ScopingReviewArticle SB Occupational therapy practice psychiatric day hospitals.docx

by July Masango

Submission date: 02-Aug-2024 03:32PM (UTC+0200)

Submission ID: 2426279121

File name: ScopingReviewArticle_SB_Occupational_therapy_practice_psychiatric_day_hospitals.docx (904.1K)

Word count: 8269

Character count: 50226

Scoping Review

Occupational therapy practice in psychiatric day hospitals: A scoping review

ABSTRACT

Introduction: The aim of this scoping review was to explore the practice of occupational therapists in psychiatric day hospitals, globally.

Methodology: Searches were conducted in January 2024; 38 articles were screened and 22 identified for data extraction. Articles were imported onto Covidence software. Data charting was done, data exported onto a Microsoft Excel sheet, where content analysis was performed based on review's objectives. Synthesis of the results was done through discussion and reported according to the PRISMA for Scoping Reviews guidelines.

Results: 38 articles were included but only 22 were relevant. Group therapy, individualised therapy, vocational and community workshops were identified as common modes of intervention in psychiatric day hospitals. Occupation-based activities are integral in the context of intervention. However, there is no explicit definition regarding the role of occupational therapy and practice guidelines for psychiatric day hospitals.

Conclusion: The general scope of occupational therapy remains the same as at overnight hospitals, day hospitals and community-based centres. It is mainly occupation-centred, function-orientated, and patient-centred. However, there remains ambiguity on specific practice principles and guidelines that clearly define the role of occupational therapists in day hospitals. There is a need for occupational therapy specific practice guidelines for psychiatric day hospitals.

The implications for Practice

- The results of this study will give insight into what is available and known about the role and scope of practice for occupational therapy in the fast-growing psychiatric day hospitals and identify gaps to be filled.
- The results of this study will provide tangible evidence on therapeutic principles, practice approaches, programme content, and guide resource allocation for psychiatric day hospitals.

- These will ultimately inform occupational therapy treatment protocols, solidify our role in psychiatry and contribute towards National Health Insurance (NHI) policy development.

Keywords: evidence-based practice, mental health, scope of practice, principles and guidelines, day care centre, good health and well-being

INTRODUCTION

Mental health is an essential element to health and central to the well-being of individuals, and societies at large. As noted by the World Health Organization and highlighted in Prince et al.[1:1], "there is no health without mental health"[1,2]. Globally, one in seven people has experienced and/or is living with a mental illness[3]. Generally, within healthcare, mental health interventions are notoriously low on budget and resource allocation[4]. This is especially so in low- and middle-income countries such as South Africa[5]. The South African healthcare system is socio-economically divided into public sector and private sector. The public healthcare sector, funded by the state, serves 84% of the South African population with 41% of its registered healthcare practitioners[6]. The private healthcare sector is a profit-driven healthcare system, which is available to insured South Africans and caters for the remaining 16% of the population.

To address this unsustainable and unconstitutional divide, the South African government has embarked on a process of implementing a National Health Insurance (NHI)[7, 8]. The NHI has now been signed into law and officially promulgated on the 15th of May 2024. Treatment protocols that will be adopted by NHI need to be evidence-based. Central to the current and the future healthcare systems in South Africa, is the need for evidence-based practice. Both public and private healthcare systems require reputable evidence that justifies healthcare practices for remuneration, budget, and resource allocation. The South African healthcare system has also been burdened by the high prevalence of mental health care as reported in global literature; mental and behavioural disorders account for approximately 7.4% of the global burden of disease and are the leading cause of disability, accounting for 22.2% of the world's disability, yearly[9]. Thus, mental illnesses and disorders can be classified as a pandemic. This, however, has been greatly neglected, and should be considered in a new light[9]. It necessitates more accessible and innovative mental healthcare services, such as psychiatric day hospitals, to ensure continuity of care from inpatient treatment to outpatient treatment.

Day-community healthcare centres and day-hospitals form part of primary healthcare, and a psychiatric day hospital is regarded as an effective, accessible and inexpensive way of meeting mental healthcare users' needs[10]. Although there is a lack of literature on day hospitals for mental health care, Heekeren et al.[11] argue that day-hospital treatment closes the gap between outpatient care and hospital admission. The benefit for mental healthcare

users in such facilities is that they can receive comprehensive therapy without being institutionalised and isolated from their personal and social environments and the latter can be incorporated into treatment and intervention[11, 12]. Similar to an inpatient programme, the psychiatric day hospital is typically run by a multidisciplinary team comprising a psychiatrist, clinical psychologist, occupational therapist, professional nurse, social worker and dietician[10].

Despite the involvement and featuring of occupational therapists in psychiatric day hospitals, evidence for occupational therapy programme development in psychiatric day hospitals in South Africa is not clear[13]. Lack of published evidence that could guide practice is notoriously problematic in occupational therapy epistemology[14]. The increase and availability of evidence ensures the refinement of treatment techniques and the development of new therapeutic options[14]. Law et al.[15] opine that evidence-based practice is important when discussing with other professionals; this attracts referrals[15]. Moreover, the need for evidence is crucial when discussing healthcare spending and reimbursement[14].

