

Incorporating a client-centered approach in the development of occupational therapy outcome domains for mental health care settings in South Africa

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ABSTRACT

Occupational therapists use a client-centered approach as part of embracing a philosophy of respect for, and partnership with people receiving services. This approach must also be incorporated in measuring outcomes of the service and clients must have input in evaluating the outcomes of their intervention. This article reports on a specific phase of a larger study in which clients have been included in confirming the domains for an outcome measure in occupational therapy in mental health care settings.

A case study strategy was used which enabled mental health care users to express their needs and expectations of the occupational therapy service. These were captured during 12 individual interviews and two focus groups. The findings were thematically analysed and constantly compared with the domains identified by occupational therapy clinicians in Phase 1 of the larger study.

Results from this study indicated that the service which the participating occupational therapy clinicians were rendering, were in keeping with the needs and expectations of the mental health care users.

Key words: Client-centered approach, outcome measure, mental health care settings, occupational therapy

Introduction

Occupational therapists aim to enable their clients to learn how to do what they need and want to do¹ and assume that the clients are the experts in their lives². The implications of a client-centered approach for practice are that clients and their families should be asked to identify occupational performance needs. Measurement should reflect the individual nature of people doing occupations and should focus on the subjective experience of the client as well as the observable qualities of occupational performance³. The evaluation of the outcome of therapy intervention will thus focus on change in occupational performance.

The client-centered approach has further been defined as “an approach to service which embraces a philosophy of respect for, and partnership with, people receiving services”^{4:253}. This respect for and partnership with clients should also be applied when doing research about them.

This article describes a particular section of a larger research project in which mental health care users (MHCUs), the term used for “persons receiving care, treatment and rehabilitation services” under South Africa’s Mental Health Care Act of 2002^{5:10}, has been included to confirm domains to be measured in an outcome measure for occupational therapy services rendered to MHCUs.

Literature review

The concept of client-centeredness started as early as 1939 when Carl Rogers described a non-directive approach that centered on the person’s articulated needs⁶. Since the 1980’s the Canadian Occupational Therapy Association has published reports on many research projects that developed and investigated the use of client-centered practices in occupational therapy. Today the client-centered approach or practice is well accepted globally as one of the core aspects of care in any occupational therapy service⁷.

Law and Baum⁸ discussed the implications of client-centered practice in the measurement of occupational performance and pointed out that client-centered principles have to be applied throughout the occupational therapy process, starting with the

evaluation or measurement of a client’s occupational performance deficits. The first implication is that occupational performance needs have to be identified by the client or his/her family and not only the therapist and the evaluation of the success of intervention will focus on change in occupational performance. Secondly, measurement techniques must enable clients to have a say in evaluating the outcomes of their intervention. Thirdly, measurement must reflect the individual nature of participation in occupations. Fourthly, measurement has to focus on both the subjective experience and the observable qualities of occupational performance and finally, the influence of the person’s environment on his/her occupational performance needs to be measured to foster participation.

Examples of client-centered models used in practice are available in abundance. The Canadian Occupational Performance Measure (COPM) developed by Law et al⁹ is probably the best example of a truly client-centered outcome measure that is designed to detect change in a person’s occupational performance over time from the client’s point of view. A client is asked to rate his/her performance and satisfaction in preferred occupations or activities (likes to do, needs to do). When a client has diminished insight and judgment into his/her own performance, a proxy may be used. This measure is easily accessible and is widely used and well researched⁹.

The Vona du Toit Model of Creative Ability (VdTMoCA)¹⁰, which is not as well researched and published as the COPM, is a South African client-centered practice model that guides service delivery in many mental health care settings in South Africa and the United Kingdom. Embedded in this model is the assumption that people’s participation in activities and occupations occur according to their level of motivation and action. When a clinician has determined a person’s level of motivation and action, activities and intervention could be tailored to the person’s abilities on that specific level, thus making it client-centered and individualised. This model is especially successful with clients who have limited decision-making and judgment abilities and is used to determine which goals to address in therapy. The model further strongly emphasises the uniqueness of the individual and the continuous interaction between the therapist



and the “human being who turns towards her [the therapist]”^{10:18}.

The Model of Human Occupation (MOHO) is also consistent with client-centered practice. Kielhofner and Forsyth^{11:163} described the MOHO as an “inherently client-centered model in two important ways”. The first being the client who is being viewed as a unique individual who directs his/her therapy goals and strategies and secondly what the client does, thinks and feels, is central to the changes in his doing.

