EXPERIENCES OF MENTAL HEALTH CARE USERS ATTENDING AN OCCUPATIONAL THERAPY PRODUCTIVE OCCUPATIONS PROGRAMME

A research report submitted in the partial fulfilment for the Masters in Occupational Therapy degree

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DECLARATION

I, Amelia Ruth Chiringa, student number 1712974, declare that this research report is my own work. It is being submitted for the degree of Masters of Science in Occupational Therapy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

, 26th day of August 2022

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Definition of Terms

Productive occupations – occupations that allow individuals a means to provide for themselves and their families, a means of survival and sustenance, a means to abate poverty, and a means to contribute to the social and economic fabric of society (Mcelroy *et al.*, 2012; AOTA, 2016) .

Food Gardening - growing vegetables, grains, fruits and various foods for the household, in this research, with the deliberate aim of having surplus for selling, barter trade or profit, enhancing food security (Galhena, Freed and Maredia, 2013; Mullins *et al.*, 2021).

Self-sustenance - The ability for an individual to provide for their needs through engaging occupations, resulting in them not needing external assistance to meet their needs. The needs encompass the ability to provide food, clothes, school fees, shelter for themselves and the people who depend on them (Durocher, Gibson and Rappolt, 2017).

Open labour market – Competitive place where all people are free to actively look for employment, or set up businesses to earn an income.

Livestock rearing – The breeding, raising and management of domestic farm animals in order to obtain meat and products for economic purposes (Galhena, Freed and Maredia, 2013).

ABSTRACT

Background: The study explored the experiences of mental health care users (MHCUs) engaging in an occupational therapy productive occupations programme at a long-stay mental health institution. Productive occupations enable MHCUs to earn an income, to promote their health and to contribute meaningfully to society. Occupational therapists use productive occupations as part of interventions in various contexts to facilitate the above outcomes. Incorporating the experiences of MHCUs in the planning and development of occupational therapy programmes allows an evaluation of whether the service offered meets their needs. However, the MHCUs in this study were not included when the occupational therapy productive occupations programme was developed and implemented. This study therefore explored their experiences and whether the programme met their productivity needs.

Methods: This is a descriptive qualitative study which used semi-structured interviews to explore the participants' experiences of the occupational therapy productive occupations programme. Ten participants who gave consent were selected and interviewed. Thematic analysis guided the data analysis process.

Results: The findings of the study reveal that not only is the programme meaningful to the participants but it also allows them to learn various necessary skills that enable their reintegration into society. However, the programme had areas that the MHCUs felt needed to change to allow the programme to meet their needs. The identified needs are expanding the programme and allowing the programme to be responsive to their future goals with regards to the engagement in productive occupations within the community beyond hospitalisation.

Conclusion: The experiences of the MHCUs were not only empowering to them but also provide a platform to give valuable input towards programme adaptation.

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LIST OF ABBREVIATIONS

AOTA	American Association of Occupational Therapists
ILO	International Labour Organisation
LMIC	Low- and Middle-income Country
MHCU	Mental Health Care User
OTPFIII	Occupational Therapy Practice Framework and Domain III
WFOT	World Federation of Occupational Therapists
WHO	World Health Organisation

1 INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Mental disorders are among the main contributors to disability worldwide. These disorders have been identified to be among the top 20 disabling disorders in a global systematic analysis of the global burden of disease as of 2013, accounting for 11.23% of disability adjusted life years (Vigo, Atun and Thornicroft, 2016; Duffy et al., 2017; World Health Organisation [WHO], 2018). While the disabling nature of mental disorders has been globally acknowledged, the management of these disorders remains a challenge. The health system has not yet responded adequately to the growing burden of mental disorders, and as a result, there is a gap between the need for treatment and the provision of treatment. In low and middle-income countries (LMICs), such as Zimbabwe, 76–85% of persons living with mental disorders do not get treatment, whilst those able to access treatment receive substandard care (WHO, 2017). The national strategic plan in Zimbabwe alludes to the needs to recruit and retain mental health professionals to alleviate this problem (MoHCC, 2019). However, lack of updated mental health policies to direct mental health programmes and insufficient resources in LMICs including Zimbabwe restrains the access to quality therapeutic and rehabilitative services for mental disorders, precipitating the disabling nature of mental disorders (Institute of Medicine, 2010; Vigo, Atun and Thornicroft, 2016; Oyelade and Nkosi-Mafutha, 2021).

Persons living with mental disorders often experience constantly recurring symptoms that have a major effect on their everyday functioning. These symptoms include loss of contact with reality, social withdrawal, apathy, delusions and hallucinations; all of which directly affect engagement in daily occupations (Falkum et al., 2017). As a result of the chronic nature of mental disorders, mental health care users (MHCUs) have difficulty meeting the demands of their desired and/or expected roles. They have difficulty engaging in self-care, home maintenance, work-oriented activities and social interaction, limiting their ability to meaningfully contribute to their communities (Mee, Sumsion and Craik, 2004). In order to contribute to their communities, MHCUs need to equitably participate in meaningful and productive occupations. A notion supported by the Zimbabwe mental

health policy of 2007 which emphasises the need for comprehensive rehabilitation services aimed at promoting self-autonomy, independence, self-sufficiency and productivity (MoHCC, 2007).

Mcelroy et al. (2012) describe productive occupations as occupations from which an individual earns a livelihood, meet their human needs and ensure survival. Productive occupations are crucial for forming individual and social status, to create wealth for some, and to survive or earn a livelihood for others (Blank, Harries and Reynolds, 2015; Prainsack and Buyx, 2018). Additionally, productive occupations facilitate the development of a routine, improve social interaction and social identity and provide an opportunity for regular exercise (International Labor Organisation (ILO) and WHO, 2002; Prainsack and Buyx, 2018). Thus, facilitating engagement in productive occupations is crucial in the management and care of MHCUs.

Participating in productive occupations has been seen to counter the dire effects of mental disorders and to enhance health, wellbeing, and participation in life (Kennedy-Jones, Cooper and Fossey, 2005; Bade and Eckert, 2008; Southern and Miller, 2012; Blank, Harries and Reynolds, 2015). The benefits of engaging in productive occupations include gaining a means of survival, facilitating social connectedness, physical activity, promoting emotional wellbeing, and helping MHCUs find meaning and hope in life (Muñoz, Dix and Reichenbach, 2009; Whatley, Fortune and Williams, 2015; Smidl, Mitchell and Creighton, 2017).

Despite the desire to engage in productive occupations, MHCUs are often excluded from participating equitably in these occupations (ILO and WHO, 2002). Disability statistics from Zimbabwe indicate that most people with disabilities are excluded and have limited opportunities to participate in productive occupations, however, persons living with mental disorders are the most affected (Mandipa and Manyatera, 2014). This exclusion further exacerbates the symptoms of mental disorders as it is often associated with feelings of shame, fear and rejection. Subsequently, MHCUs get trapped in deeper economic marginalisation and poverty. As such, comprehensive treatment programmes are required to facilitate MHCUs engagement in productive occupations.

Productive occupations in occupational therapy embrace occupations that satisfy human needs and are sensitive to people's environments (Asaba et al., 2021). These occupations include self-directed work-oriented occupations through which individuals can earn a livelihood from or productively occupy their time. Productive occupations include, but are not limited to, agriculture, construction, livestock rearing, vending and wage-earning labour (Iannelli and Wilding, 2007). These occupations provide self-worth and hope for a better future and positively influence the health and wellness of MHCUs. Therefore, the engagement of MHCUs in productive occupations should be a priority for development programmes.