As more ground is slowly gained by occupational therapists in the psychiatric day hospitals, there is a need to clearly define the scope of practice and have guidelines that are evidence based to inform the intervention programmes that are used. Evidence-based guidelines will enable occupational therapists to have a better and unified understanding of their scope of practice and be aware of their boundaries when working in a psychiatric day hospital. Furthermore, the guidelines may enable occupational therapists to avoid grey areas, scrutiny, criticism, and possible litigation, as they will have researched guidelines that are based on evidence, to use at the developing psychiatric day hospitals.

This scoping review aimed at exploring the practice of occupational therapists in psychiatric day hospitals, globally. The aim was broken into two objectives: to provide a focused overview of occupational therapy practice; and to identify and map content areas, principles and guidelines that need to be considered in the development of an occupational therapy programme that can be applied in a psychiatric day hospital.

METHOD

This scoping review was part of a larger PhD study that aimed at developing evidence-based occupational therapy guidelines for a programme that can be applied to a psychiatric day hospital in South Africa.

A preliminary search was conducted using Google Scholar, and no similar reviews were found. The Joanna Briggs Institute (JBI) scoping review framework was followed[16]. The stages of the scoping review are shown in Table I. Stage 1 entailed development of the scoping review protocol, which can be accessed through the corresponding author. An information specialist from the University of the Witwatersrand Health Sciences Library assisted with stage 2 (search strings and identification of literature), and also assisted with aspects of stage 3 (data searches). EndNote was used to collate full texts of articles. The relevant articles were uploaded into Covidence software for management and screening of selected articles (stage 4), and data extraction and charting (stage 5). The data extraction template that was used in Covidence is included as Supplementary File 1. The extracted data were summarised and interpreted during stage 6. Data were exported from Covidence software into a customised Excel template, and manually analysed by the reviewers through content analysis.

Table I: Stages, actions and timelines of the scoping review

Scoping review stages	Actions taken	Timeline
Stage 1. Developing the scoping review design	Develop the scoping review's question, aim, objectives, inclusion and exclusion criteria, search strategy, to draw up a protocol.	5 April – 15 May 2022
Stage 2. Identifying relevant literature	Iterative interaction, defining, and aligning the search strings, key, and index words, and confirming the exclusion-inclusion criteria.	30 May – 20 September 2022
Stage 3: Searching the evidence	Searches were run on the following databases: Google Scholar, Medline, Embase, PsychINFO, Central, and Scopus international.	15 January – 20 March 2024
Stage 4. Selection of eligible literature	Screening (titles and abstract) of 22 articles on Covidence software by reviewers, followed by full	21 March – 30 April 2024

Scoping review stages	Actions taken	Timeline
	text screening. Conflicts were resolved through discussion on Teams.	
Stage 5. Data extraction and charting	Data were extracted and charted on Covidence software through data extraction template	April – May 2024
Stage 6. Collating, summarising, and interpretation	Data were exported from Covidence software into a customised Excel template, and manually analysed by the reviewers through content analysis.	May 2024
Stage 7. Interpreting, reporting of results	Results were interpreted, written into a scoping review journal article and submitted for publication to a peer review journal	June 2024

Eligibility criteria

The eligibility criteria of the review entailed 1) global primary research that is published in English; 2) peer-reviewed journal articles; and 3) relevant grey literature, dating from 2000 to 2020. The first author started his PhD study in 2021 and had hoped to review papers of the then past 20 years, however a further search was conducted up to March 2024. Some of the articles were traced from the references' lists and included as part of the reviewed papers. Non-English papers were excluded if translation was not available.

Population

For this scoping review, Population, Context and Concept (PCC) were as follows: the population was 'occupational therapy clinicians', the concept was 'occupational therapy practice', and the context was 'psychiatric day hospitals and facilities', globally. Therefore, the scoping review question was: what global published evidence is available on occupational therapy interventions and practice in psychiatric day hospitals and facilities?

Search strategy

Medical Subject Headings (MeSh), a thesaurus that assists with creation and refining of search strings and facilitates the searching process, together with the Participant, Context, Concept were used to develop the following search strings: "Occupational Therapy" OR "day hospital" OR "Art Therapy" OR "community centres" AND "outpatients AND practice" AND

"guidelines". The search was conducted and completed in six databases (Google Scholar, MEDLINE, Embase, PsychINFO, CENTRAL and Scopus International). For additional articles, the reference lists of all included sources of evidence were screened. After the search, all identified articles were collated and uploaded into EndNote[17].

Selection process

The first five included articles were screened together by the two reviewers (first and second authors), to refine the selection criteria and enhance inter-rater reliability. As part of this process, reasons for excluding articles were inductively developed and captured on Covidence. Reviewers jointly met and embarked on thorough screening (Titles and Abstracts) of articles, which were subsequently moved either into full text screening or exclusion. Duplicates were removed. Conflicting votes were discussed between the two reviewers until consensus was reached. Using the same format and selection criteria, full text screening commenced between the reviewers.