There are many more theoretical and practice models described in the literature and too many to report in this article, but in spite of the abundance of guidelines for client-centered practice, implementing this approach is not happening without problems. Law and Baum⁸ reported that the client-centered approach is accepted by all but has been criticised for its lack of specific techniques and inherent optimism.

Lim, Morris and Craik¹² reported that despite a commitment to client-centered practice, involving clients in decisions about their own intervention has been slow especially with clients having a mental illness. This could be due to a narrow view that mental health care users might be unfit to make decisions on what they need or what will be beneficial to them.

A literature review by Goulet et al¹³ revealed many challenges in client-centered practices. They stated that this approach is not seen as a priority by both service providers and clients in mental health care settings. Little agreement between clients and service providers has been reported regarding intervention needs. Clients' needs that seem to be unfulfilled included interpersonal relationships, independent life skills, productive activities, coping with illness and health care¹³.

Goulet et al¹³ provided guidelines to occupational therapists to adopt a client-centred approach yet again. These guidelines include the evaluation of the overall needs of the clients, the development of services to encourage clients to engage in social or productive activities and consulting the clients and their families in the evaluation of the outcomes of the intervention. This information is not unknown and has been described in the literature and in theoretical models but it seems that it is not being implemented in practice^{8,12,13}.

It is crucial that occupational therapy clinicians identify and address barriers to including the client's needs and expectations of the service and collaborate as closely as possible with clients or proxies to guarantee client satisfaction, and ultimately, successfully implement client-centered practice.

Aims of the study

The purpose of the larger study was to develop an outcome measure for occupational therapy clinicians in mental health care practices. It was important that this measure represented the service outcomes from the clinicians' point of view but also reflected the needs and expectations of the MHCUs. The development of this outcome measure took place in three phases.

The first phase consisted of a situational analysis to determine the views and perceptions of occupational therapy clinicians as well as MHCUs. Phase I of the study comprised of two stages. The first stage was to determine the views and perceptions of occupational therapy clinicians about outcomes and which domains they would select for inclusion in an outcome measure. This stage has been reported in another article¹⁴. The second stage of Phase I was to determine the expectations of the MHCUs of the occupational therapy service and compare their expectations to the domains as revealed by a research process during the first stage. This objective was included in the study to enable clients to have a say in the evaluation of the outcomes of their intervention.

This article reports on the comparison between the expectations of the service from the MHCUs point of view with the domains that clinicians identified.

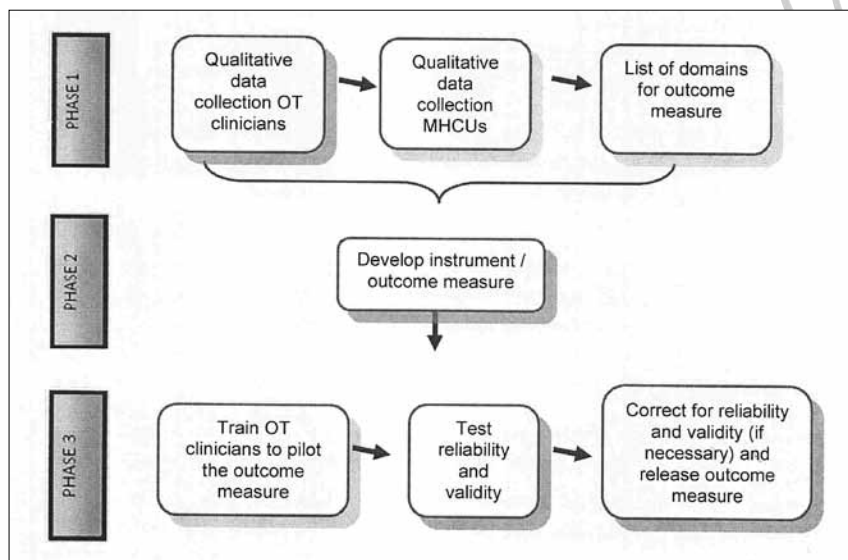


Figure 1: The three phases of the entire research study

Phase two of the research consisted of the development of the items for the domains and designing a consistent rating system. Phase three included the implementation and investigation of psychometric properties of the outcomes measure. Figure 1 presents the three phases while the entire research has been reported in a doctoral thesis.