The WHO document on mental health and development highlights that MHCUs are a vulnerable group and they should be targeted for development programmes (Funk, Drew and Knapp, 2012). These programmes should promote the participation of MHCUs in productive occupations and including income-generating projects (Funk, Drew and Knapp, 2012). Occupational therapists' core mandate is to facilitate the engagement of individuals, communities and populations in occupations that facilitate their health and wellbeing. Therefore, enabling the participation of MHCUs in productive occupations is of significant concern in occupational therapy (World Federation of Occupational Therapists [WFOT], 2016).

Occupational therapists are positioned to work with groups that are traditionally marginalised to provide opportunities for participation in productive occupations, promote equity and social inclusion for MHCUs (Hammell and Iwama, 2012). Engagement in productive occupations is vital for recovery in mental health (ILO and WHO, 2002). When there are opportunities to engage in productive occupations, MHCUs can make a meaningful contribution to their society while also improving their own health and wellbeing.

A productive occupations programme was introduced in the occupational therapy department at a long-stay mental health institution in Zimbabwe. This was seen to be relevant for the empowerment of MHCUs in an economic environment that poses many challenges for the average Zimbabwean. The productive occupations programme was seen as pivotal in challenging negative societal views surrounding MHCUs, particularly

that they were considered unable to engage in productive occupations. The productive occupations programme afforded them an opportunity to engage in meaningful occupations that facilitated meeting their survival needs. As much as the introduction of the programme at the long-stay mental health institution was deemed necessary by the occupational therapists, the planning of the programme did not involve MHCUs. It was therefore unclear whether the programme is responsive to the needs of the MHCUs.

According to Wright et al. (2015), introducing a programme without including the service users results in the service users losing their voice and having their choices and opinions disregarded. The exclusion of MHCUs in the planning, implementation and evaluation of programmes may perpetuate the marginalisation that they already face as a result of stigma. Mental health care users bring a unique perspective to programme development and implementation because of their experience of mental illness (Kleintjes et al., 2010). Wright et al. (2015) emphasize that exploring the experiences of MHCUs is important to satisfy their expectations and needs. Active MHCUs involvement in programme planning is a critical aspect in rehabilitation (Wright et al., 2015). Since MHCUs were not involved in this programme's development, it is essential to explore their experiences of the occupational therapy productive occupations programme.

1.2 STATEMENT OF THE PROBLEM

It is important to explore MHCUs' experiences in order to evaluate intervention programmes (Semrau et al., 2018; Mugisha et al., 2019). Currently, there is a scarcity of literature on MHCUs' experiences of occupational therapy programmes in LMICs. Programmes are often developed for MHCUs without their involvement, especially in LMICs like Zimbabwe (Kidia et al., 2017; Semrau et al., 2018). A small number of studies have been done to explore the experiences of MHCUs engaging in productive occupations with a focus on modifying and developing programmes to meet the needs of MHCUs (Lannigan, 2014; Hendler et al., 2016; Schindler, 2018). As a result, MHCUs' needs may not be met and there can be a lack of satisfaction with existing mental health programmes. Additionally, MHCUs may lose their voice at key health delivery points when they encounter programmes that are unable to meet their needs (Chambers et al., 2014; Wright et al., 2015; Schindler, 2018; Mugisha et al., 2019).

In the occupational therapy department at the long-term mental health institution in Zimbabwe where the study took place, MHCUs' experiences were not included during the development and implementation of the productive occupations programme; therefore, it is unknown whether the programme is meeting their needs.

1.3 RESEARCH QUESTION

What are the experiences of MHCUs attending the occupational therapy productive occupation programme at a long-term mental health institution in Zimbabwe?

1.4 AIM OF THE STUDY

The aim of the study was to explore the experiences of MHCUs attending the occupational therapy productive occupation programme at a long-term mental health institution in Zimbabwe.

1.4.1 OBJECTIVES OF THE STUDY

This study had the following objectives:

- To explore MHCUs' experiences of their productive occupations before hospitalisation;
- To explore how MHCUs' productivity needs link to the choice of occupation within current programme; and
- To explore MHCUs' experience of the current productive occupations programme.

1.5 JUSTIFICATION OF THE STUDY

Exploring MHCUs' experiences of a programme is the first step in advocating for their involvement and to lessen the stigma and discrimination connected with having a mental disorder. In addition, MHCUs are experts in relating their experiences of mental illness and can make meaningful contributions to inform mental health practice (Lawn, 2015). Therefore, MHCUs' experiences and MHCUs themselves should be included in the formulation of intervention programmes. Sather et al. (2019) show that including MHCUs' experiences and allowing them to participate empowers them and contribute to their self-

esteem. Therefore, exploring the experiences of MHCUs increases the responsiveness of the programme to the needs of the targeted group (Mugisha et al., 2019).

1.6 SIGNIFICANCE OF THE STUDY

The outcome of this study will form a baseline through which MHCUs can be given an opportunity to contribute towards the development and adaptation of occupational therapy productive occupations programmes, enabling more effective intervention outcomes for MHCUs. Additionally, exploring the experiences of MHCUs in these programmes will facilitate changes that are directed at meeting their expectations of participating in meaningful occupations in wider societies.

1.7 SUMMARY OF CHAPTERS

1.7.1 Chapter 1: Introduction and background of the study

This section discusses the introduction, scope and aim of the study. The chapter uses relevant literature to outline and discuss the title of the research, the problem statement and its justification with special emphasis on the Zimbabwean context.

1.7.2 Chapter 2: Literature review

This chapter outlines the synopsis of literature in productive occupations and work practice in occupational therapy and discusses this with relevant research. It also looks at the value of including the experiences of MHCUs in programme development and supports this with contextually relevant literature.

1.7.3 Chapter 3: Methodology

This section outlines the results and provides a detailed description of the study design, how the data was collected, the analyses framework and the ethical considerations that justified the processes that were followed. There is a detailed discussion of the analysis process that highlights the back translation process that was pivotal to ensure the outcome of the analysis maintained veracity. This study included a vulnerable group of

people, and therefore, additional precautionary measures were taken to protect their autonomy.

1.7.4 Chapter 4: Results and discussion

This chapter presents the results and discusses the findings of the research, referencing relevant previous research. It discussed main themes and emphasises the context of the research.

1.7.5 Chapter 5: Conclusion and recommendations

This section outlines the limitations, evaluation, recommendations and conclusion of the study. It brings out the important outcomes of the study and their contextual relevancy.

2 LITERATURE REVIEW

2.1 INTRODUCTION

This section attempts to understand prevailing research on the experiences of MHCUs attending productive occupations programmes. This chapter is organised into three major parts: The first part introduces productive occupations and looks at the general characteristics of productive occupations used globally in the occupational therapy profession. This is narrowed down to characteristics of productive occupations within African societies. The importance of engaging in productive occupations in the Zimbabwean context is discussed further. The second part discusses MHCUs' experiences of intervention programmes and how the experiences can be used to inform the development of mental health programmes. This also includes looking at the experiences of MHCUs in intervention programmes, and particularly, in work and productive occupations. The last section discusses the impact of involving MHCUs' experiences into developing and implementing intervention programmes and the importance of MHCUs engaging in productive occupations.

2.2 GENERAL CHARACTERISTICS OF PRODUCTIVE OCCUPATIONS

2.2.1 A brief history of work in occupational therapy and its link with productive occupations

The conceptualisation of work has changed over time with the growth of the occupational therapy profession (Ehrenfried, 2016; Kirsh et al., 2019; Asaba et al., 2021). Ross (2007) explains that the use of work in occupational therapy became evident in the moral treatment period. Persons living with mental disorders were deemed to be less human and were given manual work, such as agriculture, to help them conform to societal norms (Harvey-Krefting, 1985). However, the use of work seldom went further to fulfil the ultimate goal of paid employment or reaching financial independence (Harvey-Krefting, 1985). Interestingly, Harvey-Krefting (1985) notes that this use of work was insubstantial in connecting MHCUs to their wider societies.