Data extraction and analysis

In Covidence, the finally selected articles were identified, and were ready for data extraction. Data were extracted from the articles by the reviewers using a data extraction template. The template was developed collaboratively on Covidence software (see Supplementary File 1), which was informed by the review objectives. The Covidence data extraction template entailed: title of the article, author(s) names, year of publication, name of the journal, country of origin, study population, diagnostic criteria group, programme content (client factors and performance skills, occupations, roles, habits and routines), programme process (evaluation, intervention mode and content), outcomes (clinician and patient reported), theoretical approach, programme principles (layout, number of clients and frequency), facility and context of practice, practice detail, equipment and resources used. The template was not modified or revised; however, when the reviewers could not find suitable data under any category of the template, they used "none stated" (see Supplementary File 2). When all data were extracted, quantitative extracted data were moved to Excel for analysis with SPSS. The two reviewers frequently met and, through collaborative discussion, refined the categories, identifying themes by consensus. Results of the review are presented in tables, and figures. The characteristics of selected articles and identified practice results are discussed below.

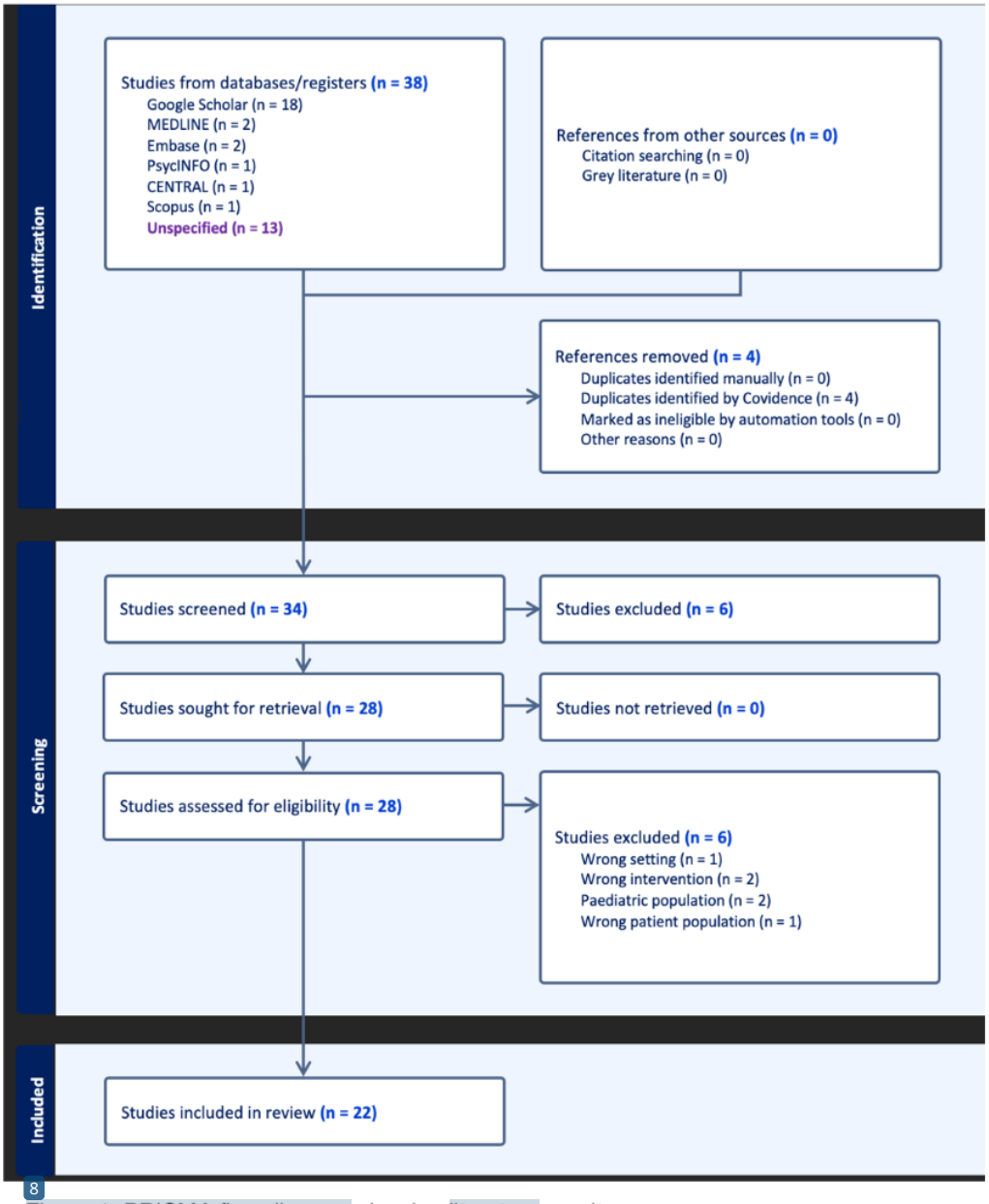

Figure 1: PRISMA flow diagram showing literature results

RESULTS

Study selection

A PRISMA 2020 flow diagram[18], with information on the selected and included articles is elucidated as Figure 1.