Methodology

Design

The research design for this specific aim was a qualitative design with a case study strategy^{15:13}. A case study strategy is used when a researcher explores a programme, studies a process or one or more individuals. Cases are confined by time and a specific situation. In this study the “case” was the MHCUs and was confined by their expectations of the occupational therapy service at a certain time.

The sample

A purposive sample was used and criteria for inclusion were that participants had to be involved in the occupational therapy programme, be able to understand and answer the questions during the interview and give sufficient information that related to the question. Three mental health care settings in the Tswane area gave permission for their MHCUs to be approached for inclusion in this part of the research.

Data gathering methods and procedure

Ethical clearance was obtained from the relevant authorities and the MHCUs had to give written consent to be interviewed and audiotaped. The researcher explained the purpose of the study and the interview procedure to them and made sure that they understood the content of the informed consent letter. After signed informed consent was obtained from the MHCUs, the researcher conducted individual interviews which were audio taped. The interviews took place at a location where the MHCUs felt comfortable, that is in a consultation room in the ward or at the Occupational Therapy Department. An interview guide with questions and cues was used during the interviews. Table 1 on page 10 contains the questions and corresponding cues. The researcher transcribed the individual interviews soon after they were conducted. The data of each interview were scrutinised for narratives that would match the domains selected by the clinicians in stage one. Interviews continued until no unmatched narratives emerged from the data. One focus group at a third institution followed to confirm that no new data emerged from MHCUs.

Data analysis

The interviews were transcribed verbatim. Constant comparison was used as the analytical tool to compare new data with theoretical



Table I: Interview guide for MHCUs

Question	Cues/prompts
What is the meaning of occupational therapy to you?	What do you get from the OT programme? Which successes do you feel you have achieved since attending OT? What is the most important thing that OT did for you? Could you mention anything that has changed in you since attending OT?
Which things in the programme, according to you are the most valuable to patients?	What are the things in the OT programme that the therapists must NOT remove? Which things at OT work very well for patients? Which groups or activities are the best attended by the patients?
Is there anything in the OT programme that is unnecessary in your opinion?	Is there anything in the programme that does not work or which you think is wasting your time? Is there some things that the patients never attend?
Is there anything that you would like to work on in your situation which the therapists could help you with?	What else would you like to achieve here at OT? Do you feel you are ready for discharge? When do you think you will be ready for discharge?

Table II The domains that clinicians selected

Process Skills	The cognitive and executive functions that one uses to perform a task. This includes the ability to plan a task, select and use tools and materials appropriately, to pace the actions and to adapt one's performance when problems are encountered.
Communication/ Interaction skills	Exchange of information using the physical body and spoken language to express intentions and needs in building and maintaining social relationships.
Lifeskills	Skills and competencies required by a person to manage independently in the community. It includes the abilities individuals acquire and develop to perform everyday tasks successfully.
Role performance	The ability to meet the demands of roles in which the patient engages. A set of socially agreed upon expectations, tasks or obligations that a person fulfills and which become part of that person's social identity and participation in everyday life.
Balanced Lifestyle	Use of time, habits and routines that address personal needs and demands of environment, occupational preferences in balance (good mix of occupations in all areas: physical, mental, social, spiritual, rest). It includes occupations that are meaningful and promote wellness.
Motivation	The desire to explore and master the environment through occupation or engagement in activity. It includes the basic drives and motives for action as well as the perception about the underlying main causes of events in one's life.
Self-esteem	The worth that one ascribes to one self, the evaluation of one's virtues, the desire to feel accepted and expectations of success or failure.
Affect	The observed expression of emotion by others, what one is able to see from the outside. The appropriateness of the emotion, how it is controlled and the range or repertoire of different emotions are aspects that one could observe in a person.

Table III Profile of the participating MHCUs

Setting	Nr of clients	Individual or group interview	Age range	Length of stay at the time of interview (range)	Primary Diagnoses
Hospital 1	12	Individual	28 - 58 yrs	4 weeks - 12 years	Schizophrenia, Mood disorders
Hospital 2	4	Individual and group	25 - 52 yrs	2 - 3 weeks	Mood disorders, Post traumatic stress disorder
Hospital 3	5	Group	22 - 55 yrs	2 - 3 weeks	Mood disorders, Post traumatic stress disorder

cal constructs¹⁶. In this study the theoretical constructs were the domains of the outcome measure identified by the clinicians and the new data were the categories and themes that emerged from the responses of the MHCUs. A process of inductive category coding followed and the specific responses in the form of narratives from each interview were then considered for matching with the best possible domain. The aim of this constant comparison was to determine the extent of congruency between the MHCUs' expectations and the domains identified by the clinicians. Table 2 is a presentation of the domains that were selected by the clinicians and which were used to match the responses from the MHCUs.

