buys.

J.l d'Oliveira

Signed by: F.P. d'Oliveira.
Date: 12/2019

Signed by: J d'Oliveira
Date: 12/2019.

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Annexure H

Ethical clearance certificate issued by the Faculty of Health Sciences Research Committee

UNIVERSITEIT VAN PRETORIA
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YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved on 22 May 2002 and Expires 03/20/2022.
- IRB 0000 3235 IORG0001762 Approved on 22/04/2014 and Expires 20/14/2020

6 August 2019

Approval Certificate
New Application

Ethics Reference No.: 467/2019
Title: Occupation-centred practice: perspectives of occupational therapists working in acute mental health care

Dear Mrs J d'Oliveira

The **New Application** as supported by documents received between 2019-06-25 and 2019-07-31 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2019-07-31.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2020-08-06.
- Please remember to use your protocol number (467/2019) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

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Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tSa Maphelo