Demographics of articles

A total of 38 papers were identified during the database search. Four duplicates were identified and removed, while 6 papers were excluded as they did not contain relevant information. However, there were 12 papers that were manually hand-searched through perusal of the articles' reference lists, which were included. Among the total of 38 papers, only four were duplicates and removed, which led to a total of 34 papers undergoing initial screening. Out of the 34 papers, 6 papers were found to be irrelevant and did not contain necessary data and were removed, which led to a total of 28 papers. Of the 28 papers that were carefully screened, a further 6 papers were excluded, resulting in 22 papers undergoing full-text review (see Figure 1, and Supplementary File 1 attached).

Terminology used for psychiatric day hospital

The review highlighted that there are different terminologies used in different countries, with regard to the naming of the psychiatric day hospital, as shown in Supplementary File 1. Tjörnstrand et al.[20], and Eklund et al.[21], use words such as day centres for people with psychiatric disabilities[19-21]. Generally, there seems to be a consistent wording around "day centres for people with psychiatric disabilities" in Sweden and they mostly seem to ascribe to this terminology, as also noted from other reviewed articles (Leufstadius 2014; Hultqvista 2017; Leufstadius 2014; and Lundqvista 2017). However, Bryant et al.[22] use "mental health day services" in the article that reported on services in the United Kingdom[22], whereas an article from Canada uses "psychiatric day hospital", as reported by Mackenzie et al.[23]. In South Africa, Engelbrecht [24] noted the use of "mental health day treatment centres"[24].

Intervention mode

Eighteen articles out of 22 (82%) mentioned that occupational therapy practice at psychiatric day centres is predominantly provided through group therapy format. At some settings, the patients and/or group members in the programme were grouped according to their different levels of function. As elucidated in Supplementary File 2, the wording of 'group' is rendered differently in different countries, namely: group therapy (Sheki 2010; Engelbrecht 2015; Liriviére 2009)[25], and group (Maone 2002; Hultqvista 2017; Flokén 2016; Bartak 2011; Eklund 2013; Argentzell 2012; Eklund 2015; Lundqvista 2017). It is noted that there is also mention

of individualised therapy (n=6), and in other articles such as Gibson et al.[26] and Flokén et al.[27], they expressed a need to complement group therapy with individualised sessions[26, 27].

In Italy, Maone et al.[28] noted that a specific mode and service offering includes vocational training[28], or is referred to as vocational rehabilitation; and by Larivière et al.[29] as vocational programmes[29]. These are consistent with the services that are offered in Sweden as work-orientated programmes, as noted in Eklund et al. (2014) from Sweden. Workshops, as an intervention, is also one of the modes of intervention that was mentioned in the reviewed articles, as noted in Supplementary File 2. However, in some places such as Sweden, there are specific work-orientated programmes and meeting-orientated places, workshops and community-based centres, and there are also large groups of people, who may be working independently on the same programme[20,21,30].

Programme content

Maone et al.[28], identified social skills, instrumental activities of daily living and leisure as among the areas of focus for the day hospital programme[28]. Eight out of twenty-two (37%) articles identified social interaction and social networking as a theme. Work, productivity and transitioning employment are listed under occupations in the content of the programme[20, 27, 30]. Eklund et al.[21] note that, in Sweden, the daily schedule of the programme and the demands of the activities that the patients participate in, are adjusted according to their functional capacities and needs[21], to improve their occupational balance. In the United Kingdom, Bryant et al.[22] assert that there is structuring of time by engaging the patients in meaningful occupations in the structured programme[22]. This is consistent with what is taking place in Canada, as noted by Larivière et al.[29], that the programme is structured as part of their daily routine[31]. Lundqvist et al.[31] noted that there is a need to find the right type and amount of occupation and the right variation between occupations in the programme[32].

The reviewed articles show that among the client factors and performance skills[33], anxiety management and confidence can be addressed in the programme; also relaxation and planning skills, as noted by Tjörnstrand et al.[20]. In South Africa, problem solving, self-esteem, cognitive abilities and life skills were identified by Engelbrecht (2019)[24], which is consistent with Sweden, as indicated by Tjörnstrand et al.[20], in terms of the common client factors that can be addressed on their programme. Furthermore, motivation through contributing and being entrusted with responsibility; structuring time & setting goals; self-mastery and self-esteem, formulating goals, and strategy to reach goals, were also reported to be part of possible contents for the programme[21]. How to be optimistic and hopeful, impulsive

behaviours, self-acceptance, insight, self-awareness, life skills, and coping with losses were noted in Canada by Larivière et al[29].