Results

The sample

Table 3 presents the profile of MHCUs who participated in the interviews.

Two individual interviews were discarded. The responses from these MHCUs turned out to be inappropriate because they focused on their own personal problems and diverted constantly from the

original question. Also, they did not understand the questions. They were thus not information rich participants.

Constant comparison of responses of MHCUs to domains identified by clinicians

After transcribing each interview with the MHCUs, their responses were compared to each domain and then matched with the most appropriate domain. The eight domains were: Process skills, Motivation, Communication and Interaction skills, Self esteem, Balanced lifestyle, Affect, Lifeskills and Role performance. Responses from MHCUs and how they have been matched with a domain are described below.

Process skills:

Some MHCUs felt that participation in activities helped them to concentrate and compelled them to put effort into a task. Some reported that craft activities assisted them to rediscover their planning abilities. The majority of responses that matched Process skills emphasised the importance of regaining concentration and memory so as to be able to complete a task or activity successfully for instance, by following a recipe.



Motivation:

MHCUs pointed out “being occupied” as an important concept. Statements like the following were expressed: *My personal opinion is that you can't stay around doing nothing the whole day you can't stagnate the whole day.* The same person continued and said: *If you stagnate the whole day [then] you're getting older [and] you[re] getting up to mischief, you[re] getting bored. I think all patients come here to keep them occupied.* Another MHCU reported that: *We do things, it is something to do, and I have learnt the value of your hands being kept busy.*

One of the assumptions in VdTMoCA is that successful engagement and mastery in one task, motivates the person to engage into another, and sometimes an even more challenging task. One can therefore link the statement on the MHCUs being occupied, to that of being motivated.

Communication / Interaction skills:

Many positive effects of occupational therapy groups were mentioned. The MHCUs specifically mentioned social skills groups that showed them the value of interacting with others. One person said that *Social skills groups are good; they teach you about how to handle yourself in society.* One individual mentioned the positive effect of the assertiveness group and that he was now more aware of the feelings of others, another pointed out that, *In the groups you hear about other people's stories and you realise you are not the only one with problems*, while a third person stated the opposite and was not that positive about being involved in groups. She said that she did not come to hospital to hear about other people's sad stories.

Self-esteem:

This domain matched well with the responses of the MHCUs. They reported that being involved in craft activities, cooking sessions, games or sport groups gave them a sense of self-worth. The process of creating a product which they could offer to significant others initiated a positive feeling about themselves and this renewed belief in themselves: *In groups you learn about yourself, you get to know yourself and in the end you feel good about yourself*, one person said. Others said: *Other people give nice comments about your stuff. The art classes, that was great, you feel good about yourself, you have done something, and [they] make you feel worth something.*

Balanced lifestyle:

MHCUs, who attended a maintenance intervention programme, reported that the occupational therapy programme helped them to live a balanced life inside the hospital. They had the opportunity to participate in games and sport groups, as well as craft activities, and worked in the protected workshops inside the hospital or did work in the laundry, the garden or in the administration block.

MHCUs in the acute phase of treatment mastered new craft activities to do at home and which permitted them to incorporate meaningful and enjoyable activities in their lifestyles. One user mentioned that time planning had helped her to realise that she had insufficient variety in her lifestyle. Another client expressed the need to have occupational therapy during weekends as well because those were the times when she found it difficult to structure meaningful engagement in activities.

Affect:

Many MHCUs realised the positive effect of craft activities on their emotions. *Being occupied in something enjoyable like making leather belts reduced my anxiety and fear. I could focus on something else. My hands are busy and my mind becomes clear and When you feel good about yourself, your mood also improves. You don't feel so depressed anymore.* One MHCU, as mentioned earlier, felt she did not benefit from a group focused on emotions. She reported that talking about depression and listening to other people's problems made her feel more depressed.