History is studded with the exclusion of MHCUs from occupations that support their health and wellness in a bid to support the prevailing ideas. In the 1920s, work rehabilitation did not apply to psychiatric patients as mental illness was considered incurable and efforts to improve health and wellness through work were concentrated on other conditions (Harvey-Krefting, 1985). In the mid-1900s, the medical view of conceptualising work took precedence and work began to be regarded as synonymous with employment (Harvey-Krefting, 1985; Asaba et al., 2021). However, this narrow view served only a small proportion of individuals who could benefit from work rehabilitation programmes and ultimately secure paid employment (Harvey-Krefting, 1985). Therefore, individuals who had recurring conditions and had challenges engaging in work, for example, individuals with chronic mental illness, were excluded from ultimately assuming productive roles in society.

Prainsack and Buyx (2018) demonstrate that if paid work is ascertained to be the only way people can gain an income, it becomes not only a threat to peoples dignity but also to their wellbeing, health and quality of life. Failure to obtain an income through paid employment means the inability to satisfy various human needs. Pereira and Monteiro (2019) describe work as an occupation that enables people to meet their basic needs. Similarly, productive occupations are seen to help people provide for their families' needs and ensure survival (Mcelroy et al., 2012). Productive occupations for people in Northern Uganda include rearing animals and cultivating crops. These occupations are perceived as work by people who engage in them but cannot be classified as paid employment. Therefore, for most people engagement in productive occupations becomes the difference between meeting needs and being in a state of poverty (Mcelroy et al., 2012).

Pierce, (2000) highlighted that productivity is in the nature of all individuals and thus considered all the occupations that have a goal-oriented focus to fall in the domain of productivity. This means that various work and non-work occupations can be considered as occupations which can be grouped under productivity occupations as long as they allow a person to reach a goal or purpose. Therefore not all productivity based occupations have been described as having a work oriented focus. However in this study, the interest was the work-oriented focus of productive occupations.

In a statement by the American Association of Occupational Therapists (AOTA, 2016), work is given as an example of productive occupations. Therefore, expanding productive occupations to include work-oriented occupations shows sensitivity to what people do in different contexts to provide for their needs and survival. Engagement in productive occupations is not only valuable to meet needs but also has many other benefits for MHCUs. For people with schizophrenia, substance misuse disorders, anxiety disorders and depression, various benefits have been noted through the engagement in productive occupations.

2.2.2 Characteristics of productive occupations

Oyelade and Nkosi-Mafutha (2021) indicate that persons with mental disorders can start self-directed small businesses, engage in formal paid employment pursuits and learn new skills as part of their engagement in productive occupations. Engaging in productive occupations is therefore an important aspect of the reintegration of MHCUs into their communities, which is the ultimate goal for most psychosocial rehabilitation programmes (Cipriani et al., 2018). Within occupational therapy, various productive occupations are used to facilitate the outcome of social reintegration. However, social reintegration is made possible if MHCUs are able to secure and maintain meaningful employment. Hence, the use of various productive occupations, including tailoring, hairdressing, shoe making, beading, wool works, gardening, livestock rearing, and vending, facilitate this process (Oyelade and Nkosi-Mafutha, 2021).

Horticulture and/or gardening is a productive occupation that has been and is increasingly being used in occupational therapy for almost a century (Smidl, Mitchell and Creighton, 2017). Gardening is not unique to occupational therapy and has been referred to as therapeutic horticulture, therapeutic gardening and agrarian-based occupations by various researchers and professions, and all of these refer to the tending and cultivating of plants in different mediums and contexts (Mcelroy et al., 2012; Liu et al., 2014; Smidl, Mitchell and Creighton, 2017). In this literature review, the researcher specifically zones in on food gardening to distinguish it from other forms of gardening such as landscaping and flower gardening. This is because food gardening in addition to allowing people to

have food security in an environment with economic crisis, they can also sell excess produce and generate income to meet other needs such as clothes, bills and school fees.

Smidl, Mitchell and Creighton (2017) describe gardening as both a productive occupation and a leisure occupation. Depending on how it is designed, food gardening can be used to reduce stress, develop confidence, support social interaction, provide network building opportunities and improve the social wellbeing of an individual (Liu et al., 2014). Food gardening has been used and is currently being used for MHCUs within occupational therapy to meet different patient goals (Smidl, Mitchell and Creighton, 2017). Contextually, some societies, for example, most of Zimbabwe, still maintain a rural agrarian way of life, and food gardening or farming cannot be separated from peoples' way of life (Mcelroy et al., 2012). Food gardening for rehabilitation purposes, particularly in mental health, is done within community mental health facilities, allotment groups, clubhouses, general mental health hospitals, day care centres and/or in collaboration with non-state-funded organisations (Perrins-Margalis et al., 2008; Mlambo et al., 2014; Smidl, Mitchell and Creighton, 2017; Cipriani et al., 2018).

Food gardening is an activity that requires less funding and can be done with limited space and material (Cipriani et al., 2018). This means that food gardening as a productive occupation is considered a cost effective activity for psychosocial rehabilitation programmes. The therapeutic benefits of food gardening has been shown to include a variety of physical, emotional and sensory benefits (Smidl, Mitchell and Creighton, 2017). Elsey, Murray and Braggy (2016) highlight that food gardening allows individuals to be socially connected. Food gardening allows social inclusion among MHCUs who are often excluded from their communities (Cipriani et al., 2018). Additionally, gardening activities that are done in a group set-up within the community are identified to be both a community and a shared resource, allowing MHCUs to interact amongst themselves and in the society (Whatley, Fortune and Williams, 2015). The buying and selling of food garden produce also attracts people from the community, reducing the effects of social isolation that MHCUs often experience.

People with schizophrenia are often socially withdrawn, isolated and excluded from their communities (Liu et al., 2014). Encouraging their engagement in food gardening helps

improve their recovery outcomes. Similarly, Liu et al. (2014) indicate that for patients with depression gardening plus standard care led to more improvements in relieving depression, anxiety and stress than standard care alone.

Food gardening is also seen as a way for individuals to attain financial independence (Elsey, Murray and Braggy, 2016). According to Cipriani et al. (2018), engaging in food gardening creates experiences of participating in work-oriented occupations that are parallel to employment. The African perspective of food gardening occupations is strongly represented as part of people's lives and livelihood (Mcelroy et al., 2012). An abundant natural land resource supports the importance of food gardening in this context.

In sub-Saharan Africa, most rural households depend on cultivating crops for consumption to secure food (Glass et al., 2014), and other households have food gardens close to a water source for the same purpose. In Zimbabwe, with erratic rainfall in 2010, 2015 and 2017, those households which depend on rainfall for food security have been severely affected (Sakadzo and Kugedera, 2020) and trends like these may continue because of climate change. Mujere, (2021), highlights that food security becomes challenge due to the vulnerability of the climate and various measures need to be considered to ensure food security for households which depend on food gardens. Most people in Zimbabwe grow maize as their staple food however with reduced rainfall this crop does not fare well. There is need therefore to educate and encourage MHCUs on the farming of small grains for example, sorghum, finger millet, pearl millet, which fare better with reduced annual rainfall, especially for those who depend on rainfall for their yearly crop. As a result to families are able to gain an income through selling the small grains to the grain marketing board so that they can use the money to acquire maize which they may need.