Occupational therapy process

Engelbrecht et al. noted that among the important aspects of the occupational therapy process, is the assessment of patients' needs[24], which should be differentiated (i.e. based on the unique needs, abilities, deficiencies, and environment of each mental health care user)[24], by performing a functional assessment[24]. Eklund et al.[21] noted the use of interviews and questionnaires to assess patients[21]. This is consistent with the work of Bryant et al.[22], that reported that there must be a systematic approach to evaluation and the use of different methods such as questionnaires and interviews[22]. Gibson et al.[26] further added self-reporting checklists as part of the questionnaires that can be filled out by the patients as part of assessment[26]. Cognitive and functional evaluations are also being used as part of the occupational therapy assessment at a day hospital programme[29], as indicated by Larivière et al. With all the different assessment methods, Argentzell et al.[33] identified observation as one of the tools, which occurs when using all the other tools of evaluation in the programme[34].

In addition to assessment in the occupational therapy process, as noted in the occupational therapy practice framework fourth edition[35], there are also intervention and outcomes. Different components and ingredients of intervention are reported herein, however there was not sufficient evidence to harvest on outcomes in the reviewed articles.

Programme guidelines and principles

The review found that the occupational therapy programme at a psychiatric day hospital should involve family members[28] who play a critical role as a bridge between hospital and community[22]. Secondly, the programme should ensure that patients are engaged in social settings and actively participate in different occupations[20]. There should be opportunities for emotional reactions in various settings to facilitate change; they should have occupational balance and structure in daily life and be mastering challenges and learning something new[20]. The programme should facilitate a sense of belonging; it should cultivate motivation through contributing and being entrusted with responsibility; it should enable individuals to make choices and acknowledge their power and abilities to decide[20]. In essence, the programme must be structured and presented at 'just right challenge'[20]. This will ensure "autonomy and a feeling of social inclusion, which are concepts of importance for well-being and recovery"[30].

The emphasis is on the "here and now"[36] rather than on problems from the past[24]. The rehabilitation that takes place at the day centre also needs to be individualised to account for

individual differences within a general need to be actively engaged[27]. Leufstadius et al. (2014) noted the importance of being together with others and belonging to a group to facilitate a process of recovery[37]. Experiencing a high level of empowerment increased with a high level of perceived meaning in the domain of personal development[34]. Argentzell et al.[33] noted that the programme should be client centred and individually based[34]. Eklund et al.[36] asserted that the programme should follow a set schedule[21], and this was as a comment from one of their participants, that 'doing things that were pleasurable were the strongest motives for coming to the day centre rehabilitation'[21].

Programme format (structure, frequency, and length)

The format of the programme differs across different countries in terms of daily suggested operating times and frequency of group sessions in a day. The reviewed articles show that the occupational therapy programmes at the psychiatric day hospitals may take place every day, with daily attendance[28,21], every day of the week[20], or during workdays[30]. Other reports included 2 to 3 days per week and that patients should be occupied throughout the day[24]; 4 hours per week[20]; 13 hours average per week[37]; daily, with four occupational therapy services per day for at least three days a week[22]; four to five days per week, on average for eight weeks[29]; one morning and/or one afternoon per week[38]. Literature suggests that there are greater benefits from longer intervention, more intensive intervention, and/or both[26]; all day each day of the week[34]; and there should be daily visits[36].

Theoretical approaches

Engelbrecht reported that the commonly used theoretical approaches in South Africa include family orientated approach; psychoeducation; and Person–Environment–Occupation (PEO) model[24]. The psychoeducation programme was also reported by Flokén et al.[27], as commonly practised in Sweden[27]. In the United Kingdom, there is a structured approach that is followed.[22]. Larivière et al.[29] assert that Canada subscribes to Cognitive Behavioral Therapy (CBT)[29], Interdisciplinary Approach, Fundamentals of Human Occupation and Psychodynamic Approach[29]. In the United Sates, Gibson et al.[26] noted the Behavioral and/or Cognitive-Behavioral Approaches[26], which are the basis of the intervention programme, whereas articles from Sweden also include the Activity-Based Rehabilitation Approach[39]. Therefore, there are different theoretical approaches and frames of references that are used in different countries, which are all patient-centred and dependent on the patient's specific needs.

Table II: Intervention Content

Author(s), Year and Country	Intervention contents
Maone et al. (2002)	Expressive therapy: painting, music, handicrafts, theatre, photography, video, looking after one-self, managing the environment and daily life, preparing meals, housecleaning
Shek et al. (2010)	Productive activities, recreational activities
Yoshimasu et al. (2002)	Recreation therapy, social skills training, occupational therapy
Tjörnstrand et al. (2013)	Craft activities, productive activities
Hultqvista et al. (2017)	Manufacturing, playing cards
Engelbrecht (2015)	Vocational rehabilitation, use occupation as basis of treatment, music therapy, recreational activities, social skills training and occupational engagement, vocational rehabilitation, psychoeducation, life skills training and social integration
Tjörnstrand et al. (2013)	Social activities, information orientated, maintenance and manufacturing tasks, crafts, repairing bicycles and furniture, creativity
Eklund et al. (2014)	Occupations that are meaningful, set goals with service users and implement strategies, gardening groups, small shop (to increase contact with surrounding community), increase shared decision-making in weekly meetings.
Flokén et al. (2016)	Physical occupations, aerobics exercises, crafts
Widerberg & Eklund (2018)	Carpentry work and textiles, or through services such as food catering, cleaning or gardening, work-like occupations, crafts
Leufstadius et al. (2014)	Empowerment and meaningfulness through individualised activities, kitchen activities, service tasks, and social activities, woodcraft, textile crafts
Bryant et al. (2011)	Social and recreational activities, practical and social activities, craftwork
Eklund et al. (2014)	Producing things and adding a sense of value, cognitive behavioural
Mackenzie et al. (2007)	Psychodynamic and interpersonal approaches
Larivière et al. (2009)	Psychoeducation and support, lifestyle management and balance of occupations