Lifeskills:

This domain was also well supported by the responses of the MHCUs. Statements like *They helped me to cope with my problems*

better, I learnt how to make stuff, you know, I've learnt a lot from news groups about news I didn't know, you know, I learnt how to cook better you know, confirmed the relevance of lifeskills. One MHCU suggested that more groups on the handling or raising children ought to be arranged.

Stress management and time planning were worthwhile for some. *We have learnt a lot of tips and skills here, and, I cannot solve my problem now, but I got guidelines to cope.*

Role performance:

MHCUs did not talk about role performance per se, but nonetheless expressed some concern about facing reality. They felt safe inside the hospital or clinic given all the support they received from staff and fellow-clients who understood their problems. Once they were discharged, they had to use the skills acquired in the hospital. The reality that was waiting was actually the roles that they had to fulfill, for example a worker role, a mother role, running a household and the like. *The work only begins when you go out, you have to get a place to stay, a new job.* One user who was readmitted said that he did not use the skills immediately but only at a later stage. He then realised how he had grown. Another user said the clinic is *an unnatural world and I do not feel prepared to go and The discharge group helped me a lot.*

There were overwhelming similarities between the domains and the expectations of the MHCUs. Only one disagreement was noticed; the response by a MHCU who felt that groups were not beneficial and it did not help to improve her mood.

A number of additional themes that did not fit any of the domains emerged from the interviews. These are discussed below.

Additional themes from the interviews with the clients

Healing Factors

MHCUs mentioned two aspects that helped them on the road to recovery. Firstly they reported the therapists' friendliness and caring attitude towards them, much more than other health care professionals in the team. One user said that *therapists treat you with dignity.* However, responses from clinicians in the focus groups expressed concern over the fact that they did not have enough time to form good therapeutic relationships with MHCUs due to time constraints and patient overload.

Secondly, support from fellow-clients in the ward or in the occupational therapy groups were mentioned by the majority of users. They said that it comforted them to share their problems with others and that this helped them feel that they were not alone. Only one user experienced the opposite by mentioning that sharing experiences with other depressed patients made her feel more depressed (as mentioned earlier).

Although the healing factors theme emerged from the MHCUs' data set, no new domains were added or removed from the outcome measure. The theme of therapists being seen as caring was not addressed as such in the intervention programmes and was therefore not measured as an outcome. “Caring” is an essential characteristic of any health care worker and would therefore be part of the generic tools of practice, namely therapeutic relationship or use of self.

Out-patient programmes

There was a suggestion from two MHCUs that discharged users be permitted to participate as out-patients and to attend the craft sessions or other occupational therapy groups to assist them with *facing the reality outside.* They felt that when they had to face a new or difficult challenge, it would help if they could attend one or two groups that dealt with this specific challenge.

This theme was not added to the domains as this is not a specific outcome of the occupational therapy programme and could happen in circumstances that fall outside the occupational therapy programme. In- or outpatient status was added to the minimal data set; in other words, a MHCU could receive treatment as an in- or out-patient and this was clearly noted.



There seems to be a match between clients' expectations and what they have received from occupational therapy and what clinicians wish to include in an outcomes measure.

Discussion

The participation of MHCUs to generate information that determined the domains for the outcome measure accentuated the value of a client-centred approach. Working in partnership with clients and respect for their needs ought to be embedded in occupational therapy interventions in order to improve their occupational performance. Law et al^{2,4} felt that measurement techniques have to include the client's say in evaluating outcomes of his intervention. This aspect of client-centred practice was implemented in this study.

Another aspect of client-centred practice that was firmly integrated into this study was the notion that measurement had to focus on both subjective experience and observable qualities of occupational performance^{3,17,18,19}. Clients' responses reflected their subjective experiences. They were granted an opportunity to express their need for and expectation of occupational therapy service. At the same time, domains selected by the clinicians were indicative of the observable qualities of occupational performance.

Responses from MHCUs corresponded well with the domains in which the clinicians wished to see change. This indicated that clinicians in this study were in touch with their clients' needs.

Responses from the MHCUs in this study compared well with a study done by Lim et al¹². The researchers gathered data by way of a self-report semi-structured questionnaire to examine acute mentally ill inpatients' perspectives on occupational therapy. Three-quarters of the patients reported the importance of occupational therapy's capability to provide them with daily structure, breaks with the ward environment, acquisition of new skills and creation of space for creative expression to improve confidence. Participants further reported the need to have occupational therapy available during both evenings and over weekends when lack of available therapeutic activity and boredom are common. This need was also expressed by the MHCUs in the current study.