Another measure which the government of Zimbabwe has taken to support food security through the agricultural intensification program is the pfumvudza conservation agricultural programme (Mujere, 2021). This programme ensures food security through conservative agriculture and various techniques such as mulching, water harvesting, use of organic fertilisers (Mujere, 2021). Occupational therapists can therefore link with NGOs that are already facilitating such programmes for ensuring food security with communities. These

NGOs can support and provide education to MHCUs as part of the occupational therapy productive occupations program so that MHCUs may utilise the skills and knowledge upon discharge. Regardless of the risks, food gardening facilitates creating an income, improves quality of life, and gives an individual the ability to take care of themselves and the people around them.

In Western societies, although facilitating the development of a worker role in MHCUs is a noted benefit, literature shows that food gardening has other recorded benefits, including facilitating emotional wellbeing, providing opportunities for socialisation, facilitating personal responsibility, supporting social inclusion and providing learning opportunities (Whatley, Fortune and Williams, 2015; Joyce and Warren, 2016; Smidl, Mitchell and Creighton, 2017).

It can be deduced that the primary aim of food gardening in African societies is creating a livelihood or productivity, unlike in Western societies. However, although the aim is earning a livelihood, other therapeutic benefits, such as finding meaning in life through food gardening, are still noted (Mcelroy et al., 2012). It is the gaining of livelihoods through gardening in African societies that occupational therapists should emphasize and provide opportunities for participation, to maintain the productive roles of MHCUs within society (Cipriani et al., 2018).

Similar to food gardening, Gamieldien and Van Niekerk (2017) describe vending as a possible productive occupation from which an individual can earn a livelihood. Vending tends to be informal in contexts with high unemployment rates like Zimbabwe (Chekenya, 2017). However, the informal economy is regarded as a functioning part of each economy because it alleviates poverty for a large part of the population (Chekenya, 2017). Vending is therefore seen as a productive occupation that becomes relevant in a country where most of the population faces limitations in acquiring and maintaining formal employment (Gamieldien and Van Niekerk, 2017).

In Uganda, Mcelroy et al. (2012) saw an increase of buying and selling in a refugee camp as the agrarian way of life of people in the camp was hindered by socio-political constraints. Limited opportunities within the formal sector leave people with few occupations that support livelihoods (Gamieldien and Van Niekerk, 2017). Often, many

individuals are then forced to engage in informal occupations, such as vending, in order support themselves, and most people eventually realise that it is an occupation that provides well for their needs (Gamieldien and Van Niekerk, 2017). A main characteristic of productive occupations is that they allow people to address their needs to provide shelter, food, education and clothing.

People who engage in vending or buying and selling are not classified as people in productive occupations because they often operate in the context of the informal economy (Gamieldien and Van Niekerk, 2017). Chekenya (2017) calls for formalisation of the informal economy in Zimbabwe as its contribution towards gaining livelihoods for most of the population cannot be discounted. Contexts are changing and therefore vending is a productive occupation that one can do as a self-directed livelihood opportunity (Monareng, Franzsen and Van Biljon, 2018). Mental health care users already face many challenges in securing jobs in the formal sector, and in contexts where there are limited opportunities for formal employment, it is even harder for someone with a mental illness to get a job. Although the research highlights the importance of the full inclusion of MHCUs in maintaining formal jobs (Cameron *et al.*, 2012; Blank, Harries and Reynolds, 2015), those who end up engaging in informal employment opportunities, such as vending, should be equally acknowledged and supported as people who are engaging in an occupation that is both meaningful and that support their fundamental human needs (Gamieldien and Van Niekerk, 2017).

Small self-directed businesses such as vending are an important consideration for MHCUs as they support their inclusion within the wider community (Tjörnstrand, Bejerholm and Eklund, 2011). Day care centres can also facilitate social inclusion for MHCUs within communities (Tjörnstrand, Bejerholm and Eklund, 2011). However, one downside of day care centres is that they support more social integration among MHCUs than in the wider community the day care centre is a part of (Tjörnstrand, Bejerholm and Eklund, 2011). Occupations such as vending, however, places the individual in the wider community as a vendor that fulfils their need and that of the community. Therefore, when MHCUs engage in vending as a productive occupation within communities, it should be supported rather than discriminated against.

Occupational therapy is historically marked by its unique ability to incorporate the context of their service users into the treatment (Dunn, Brown and McGuigan, 1994). Wortman et al. (2018) further highlight that occupational therapists must be mindful of environmental resources and how these can support meaningful productive occupations. Taking care of farm animals is quite common in African societies, and breeding of farm animals contributes to household needs, food, wealth and school fees (Glass et al., 2014). In resource limited contexts, livestock rearing is seen as one of the occupations that support mental health because of how it places the individual in control of their finances, enabling them to meet their needs and those of the people who depend on them (Glass et al., 2014). Mlambo et al. (2014) identify livestock rearing as one of the productive occupations that can be done by MHCUs in Zimbabwe to facilitate the process of meaningful community living after discharge.

When MHCUs participate in livestock rearing, they engage in activities that include feeding, milking, grooming and cleaning where the animals stay (Pedersen et al., 2016). There are several therapeutic benefits for MHCUs that arise from being in physical contact with animals and the environment where the animals are kept. Pedersen et al. (2016) revealed that work activities with farm animals provide a distraction from the effects of mental illness. Elsey, Murray and Braggy (2016) affirm that tending to animals dissipates constant worrying as it has been established that interacting with animals reduces stress and anxiety. Paying attention to the needs of animals allows the same skills to be transferred to human interactions, supporting the development of good social skills (Elsey, Murray and Braggy, 2016). There is an opportunity to use the skills learned in Livestock rearing as a stepping stone for employment (Elsey, Murray and Braggy, 2016; Pedersen et al., 2016). It is this ability of livestock rearing to allow an individual to subsequently earn a living that is important for this research. Some farm animals can be sold for income, whilst some can be used to provide food for the families.

Livestock are capital assets and therefore can be a store of value for household communities (Upton, 2004). Apart from being a store a value, livestock can be used as circulating capital, to meet current needs (Upton, 2004). Livestock can be sold to raise money that is needed , or slaughtered to meet household food needs (Upton, 2004).

Livestock rearing is considered as one of the ways to boost the income of the poor in both urban and rural Zimbabwe (Assan, 2014). MHCUs are able to start small livestock rearing projects in the community with assistance on how to breed, raise and allow livestock to support and meet their economic needs.

Training should also focus on how to increase the volume of livestock produced to provide extra beyond that which is produced for consumption so that the excess can then be used as a source of income. Small livestock rearing projects are classified as micro livestock rearing which is the keeping of small vertebrates, for example, pigs, goats, rabbits poultry to mention a few (Assan, 2014). Occupational therapists can therefore link with micro livestock professional trainers to assist MHCUs on setting up projects, and sustaining the projects within the community through the occupational therapy productive occupations program. This technical knowledge is important for ecologically friendly approaches of keeping micro livestock in settings with limited space while also conserving the environment within which these occupations are done (Assan, 2014). The rearing of livestock on a small scale at a household level through free range means, has various advantages, which include the production of healthier meat and meat products that are produced and the low cost in setting up the projects within the community , including areas where there is limited land availability (Upton, 2004; Assan, 2014).

Lastly, arts and crafts were used extensively as work projects from the 1900s to the 1940s by leaders of the occupational therapy profession (Harvey-Krefting, 1985). Surprisingly, despite having been used in occupational therapy for a long time, there is a general decline in the use of arts and crafts (Horghagen, Josephsson and Alsaker, 2007; Bathje, 2012). However, occupational therapists in psychosocial practices intensively use arts and crafts activities (Leenerts and Evetts, 2016). The benefits to MHCUs include gaining skills in preparation for a job, socialisation, a means to gain an income and being valued in society, improving sequencing, exercising control, improving decision-making, sensory stimulation and building self-efficacy (Horghagen, Josephsson and Alsaker, 2007; Leenerts and Evetts, 2016).