Author(s), Year and Country	Intervention contents
Bartak et al. (2011)	Non-verbal or expressive group therapy, psychosocial treatment, coaching for social problems
Gibson et al. (2011)	Social skills training, assertiveness training, communication skills, occupations related to self-management, home management, cooking, and community integration tasks, related to obtaining education and work, managing money, and maintaining healthier behaviours, work and education
Eklund et al. (2013)	Participation in work-like occupations in the day centre, meaningful activities
Argentzell et al. (2012)	Activity based and presented with occupations
Eklund et al. (2015)	Gardening, sell food, catering or car wash services, opening a small shop to increase contact with surrounding community, decision making, weekly meeting sessions to share ideas
Lundqvist et al. (2017)	Occupational balance

Twenty-two out of 22 (100%) articles report that there are specific activities that are utilised in the occupational therapy programme, client factors, performance skills and occupations, that form part of session content and focus of sessions, at the different psychiatric day hospitals and/or day centres. Table III elucidates the different activities, skills and occupations that were mentioned and captured from the articles. All articles agree that occupational therapy practice cannot be practised without the use of activity, either as a means and/or as an end. There are various occupations that are also used such as cleaning, leisure and recreation and work-like activities. There is also a consistent message around specific skills training and development, and life skills, that are inherently facilitated as part of the programme. Therefore, through following the occupational therapy processes to select and analyse the necessary activities, patients can be meaningfully occupied and challenged to grow and increase capacity for function.

DISCUSSION

For this review, the findings were organised to address two objectives, which were: to provide a focused overview of occupational therapy practice in psychiatric day hospitals, and to identify and map content areas, principles and guidelines that need to be considered in the development of an occupational therapy programme, that can be applied in a psychiatric day hospital. There are different fragmented yet invaluable parts of the occupational therapy programme that can be harvested from the reviewed articles to serve as a base for building an occupational therapy programme for a psychiatric day hospital in South Africa. Starting with naming of the hospital setting, words such as psychiatric centres for people with mental health disabilities, mental health day centres, and psychiatric day hospital were used. Engelbrecht reports on mental health day treatment centres, for the South African context[24].

Regardless of the differences in the terminologies, there is a common and consistent theme of providing occupational therapy services at a 'day' setting and/or programme, and not at an 'overnight' setting, meaning that patients or service recipients of the programme do not sleep over at these places. They come to the day hospital on a day-to-day basis, return to their community and homes to be with family, which allows exercising of learnt skills from the programme. It is also noted that these types of day centres, and/or day hospitals, render services to people with mental illness, psychiatric illness and/or psychiatric disabilities, as noted in the reviewed articles.

This review revealed that there is currently no specific published evidence-based comprehensive programme that is ready for implementation and contains sequential unfolding steps. There is no programme that entails clearly defined occupational therapy processes and explicit guiding principles for a psychiatric day hospital. This unveils a wide gap in the occupational therapy mental healthcare space in South Africa that should be filled. It was noted that the layout and contents of the programmes in different countries are defined according to the needs of the population and the purpose at each of the facilities. For instance, in Sweden the programme is called work-orientated and meeting-place orientated[21], where the participants attend for work related and social interaction purposes.

Although there is variation in the naming of the programme in different countries, there are certain elements and components that were found to be common and consistent. Group therapy was found to be the leading and common mode of intervention among the different

countries, although the terminology was different. Group/groups, and group therapy were among the terms that were utilised in the articles. The groups are reported on vaguely with fewer specific details regarding the layout of the group and principles of group therapy and/or how the sessions would be carried out. Furthermore, it was not clearly specified and explicitly unpacked in terms of group protocol, group layout, principles, style of facilitation, group structure and the contents of the group process and/or a typical group treatment session, with specific principles for treatment. The articles do not stipulate the style of group facilitation that should be used. Therefore, there remains a noticeable gap pertaining to group therapy and its principles for a psychiatric day hospital, which would explicitly enable occupational therapists to define their scope and role in these settings.