Findings in a study by Ecklund²⁰ in which patients also had to identify therapeutic factors revealed that the attitude and behaviour of the occupational therapist contributed to the recovery process. The participants in Ecklund's study also reported the value of being occupied and motivated through participation in activities, as well as being given the opportunity to be creative²⁰.

Much debate has taken place on whether clients with psychiatric diagnoses were able to give useful and rich information with regard to outcomes that ought to be measured. Irrespective of the debate, MHCUs were included in this study since, according to the researcher's experience, they have valuable information to share and are "experts" in how the illnesses affect their occupational performance. It was also clear from the findings of this study that they knew what they expected from the occupational therapy service. A study done by Ecklund, Erlandsson and Person²¹ indicated that the value of occupation to people with mental illness hardly differed from that of people without mental illness. These findings imply that MHCUs are able to convey their needs and occupational values adequately and must, therefore, be included in studies about their health and well-being.

The timing of gathering information from a person diagnosed with a mental disorder is crucial. There are stages in the course of mental illness when the person will be unable to provide comprehensive and reality-based information e.g. during psychotic or severely depressed phases. Both psychotic phases and severe depression usually diminish after intervention and once the appropriate treatment takes effect, the person's mental state stabilises and he or she is able to give useful information. Clients with limited cognitive abilities, e.g. mental retardation, are likely to give limited information or of a concrete nature but in their cases, their care givers or family members could supplement information and act on their behalf.

In this study, the researcher excluded the data of two MHCUs because the information was not relevant to the questions posed

to them. Both users suffered from cognitive decline due to general medical conditions. The content of their thought processes were focused on their immediate problems and questions from the researcher elicited tangential thinking. In situations like these, proxies of the MHCUs could be included to ensure that their needs for occupational therapy are being met.

Lim et al¹² reported that despite a commitment to client-centred practice, involving clients in their own intervention had made slow progress, especially among clients having a mental illness. This might be due to a narrow view that MHCUs might be unfit to make decisions on what they need or what will be beneficial to them. Goulet et al¹³ reported little agreement between clients and service providers regarding intervention needs. Unfulfilled clients' needs included interpersonal relationships, independent lifestyles, productive activities and, coping with illness and health care¹³.

The reluctance of therapists to use a client-centred approach, as reported in the literature, was not evident in this study. During dedicated individual interviews and focus group, several MHCUs mentioned the caring attitude of occupational therapists. A study by Bambling and King²² found that up to 30% of the recovery of a mental health care user could be accounted for by the therapeutic relationship, due to the fact that the person felt he/she has been listened to, understood, respected and helped by the health care professional. Johansson and Eklund²³ reported similar findings from a study that emphasised the importance and quality of therapeutic relationship with MHCUs. This seemed to be a noteworthy issue that has not been included in any outcome measure, in spite of studies that had been done on the importance of the relationship between a therapist and client.

Greenhalgh and Meadows²⁴, in a literature review of 13 studies, reported that there was little evidence that patient-based measures improved the management of patients or the patient outcomes. In spite of many client-centered models of practice mentioned in the literature review earlier, it seems that involving MHCUs in their intervention has been a slow process. The research reported in this article indicated that the perceptions of the needs of MHCUs from a clinician's point of view, corresponded with the expectations of the occupational therapy service of MHCUs. This correspondence lays the foundation for a successful client-centered service.

Limitations of the study included the sampling frame of MHCUs. Only those in three selected mental health care setting in a specific location were included. This limited sample does not necessarily represent the needs of the majority of MHCUs. Results of the study should thus be interpreted with care and be transferred to similar settings only.

Conclusion

It can be concluded that the responses from the group of MHCUs who participated in the research corresponded well with the domains in which clinicians wish to see change. It could well be an indication that clinicians in this study were in touch with their client needs, even though diagnoses or certain symptoms of MHCUs could affect their thinking and feeling. Future research projects about MHCUs could make sure to give a voice to their participants as it seems that their inputs are relevant and informative.