Arts and craft activities have been used in long-stay facilities and they have important psychosocial and emotional benefits for MHCUs. Despite this, contextually relevant

research on the use of arts and crafts in Zimbabwe is limited. This is concerning since arts and crafts activities may have either cultural or contextual significance. An example is the cultural art of basket weaving, normally done by the Tonga people of Zimbabwe and contextually because reeds grow close to water sources in the area where they live.

Despite having overall positive benefits of the productive occupations for MHCUs, various factors may contribute toward the failure to sustain these productive occupations, for example the current crisis of climate change. It is therefore imperative that MHCUs and the occupational therapists involved in enabling and supporting the engagement in these occupations be made aware of such factors so as to adequately prepare and deal with the subsequent implications of such factors. Food gardening and livestock rearing for example, are occupations which rely on the availability of water. These productive occupations can be affected directly by frequently occurring climate changes such as drought thus impacting the means to producing food and financial upkeep associated with these occupations(WFOT, 2018). Additionally, drought can wipe out the very substance that some communities depend on to survive (WHO, 2013). It is therefore, imperative that occupational therapists, in addition to, enabling MHCUs engage in food gardening which itself is a sustainable productive occupation they also promote awareness on sustainable ways of protecting the environment where these occupations occur (WFOT, 2018).

There are various ways in which occupational therapists can use to increase production and ensure sustainability of food through gardening. This includes educating communities to stopover fertilisation of soils which can increase the carbon-foot print thereby making small steps to reduce the occurrence of droughts (WFOT, 2018). MHCUs within communities can be encouraged to use manure from livestock rearing as a more eco-friendly way to boost yields and promote soil health (Han *et al.*, 2016) . Therefore, a combination of livestock rearing and food gardening becomes sustainable productive occupations which can be paired together.

Stigma surrounding mental illness also gravely affects gains that MHCUs should get through their engagement in productive occupations in the community. MHCUs can be shunned upon to such an extent that they may not be able to interact with the community (Kleintjes *et al.*, 2010; Funk, Drew and Knapp, 2012) or sell their produce or goods (Gray,

2016). It is imperative that discourses which are culturally sensitive to the local communities be used to educate and bring awareness to the general public in a bid to adequately address the occurrence of stigma and change the society's attitude (Illingworth, 2021).This will see MHCUs being accepted with equity within the communities they reside. Additionally, Kleintjes *et al.*, (2010) points that it is not only a change of attitude that is needed, but acknowledgement and acceptance of the rights that MHCUs have. To enable their equal engagement, contribution and interaction within the society as the rest of the community. This will see MHCUs being able to participate equitably within society, earn and income and contribute to society at large.

2.2.3 Implications of engagement in productive occupations for people with mental disorders

People with schizophrenia experience positive and negative symptoms as a result of the illness, for example, low motivation, social withdrawal, delusions and hallucinations (Liu et al., 2014). These symptoms make it hard for them to maintain productive roles in society (Loh, 2018). In addition, Loh (2018) indicates that for people with schizophrenia, the onset of the condition coincides with the time of the development of an occupational identity. The resulting effect is that people with schizophrenia are often unable to maintain employment or even develop a career that will allow them to be financially independent. The situation is further aggravated in countries where opportunities to find paid employment are severely limited.

Facilitating the participation of persons living with mental disorders in productive occupations becomes a priority. Research shows that people with schizophrenia can start small businesses and sustain a productive life (Oyelade and Nkosi-Mafutha, 2021). Interestingly, activities like gardening help them explore their interests and expand on activities that they can continue engaging in after discharge. These occupations are considered meaningful and allow a person with schizophrenia to contribute meaningfully to society and to form social relationships in the community. However, if rehabilitation programmes do not include a productive component, there is an increased risk of social exclusion and poverty (Glass et al., 2014; Granerud and Eriksson, 2014).

Pedersen et al. (2016) found that for people with depression the positive gains of gardening were still evident three months after the rehabilitation programme. The positive gains include reduced depression, anxiety and perceived stress levels. Reduced symptoms of mental illness were also reported with other similar studies that incorporated animals as part of an intervention (Glass et al., 2014). Granerud and Eriksson (2014) found that for patients with substance misuse, it was necessary to give structure, regularity and rhythm through engagement in productive occupations to use their free time constructively. Without structure and routine, recovery from substance use disorders is most likely to be difficult with multiple relapses.

People with psychotic disorders, depression and substance use disorders often spend long periods of time in long-stay institutions. This length of stay further disadvantages persons living with mental disorders by excluding them from the wider society and from participating in occupations that support their health, wellness and quality of life. As a result of the disconnection from society, long periods of stay also predisposes MHCUs to poverty as productive occupations that support livelihoods are done in the community. Poverty limits the chances to participate in occupations that promote health and wellbeing (Hammell, 2020). The WHO (2020) estimates that 70% of the population in Zimbabwe live in poverty and 34% in extreme poverty. Regardless of these statistics, the ultimate goal for MHCUs admitted in a psychiatric hospital is their successful reintegration into communities (Cipriani et al., 2018).

Productive occupations provide an opportunity for people to be financially independent and earn a livelihood while they engage in a meaningful occupation (Mugisha et al., 2019). The nature of productive occupations permit an individual to engage in these occupations as self-directed, employed or as working as part of a cooperative. Therefore, a lack of opportunity to find formal work does not mean that a person has no chance to provide for their needs. Facilitating engagement in self-directed productive occupations to meet financial obligations, household needs and educational needs becomes important. These occupations become pertinent in countries that are experiencing economic instability.

Within most high-income countries, MHCUs are assisted to gain and maintain productive roles through supported employment programmes (Cameron et al., 2012), and disability

grants allow other MHCUs to go into volunteering. However, in Zimbabwe, the absence of both supported employment opportunities and disability grants leave MHCUs with limited opportunities to take up productive roles in society. Occupational therapists seek to overcome the structural, systematic, or social barriers, such as poverty (Marmot, 2008), that restrain people from engaging in activities that are meaningful to them. Hence, occupational therapy interventions that facilitate engagement in productive occupations are an essential service and not a luxury. This helps enable the reintegration of MHCUs into society as members who are both productive and optimally independent.

The value of productive occupations to enable development of occupational identity despite periods where MHCUs often feel unwell is unparalleled. Granerud and Eriksson (2014) propose that health services should provide innovative ways to help MHCUs acquire and retain productive roles. Recovery models of care in mental health support this particular experience for MHCUs. MHCUs in the UK reported positive experiences after engaging in a variety of productive occupations at a care farm (Granerud and Eriksson, 2014). Affirming that it was not the absence of symptoms of mental illness that was a turning point for them but the engagement in the productive occupation itself. Therefore, it is never the absence of symptoms that enables one to be considered for productivity roles, but it is having a productive role that facilitates recovery.

The main aim of occupational therapy rehabilitation in most inpatient hospitals is to discharge MHCUs and successfully reintegrate them into their communities (Cipriani et al., 2018). Successful discharge and reintegration, however, rely on the capability of an individual to participate productively in their respective communities. Considerable qualitative research has been done in Western countries on the experiences of MHCUs, focusing on productivity and work; however, most of this research was conducted in community centres, such as allotment groups and day care centres (Whatley, Fortune and Williams, 2015; Cipriani et al., 2018). Research of this nature within an inpatient setting is limited (Cipriani et al., 2018).

Intervention programmes should make sense to the one who is receiving the service and not the one who independently tailors the intervention programme (Schindler, 2018). It is crucial to carry out more qualitative research on how MHCUs experience productivity and

work programmes designed for them (Cipriani et al., 2018), especially in inpatient settings; hence, the need for this research.