It is noted that 'group' may mean different things to different people in different countries. Patients that are 'grouped' do not automatically equate to and/or suggest that there is an inherent group cohesion and that there is intentional group formation. It is not explicitly clear in the articles how many people or group members are seen per group. In the South African context, Fouche, an occupational therapy group intervention expert[40], alluded to the fact that for the group to be interactive, have a good dynamic, and be experiential in nature, there should be a maximum of 12 patients[40]. If there are more than 12 patients in a group, there will be less interaction and fewer experiential elements, especially for patients who function at least on a passive participation level of Creative Ability. These kinds of groups are regarded as medium to intense and focus on developing insight into own behavior, abstract thinking, problem solving, planning own recovery and applications of coping skills in own life. This is valid for psychiatric day hospitals, because the assumption is that these kinds of patients have consolidated the fundamental functional aspects as they are voluntarily admitted, and they bring themselves to the psychiatric day hospitals[41].Therefore, it can be concluded that this should predominantly be the suitable population of patients for these settings[41].

In the South African context, closed groups are conducted in many overnight hospital settings and a few day hospitals, although they are not well reported. Meyer[39] asserted that there is a strong correlation between closed groups and group dynamics, which hold power for healing[42]. Although the reviewed articles report on the need for frequent contact sessions and the sense of belonging experienced by patients in the programme, they do not account for the consistency of group membership or how to develop a sense of group belonging. It is unclear whether the patients remain constant, in the same group for the duration of admission at the psychiatric day hospital, or if they are placed in different groups every time and every day they attend the programme. Considering Yalom's principles on group therapy, there is power in

constant group membership, which permits certain therapeutic factors (group cohesion, altruism, universality, impartation of information) to develop and ensure healing[43,44].

Occupational therapy literature provides evidence of the different types of groups that occupational therapists are qualified to offer and facilitate[36]. These include functional groups; activity groups; tasks groups; social groups (including role play); life skills groups; psychoeducation groups; socio-emotional groups and support groups[45], among others. The reviewed articles did not specify which types of groups should be presented at the psychiatric day hospitals. However, it was noted that there are various themes and topics that are facilitated with patients at the psychiatric day hospital settings, such as: occupations (leisure and recreation, self-care, work or prevocational skills, instrumental activities of daily living, domestic tasks, rest, and community living); performance patterns (structure and routine, structured time and structured programme); performance skills (life skills, anxiety management, and interpersonal skills); client factors (motivation, problem solving, self-esteem, and cognitive abilities); and in consideration of patients' contexts (community, workshops and hospital contexts)[35]. Therefore, when considering these themes from the articles, although not all aspects of the occupational therapy domain are mentioned[35], the message is clear that the occupational therapy services at the psychiatric day hospitals should be deeply rooted and grounded on the occupational therapy practice framework principles to guide practice[35].

There is a trail of evidence in the reviewed articles on occupational therapy practice and core foundational principles, which are consistent with regard to restoring function and facilitating a sense of meaning and purpose in people's lives[46]. There is a strong message that is captured from the articles regarding interaction and active engagement of patients in purposeful occupations[34], which leads to development of a sense of satisfaction and meaningfulness[32,34]. This unexplainable phenomenon can be traced back to the core belief that human beings are occupational beings[47]. As occupational beings, humans physically occupy space and time[48,49]. By virtue of being alive, humans are inherently occupied by activities which hold meaning to them[50]. These are strong beliefs that are deeply entrenched in the occupational science and occupational therapy principles[51], that health and well-being is also facilitated and supported through active engagement in meaningful occupations[51,52]. Therefore, in the day hospital setting and therapeutic space, finding the right type of occupation, amount of occupational engagement, and the right variation between occupations, is crucial, as noted by Lundqvist et al.[32], in facilitating a "right challenge" to the patient[32,53].

In the Occupational Therapy Practice Framework: Domain and Process Fourth Edition[35], there is mention of the importance of operationalising the occupational therapy process when delivering the occupational therapy services to patients[35]. The first step of the occupational therapy process is 'evaluation'[35]. The evaluation comprises the occupational profile and the analysis of occupational performance, which are integrated to guide and shape the intervention plan[54]. Despite the different methods of evaluation mentioned in the reviewed articles, there is no mention of specific types of standardised and/or non-standardised testing tools that can be used at the psychiatric day hospital. In phase one of this comprehensive PhD research, participants identified different types of assessment tools that can be used at a psychiatric day hospital, including: Wellness Recovery Action Plan (WRAP); KAWA model; Vona du Toit Model of Creative Ability; and Activity Participation Outcome Measure (APOM). Evaluation is crucial at a psychiatric day hospital and should precede intervention planning. This is consistent with the occupational therapy practice standard in South Africa, the Health Professions Council of South Africa (HPCSA) guidelines[55], Occupational Therapy Association of South Africa (OTASA) guidelines[56,57], and the Medical Schemes Billing Codes that are utilised in private practice, in the South African context[58].

Evidence-based practice is crucial in occupational therapy. As a result, the programme for a psychiatric day hospital should be evidence based, particularly in mental health, as evidence will inform and justify the cost implications, given the significant economic and social costs associated with mental health issues[59]. This includes both direct costs, such as healthcare services provided to patients, and indirect costs, such as loss of income and employment opportunities[59]. As day hospitals have been found to be cost effective[59,60]. there is a great need to quantify and justify the service that is rendered through group therapy at a psychiatric day hospital. This can only be achieved through evidence-based practice that can track a patient's therapy journey and record their level of improvement, which is one of the greatest gaps that was identified during this review: 'How can one measure progress of the patients, in the programme, at a psychiatric day hospital', and the effectiveness of the programme itself. Therefore, there are financial implications regarding patients' improvement which should be accounted for. Measuring the effectiveness of programmes will shed light on the average time required for patient improvement, the cost of the programme; the number of occupational therapists needed for a specific number of admitted patients; and ultimately demonstrate the value of occupational therapist's role and scope in the psychiatric day hospital setting.