References

1. Townsend E, Landry J. Intervention in a social context: Enabling participation. In: Christiansen CH, Baum CM, Bass-Haugen J, editors. *Occupational therapy: Performance, Participation, and Well-being*. Thorofare: Slack Incorporated, 2005:949 – 520.
2. Law M, Baum CM, Dunn W. Occupational Performance Assessment. In: Christiansen CH, Baum CM, Bass-Haugen J, editors. *Occupational therapy: Performance, Participation, and Well-being*. Thorofare: Slack Incorporated, 2005:338 – 370.
3. Law M, Baum C, Dunn W. *Measuring occupational performance - supporting best practice in occupational therapy*. New York: Slack Incorporated, 2001.
4. Law M, Baptiste S, Mills J. Client-centred practice: what does it mean and does it make a difference? *Canadian Journal of Occupational Therapy*, 1995; 62(5):250-257.



5. South African Government. Mental Health Care Act No 17 of 2002.
6. Baum CM, Christiansen CH. Person-Environment-Occupation-Performance: An Occupation-based Framework for Practice. In: Christiansen CH, Baum CM, Bass-Haugen J, editors. Occupational therapy: Performance, Participation, and Well-being. Thorofare: Slack Incorporated, 2005:242 - 266.
7. Law M, King G, Russel D. Guiding therapist decisions about measuring outcomes in Occupational Therapy. In: Law M, Baum C, Dunn W, editors. Measuring occupational performance - supporting best practice in occupational therapy. New York: Slack Incorporated, 2001:33 - 48.
8. Law M, Baum C. Measurement in Occupational Therapy. In: Law M, Baum C, Dunn W, editors. Measuring occupational performance - supporting best practice in occupational therapy. New York: Slack Incorporated. 2001:3 - 20.
9. Law M, Baptiste S, Carswell A, McColl M, Polatajko H, Pollock N. Canadian Occupational Performance Measure, 2005. < <http://www.caot.ca/copm/> >. (1 April, 2009)
10. Du Toit V. Patient volition and action in occupational therapy. 3rd ed. Pretoria: Vona & Marie du Toit Foundation, 2004.
11. Kielhofner G, Forsyth K. Thinking with theory: A Framework for Therapeutic Reasoning. In: Kielhofner G, editor. Model of Human Occupation. 3rd ed. Baltimore: Lippincot Williams & Wilkins, 2002: 162 - 178.
12. Lim KH, Morris J, Craik C. Inpatients' perspectives of occupational therapy in acute mental health. Australian Occupational Therapy Journal, 2007; 54:22-32.
13. Goulet C, Rousseau J, Fortier P. A literature review on perception of the providers and clients regarding the use of client-centered approach in psychiatry. Canadian Journal of Occupational Therapy, 2007; 74(3):172-182.
14. Casteleijn D, Graham M. Domains for occupational therapy outcomes in mental health practices. South African Journal of Occupational Therapy, 2012; 42(1): 26-34.
15. Creswell JW. Research Design: Qualitative, Quantitative, and Mixed Method Approaches. 3rd ed. London: Sage, 2007.
16. Whitman ME, Woszczyński AB. The handbook of information systems research. London: Idea Group Inc., 2003.
17. Fossey EM, Harvey CA. A conceptual review of functioning: Implications for the development of consumer outcome measures. Australian and New Zealand Journal of Psychiatry, 2001; 35: 91-98.
18. Krupa T, Fossey E, Anthony W, Brown C, Pitts D. Doing Daily Life: How Occupational Therapy can inform psychiatric rehabilitation practice. Psychiatric Rehabilitation Journal, 2009; 32(3): 155-161.
19. Lakeman R. Standardized routine outcome measurement: Pot holes in the road to recovery. International Journal of Mental Health Nursing, 2004; 13:210-215.
20. Eklund M. Therapeutic factors in occupational group therapy identified by patients discharged from a psychiatric day centre and their significant others. Occupational Therapy International, 1997; 4(3): 200-214.
21. Eklund M, Erlandsson L, Person D. Occupational value among individuals with long-term mental illness. Canadian Journal of Occupational Therapy, 2003; 70(5): 276-284.
22. Bambling M, King R. Therapeutic alliance and clinical practice. Psychotherapy in Australia, 2001; 8:1.
23. Johansson H, Eklund M. Patients' opinion on what constitutes good psychiatric care. Scandinavian Journal of Caring Science, 2003; 17: 339-346.
24. Greenhalgh J, Meadows K. The effectiveness of the use of patient-based measures of health in routine practice in improving the process and outcomes of patient care: A literature review. Journal of evaluation in clinical practice, 1999; 5(4): 401-416.

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