2.3 THE CONCEPT OF INVOLVING MENTAL HEALTH CARE USERS' EXPERIENCES IN THE DEVELOPMENT OF MENTAL HEALTH PROGRAMMES

2.3.1 Involving the mental health care users' experiences in mental health care systems

MHCUs' involvement in health care systems has been mentioned in mental health literature for over 50 years (Millar, Chambers and Giles, 2015). Involving MHCUs in mental health care systems focuses on three important levels that form the foundational pillars of mental health service provision, namely MHCUs' involvement in policy, in programme planning and in research. This study focuses on the planning of intervention programmes; however, literature on all three concepts is discussed in this chapter.

MHCUs have an incomparable view-point on mental health care that is valuable to both themselves and to service providers (Millar, Chambers and Giles, 2015). In high-income countries like the UK, involving MHCUs is at the core of policy initiatives; however, their marginalisation in the planning of intervention programmes seem to persist (Ásmundsdóttir, 2009; Bower et al., 2015; Schindler, 2018). Van Rooyen et al. (2019) stress that literature that explores the experiences of MHCUs is critical to provide an analysis of which services and innovations benefit them. LMICs are lagging behind in involving the experiences of MHCUs and are encouraged to provide mental health services that support a greater involvement of MHCUs. Exploring MHCUs' views will help to re-evaluate health services to achieve patient satisfaction (Schindler, 2018). Schindler (2018) states that this feedback is relevant to design programmes that benefit the targeted population.

In South Africa, research shows that the views of MHCUs often give important information when services fail to satisfy the users' needs (Van Rooyen et al., 2019). In addition, mental health care services in Africa, specifically rehabilitation programmes for MHCUs, are either unavailable to the majority or are only being offered in specialised urban facilities (Brooke-Sumner, Lund and Peterson, 2014; Van Rooyen et al., 2019). However,

where rehabilitation programmes are available for MHCUs, the research is encouraging and shows that the service is aligned with patients' needs. This is achieved when MHCUs are involved in the development and planning of rehabilitation programmes. Mugisha et al. (2019) further support this by highlighting that the exploration of MHCUs experiences is a vital strategy that can lead to effective mental health intervention programmes.

Considering the experiences of MHCUs is part of involving them in the development, planning, and evaluation of mental health services. MCHUs' involvement directly connects and interlinks with various concepts within mental health literature. This is a person-centred approach, integrated care, informed decision-making, advocacy, obtaining service users' views and collaborative practice (Millar, Chambers and Giles, 2015; Wright *et al.*, 2015). It is a collaborative process that focuses on individual needs and promotes inclusion within the care delivery pathway (Lawn, 2015).

2.3.1.1 The person-centred approach

One of the concepts that underpins including MHCUs' experiences in programme planning and development is person-centred care (Lawn, 2015). The WHO (2010) directly supports involving MHCUs and identifies it as people-centred care. It creates an opportunity for the perspectives, opinions, experiences and choices of MHCUs to be heard and incorporated in intervention programmes.

A person-centred approach emphasises the individual. Occupational therapy is often described as a holistic client-centred profession (WFOT, 2017b; Sarsak, 2018) and uses the term client instead of person. However, the occupational therapy practice framework and domain III (OTPFIII) revised the term client to persons, groups or populations; hence, the term 'person-centred' is appropriate to uphold universally acknowledged terminology (AOTA, 2014). Interestingly, in the same practice framework, a person's life experiences are part of the factors that should be included when planning for occupational therapy interventions. One of the implications of person-centred care is that it is important for MHCUs to evaluate intervention programmes targeted for them (Casteleijn, 2012). Despite the WHO's (2010) emphasis on encouraging countries to support person-centred care, LMICs are lagging in prioritising this approach. Looking into the experiences of

MHCUs with regards to a productive occupations intervention programme is one of many measures that may help facilitate this approach.

2.3.1.2 Shared decision-making

The second concept closely linked with involvement is shared decision-making. Lawn (2015) highlights that shared decision-making is one of the processes that promotes the involvement of MHCUs in health care services. Shared decision-making is defined as an approach that supports individuals to understand evidence-based information regarding the risks and positives of intervention options available to them (Lawn, 2015; Sather et al., 2019). Shared decision-making therefore allows MHCUs to have a choice in their treatment options, facilitating the inclusion of what is important and necessary to them (Légaré et al., 2018).

Participants in a study done in the United Kingdom were concerned that 'things' (treatment/ intervention) were done to them with very little explanation (Bacha, Hanley and Winter, 2020). This shows that MHCUs are often excluded from decision-making about available treatment options for them and the intervention process as a whole (Royal College of Psychiatrists, 2012). As a result, MHCUs end up with feelings of powerlessness and lack of control during intervention and care. According to Bacha, Hanley and Winter (2020), MHCUs feel that certain treatments often make them lose their dignity. Therefore, the concept of informed decision-making links with how MHCUs experience a programme or service as their individual questions, choices and opinions are heard. This ultimately results in treatment programmes that support human dignity.

2.3.1.3 Advocacy in mental health

The term advocacy is generally defined as pleading or interceding on behalf of someone else (Varghese, 2015). However, there are various forms of advocacy mentioned in the literature, including collective advocacy, independent advocacy and self-advocacy (Royal College of Psychiatrists, 2012; Varghese, 2015). In mental health, it is recommended that the advocate be the MHCU themselves because they are conveniently positioned to best articulate their experiences and views (Varghese, 2015). Therefore, self-advocacy in

mental health care empowers and gives autonomy to MHCUs (Varghese, 2015). The role of advocacy being to rid the system of challenges that MHCUs often meet within different environment from which they receive care. These challenges include difficulties in having their voices heard, failure in having their decisions respected, and shortcomings in having their interests defended (Royal College of Psychiatrists, 2012).

2.3.1.4 Obtaining service users' views and collaborating with mental health care users

Health care facilities in Africa lack adequate resources and human capital to tend to the needs of MHCUs. It therefore becomes important to identify the MHCUs' experiences in these resource constrained environments to facilitate a move towards patient directed services.

In Finland, an open dialogue model was introduced and used to allow the MHCUs' views to be heard and to encourage active coordinated collaboration with their health care professionals (Barrett and Linsley, 2017). However, within mental health practice, when there is a perceived risk of causing harm towards self or others by a MHCU, procedure instead of collaboration is pursued, putting health professionals in control of available treatment options (Barrett and Linsley, 2017). These procedures often save lives and allow health care professionals to follow ethical guidelines. Obtaining service users views however, encourages health professionals to revisit the MHCU after the risk is abated and continue with the collaboration process, allowing MHCUs to voice their concerns about intervention programmes (Barrett and Linsley, 2017).

2.4 THE IMPACT OF INVOLVING THE MENTAL HEALTH CARE USERS' EXPERIENCES IN A PRODUCTIVE OCCUPATIONS PROGRAMME

Exploring the experiences of MHCUs engaging in productive occupations is vital to highlight factors that drive their motivation to engage. Productive occupation used to be seen as compulsory (Iannelli and Wilding, 2007), and as a result, MHCUs would engage in productive occupations because they had no choice, leading to individuals losing the motivation to engage. For some, engagement may be motivated from an internal locus,

which is a person's identity concept, meaning that someone sustains engagement because they identify with a worker role (Subramaniam *et al.*, 2020). It is crucial therefore, to explore the experiences of MHCUs to get insight into their motivation, choices and options. This allows the development and formulation of relevant programmes that MHCUs are able to sustain and continue with while undergoing rehabilitation and during their reintegration into society.