Although the occupational therapist's role and scope of practice is not extensively well described in the reviewed articles, the occupational therapists hold a crucial role in mental

health. The importance of occupational therapists is evident from the time allocation and allowance to spend with patients and/or patient contact frequency. The review provides some valuable information regarding the structure and format of the programme; it provides clarity and insight pertaining to the number of occupational therapy sessions, and the duration and frequency of service delivery that should take place. The review clearly indicates that patients should be seen as frequently as possible; morning and afternoon; daily attendance (5 days a week); for 4 hours a day. Therefore, in the South African context, this kind of a format can be equated to two group sessions of 90 minutes each, and one group session of 60 minutes, according to the currently used Medical Scheme billing codes[58].

Furthermore, the evidence from this review shows that certain patterns and frequencies of patient care are consistent with current occupational therapy practices at existing overnight psychiatric hospitals in the South African context. Patients are seen every day during their admission duration, at any psychiatric hospital (overnight and/or day hospital). This may vary between 2 to 3 groups a day, which are presented by occupational therapists. Although the context of overnight hospitals may be different from psychiatric day hospitals, the occupational therapists' capacity and patients' potential to handle the reported number of sessions should be similar. Therefore, there should be a minimum of 2 occupational therapy group sessions, with a maximum of 3 occupational therapy group sessions, for the entire week (Monday until Friday), at a psychiatric day hospital.

The contents of the different programmes, as noted in the articles, were found to be population-based and structured according to the needs of the attendees, albeit there were similarities in some of the programme elements, such as approaches, occupations, guiding principles, processes, and intervention modes. Therefore, it appears that occupational therapists are integrating frames of reference, models and approaches into their programmes, at the psychiatric day hospitals. However, in the South African context, there is also an Interactive Group Model (IGM) which is commonly used with patients when facilitating groups, in mental health. This group model was strongly highlighted and reported by the participants (occupational therapists) in phase one of this research study; it is a group model that is used at the few existing psychiatric day hospitals in South Africa. The IGM model is based on Yalom's principles of group psychotherapy[40], and it employs engagement in activities and "here and now" interactions to promote healing in interpersonal relationships and social skills[40]. It fosters group cohesion and encourages therapeutic elements such as the feeling of universality[40], which are crucial group principles for any groups based programme [43-44,61] and setting such as a psychiatric day hospital[44].

CONCLUSION

This scoping review explored and examined the practice of occupational therapists in psychiatric day hospitals. Occupational therapists have a special role to play in mental health, particularly in psychiatric day hospitals. Their language and terminologies may be different depending on the country, but the scope of work and core goals for therapy remain the same. The occupational therapy practice framework domain and process emerged alongside certain theories, frames of reference, models, and approaches, which affirm that quality service and evidence-based practice are crucial for occupational therapists.

Group therapy emerged as the main mode of intervention at the psychiatric day hospitals, although this was not vigorously unpacked in detail, for example, regarding group structure, format and principles. The review findings reveal that there is a noticeable gap, and lack of a clearly defined occupational therapy programme for a psychiatric day hospital with specific step-by-step guiding principles, despite the reported components and scope-specific related ingredients. Nevertheless, this scoping review provided a basis to consider when developing evidence-based occupational therapy guidelines for a psychiatric day hospital.

Strengths and limitations

Methodological rigour and a collaborative team approach was the key strength of this scoping review. The protocol was developed using the latest evidence in scoping review methodology from the Joanna Briggs Institution (JBI)[16], and the PRISMA-ScR guidelines were used to report the findings[62]. Regular discussions and peer debriefing with co-authors has enhanced credibility and ensured trustworthiness of the study. The results of the review informed the development of evidence-based practice guidelines for occupational therapists working in psychiatric day hospitals in South Africa.

A limitation to this scoping review was that non-English sources were excluded. The authors recognise the fact that this may have excluded some evidence from countries similar in context to South Africa. It is noted that there was a lack of published articles and evidence on the occupational therapy practice in psychiatric day hospitals, globally. Although this was one of the limitations, it also dictates the need for further research on psychiatric day hospitals. Therefore, irrespective of what the programme is called in different countries, and amidst the unclearly defined scope, it is clear and consistent that occupational therapists remain core and integral to intervention planning, implementation and review throughout the service delivery processes, at the psychiatric day hospitals.

Acknowledgements and conflict of interest declarations

The staff of the University of the Witwatersrand Medical School Library are acknowledged for their assistance during the search and data charting processes.

All authors declare that there is no conflict of interest to report in this project.

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