MHCUs are able to provide meaningful feedback through their experiences of occupational therapy programmes. Schindler (2018) studied occupational programmes with employment goals and found that MHCUs provide critical analysis of programmes and offer relevant opinions for change. As a result, their goals are met and patients anticipate going to the programme. Occupational therapist are encouraged to involve MHCUs in a bid to provide more individualised treatment programmes (Lim, Morris and Craik, 2007). The impact is that the occupational therapy profession will continue to resolutely maintain their stance with regards to the provision of client-centred services.

2.5 CONCLUSION

Productive occupations are an important aspect of the lives of MHCUs and contributes to their wellbeing and recovery. However, occupational therapy programmes that facilitate productive occupation programmes for MHCUs are often developed and implemented without their involvement. Allowing the experiences of MHCUs a chance to be heard is becoming an unabated wave globally, and more so in high-income countries than in LMICs. Involving MHCUs is a key strategy that creates opportunities for the empowerment of traditionally marginalised groups, allowing them to be partners in designing programmes developed for them.

3 RESEARCH METHODOLOGY

3.1 INTRODUCTION

This section outlines the methodology used to answer this study's research question. Detailed descriptions of the study design, study population, subject sample, inclusion and exclusion criteria, research instruments, procedure used for collecting data and the data analysis methods are provided in this section. The ethical considerations relating to this study are also discussed.

3.2 STUDY DESIGN

A descriptive qualitative study design was employed. Qualitative descriptive studies are used when it is necessary to gain inside knowledge, to richly describe how the participants see the world as they experience it, and to understand the participants' perceived situation (Bengtsson, 2016; Bradshaw, Atkinson and Doody, 2017). The focus of the research was to gain insight into and to describe MHCUs' experiences, and hence, it was deemed an appropriate study design. According to Hammarberg, Kirkman and De Lacey (2016), a qualitative descriptive approach is recommended to reveal experiences, behavioural connotations and attitudes by using different qualitative techniques. This study explored experiences of MHCUs through individual semi-structured interviews. The study's focus was to explore the individual experiences of MHCUs attending the occupational therapy productive occupations programme at a long-stay mental health institution, and therefore, it followed a natural enquiry approach (Lambert and Lambert, 2012)

3.3 STUDY POPULATION

The study population were MHCUs attending a productive occupations programme at the occupational therapy department at a long-stay mental health facility in Zimbabwe. At the point of data collection, approximately 64 MHCUs were engaged in the productive occupations programme. Their ages ranged from 20 years to 68 years.

3.4 STUDY SITE

To protect anonymity, the study site is referred to as a long-stay mental health institution in Zimbabwe. It is a state funded institution with specialist mental health services. The available health professionals include psychiatrists, medical doctors, psychiatric nurses, social workers, psychologists, health promotions officers, rehabilitation technicians, physiotherapists and occupational therapists. The institution is one of the four referral centres for psychiatric disorders in the country (Medical Community of Interest [MedCOI], 2021). It has a bed capacity of 708 beds, with an average patient population of over 600 patients (Zimbabwe Human Rights Commission [ZHRC], 2015). The institution provides mental health care services to both in- and outpatients.

There are five occupational therapy departments, and for this study they are identified as Occupational Therapy Department 1 to 5. A treatment mall approach is used to access rehabilitation services where MHCUs from different care units or wards meet within the occupational therapy departments. Treatment malls allow MHCUs to access psychosocial rehabilitation services in a space away from their wards (Ballard, 2008) In this case psychosocial rehabilitation is offered in the occupational therapy departments.

Within the five occupational therapy departments, there are occupational therapists (7), rehabilitation technicians (16) and occupational trainers (2). The latter are responsible for teaching vocational skills to MHCUs and have no clinical training. The occupational therapists are holders of an honours of science degree in occupational therapy qualification, and the rehabilitation technicians are certificate holders of the rehabilitation technician course. Occupational therapists are responsible for supervising the rehabilitation technicians under them in the different departments. MHCUs who are in need of occupational therapy services are identified during ward rounds by a multidisciplinary team comprising of the doctor, the nurse and the occupational therapist. The MHCU is then referred to the occupational therapy department from the wards. Mental health care users' first contact with occupational therapy services is with Occupational Therapy Department 2 (see Appendix A). In this department, initial assessments and treatment sessions are done in the acute occupational therapy department and the length of time spent in this department varies from two to eight weeks,

depending on the individual patients' needs. This length of stay is within the occupational therapy department, it should be noted that patients would have been admitted in the wards for longer that the two to eight weeks here specified. The average length of stay within the hospital varies from 4 weeks to several years. On average, 250–300 patients are seen by staff from the occupational therapy departments every month.

Assessments target task behaviour in all domains, for example, activities of daily living, productivity, social participation, self-care, leisure, medication management, ability to set goals and insight into condition. For the productive occupations programme, we involve patients that have improved in other areas of functioning, for example, awareness of the environment, social skills and personal management. Referrals are made on the basis of MHCUs' personally identified interests and goals while in Occupational Therapy Department 2. However, it is unknown whether MHCUs then get to engage in the identified goals in the other departments. The other four departments' primary aim is facilitating the engagement of MHCUs in productive occupations up to an individual's optimal functioning level. As the discharge of patients heavily relies on relatives, most MHCUs engaging in productive occupations continue up to the time of discharge. The time spent engaging in the programme is three hours a day for five days a week. The hours differ slightly and are more for patients engaging in service occupations, such as being an attendant in the tuck shop or working in the barbershop.

3.4.1 The productive occupations programme

The productive occupations programme was developed and implemented by occupational therapy staff in 2014. The focus of the programme is to enable the full engagement of MHCUs in productive occupations. This was seen as an indispensable component for MHCUs to facilitate their full inclusion in society as members who are not only self-sufficient but also contribute meaningfully to their communities. The programme had no funding and started with donations from the occupational therapy staff members in the department. The programme was developed for MHCUs who identified with a particular productive occupation as part of their goals and for those who were recommended to take part in productive occupations as part of their intervention

programme. MHCUs can choose from the existing available options one that is congruent with their future goals.

At the time of data collection, the options of available for productive occupations included a barbershop, shoe and equipment repairs, a tuck shop attendant, a café attendant, livestock rearing, arts and crafts and gardening. These occupations were chosen on the basis of available resources to start-up the projects, for example, availability of land and water for starting a gardening project. As highlighted earlier, there was no funding and easy-to-set-up projects such as a tuck shop, café and arts and crafts projects were identified. Some of the four occupational therapy departments offer only one option while others have more than two available options for productive occupations. Appendix A shows how the different productive occupations are spread among the five occupational therapy departments.

The researcher is a middle aged female occupational therapist who has been working in the long stay mental health institution for a period of slightly over eight years. As a result, the majority of the patients in the occupational therapy productive occupations were known to the researcher and the patients also knew the researcher. The researcher was also part of the occupational therapists that pushed for the development of the occupational therapy productive occupations program.

3.5 SAMPLING

Participants were purposively sampled and consisted of MHCUs who were inpatients at the long-stay mental health institution and were engaged in the productive occupations programme within the occupational therapy department (Bradshaw, Atkinson and Doody, 2017). Purposive sampling is sampling with a predetermined purpose where the researcher targets participants who are most likely able to suit the needs of the study (Chambers et al., 2014). Therefore, the researcher, through the occupational therapists heading the occupational therapy departments identified participants who could converse well and could give as much information as was necessary for the research to yield rich information. Ten participants were interviewed, and they were spread over five of the six productive occupations options that were offered in the occupational therapy department.

Three were from gardening, two from animal husbandry, one from the barbershop, one from the tuck shop, two from the café and one from equipment and shoe repairs. Initially, there was no participant identified from the equipment and shoe repairs. However the identified patient from the arts and crafts section was discharged before the data collection began. Therefore one more participant from the equipment and shoe repair section was identified and ten participants took part in the study.

3.5.1 Inclusion and exclusion criteria

Participants who were included in the study were MHCUs aged between 18 and 55 years who could give information on their experiences of the programme. A brief mental status examination checklist (Appendix B) was used to determine whether the MHCU was stable at the time of data collection. Clients under the caseload of the researcher were automatically excluded as their autonomy was jeopardised by the patient-health professional relationship. Gordon (2020) identifies this as deferential vulnerability where relationships between patients and health professionals have power differences, making it difficult for patients to say no or to be in a position to make a truly free decision. Table 3.1 summarises the inclusion and exclusion criteria.

Table 3.1: Inclusion and exclusion criteria

Inclusion	Exclusion
Age:18–55years	Actively psychotic patients. The brief mental status examination checklist was used, in particular areas that included attitude, speech, affect, mood, thought process and thought content, orientation and memory/concentration.
Attending a productive occupations programme (at least three times a week) for ≥ 4 weeks	Clients under caseload of the researcher. It is often the case that patients feel indebted to health professionals who are providing care or treatment to them. Thus, to prevent possible coercion, MHCUs in the researcher's case load were excluded.
Clients who are able to give rich information concerning their experience of the programme	
Clients which were either able to read or not able to read.	

3.6 INSTRUMENTS FOR DATA COLLECTION

3.6.1 Demographic questionnaire

A demographic questionnaire (Appendix C) was used to capture data concerning the participants' age, marital status, level of education, diagnosis, productive occupations before admission, and what they would prefer to pursue post-discharge. This information was particularly important for this research in order to understand the participants, their backgrounds and life circumstances and to determine how this could have influenced their choices of productive occupations that they were engaging in before admission. Their preferences of future productive occupations goals also facilitated insights into changes that would have been a direct result of engagement in the occupational therapy productive occupations programme. The demographic questionnaire was translated to Shona by a colleague who is fluent in both Shona and English. To ensure that it was accurate, another colleague did the back translation process.

3.6.2 Interview guide

An interview guide was used to provide structure and consistency during the interview process (see Appendix D). Jamshed (2014) denotes that an interview guide is beneficial for methodological processes when conducting interviews as it keeps the study focused and allows the researcher to effectively use the interview time. Studies by Schindler (2018) and Estrella *et al.* (2019) were used to guide the development of the interview guide. To ensure that the questions were relevant and answered the research question, the interview guide was piloted. The interview guide was translated to Shona by a colleague who is fluent in both Shona and English, and to ensure that it was accurate, another colleague went through the back translation process.

3.7 PILOT INTERVIEW

The interview guide was piloted with one participant who fit the inclusion criteria. The participant gave consent to be interviewed. On the scheduled day of the pilot study, the researcher found a quiet place for the interview. The participant was given the information sheet (see Appendix E) that explains what the study entails and the researcher also

explained the study details to the participant. They were given a chance to ask questions and thereafter asked to sign the consent form and the consent to be audiotaped form (see Appendix F and G, respectively). The guide that was used for the pilot study had the following questions:

- Could you please tell me about your past activities in productivity?
- What were your aspirations concerning productivity before you engaged in the productive occupations currently provided in the occupational therapy department?
- What influenced your current choice of engaging in the productive occupation that you are part of now within the hospital?
- What are your experiences concerning the current productive occupations programme?
- To what extend has the current programme met your needs and expectation concerning productivity?

After the pilot interview, a few changes were made to the interview guide to simplify the terms used so that the participants would better understand the questions. Some of the questions were changed to allow the focus of the question to come out more clearly, for example Question 1. The questions also had probes that allowed a clearer picture of the participant's circumstances to come out. The following questions are the final questions that were used in the interview guide:

- Could you please tell me about your past activities that helped you to earn a living before you were admitted?
- Could you tell me about your current work activities in the productive occupations programme?
- What are your experiences concerning the current productive occupations programme?
- What are the positive aspects of this programme?
- What are the negative aspects of the programme?
- To what extend is the programme meeting your needs and expectations to become a person who is able to earn a living after discharge?

- After discharge what do you wish to do for you to earn a living?

3.8 DATA COLLECTION PROCEDURE

3.8.1 Data collection procedure: Interview process

The researcher initially asked the head of departments of each occupational therapy unit for permission to talk to the identified participants and for their assistance in the selection process. In keeping with the nature of the inquiry, data collection and data analysis were done concurrently. Ten participants who met the inclusion criteria were identified and all the interviews were conducted in a quiet room in the occupational therapy department. All the interviews were conducted in Shona. The data collection process took place between November and December 2020. Each identified participant was allowed to set the date and time they preferred to be interviewed.

On the day of data collection, the researcher gave each participant time to read through the information sheet and ask questions for clarification where they felt they did not understand. The researcher also read through the information sheet (Appendix E) with participants who could not read it. After this the participants were given the consent form (Appendix F) and the consent to be audiotaped form (Appendix G), and they were asked to sign them. The participants were then given the demographic questionnaire (Appendix C) to fill in. Those who could read and understand the demographic questionnaire filled it in independently. The researcher helped the participants who could not read to fill in the demographic questionnaire.

The researcher also asked the participants to identify pseudonyms that were then used to refer to the participants during the interview. The use of the pseudonyms was explained to the participants that it was to protect anonymity. The use of the pseudonyms was not pronounced during the interview as terms like ‘how would you…’, ‘according to you….’, and ‘what would you…’ etc. were used to address the participants. Thereby reducing the temptation of the participants to get into character as a result of the pseudonyms during the interview. Each of the interviews took approximately 30–50 minutes to complete, including filling in the demographic questionnaire. A voice recorder was used to record the interviews. Each interview was transcribed verbatim in Shona to begin the data

analysis process. The researcher went through the back translation process and the result was further checked for inconsistences by the independent co-coder who was helping with language veracity. After each transcription, the interview was uploaded onto Weft QDA, a free application for data analysis, and the data analysis process began. After transcription and analysis, the researcher went through the process of identifying another participant and followed the same process with each participant. Data collection and data analysis were therefore done concurrently.

3.8.2 Covid-19 precautions

The data collection was done at the peak of Covid-19 pandemic restrictions, and hence, it took longer than anticipated. However, no changes to the data collection processes were made and face-to-face interviews were conducted. The researcher made sure that the room in which the interviews were conducted was well ventilated. Both the researcher and the participants wore masks during the interview process. Both the participants and the researcher sanitised their hands before and after the interview as they handled stationery during the interview process.

3.9 DATA ANALYSIS

Reflexive thematic analysis was used to identify, analyse and report patterns from the data corpus that arose from the interviews. This type of thematic analysis allowed the researcher to be aware of their role with regards to the epistemological stance of the research (Braun and Clarke, 2019). Therefore, the researcher reflected on their position as an occupational therapist, who was part of the people who introduced the occupational therapy productive occupations program and as a novice with regards to qualitative research. Additionally, the researcher reflected on the need for the data analysis to be data driven, to bring out the concerns of a vulnerable group of people who oftentimes are not given a platform to bring out their experiences and opinions. This type of analysis was used to reveal what is real for MHCUs in their context (Braun and Clarke, 2006). The thematic analysis was guided by the framework of Braun and Clarke (2006). This study followed an inductive approach, meaning that the results from the study were data driven and allowed the researcher to reach conclusions from whole data (Braun and Clarke,

2006). According to Braun and Clarke (2006), conducting thematic analysis follows the following:

- Phase 1: Familiarising self with data;
- Phase 2: Generating initial codes;
- Phase 3: Searching for themes;
- Phase 4: Reviewing themes; and
- Phase 5: Defining and naming themes.

Figure 3.1 outlines the process followed during the data analysis process.

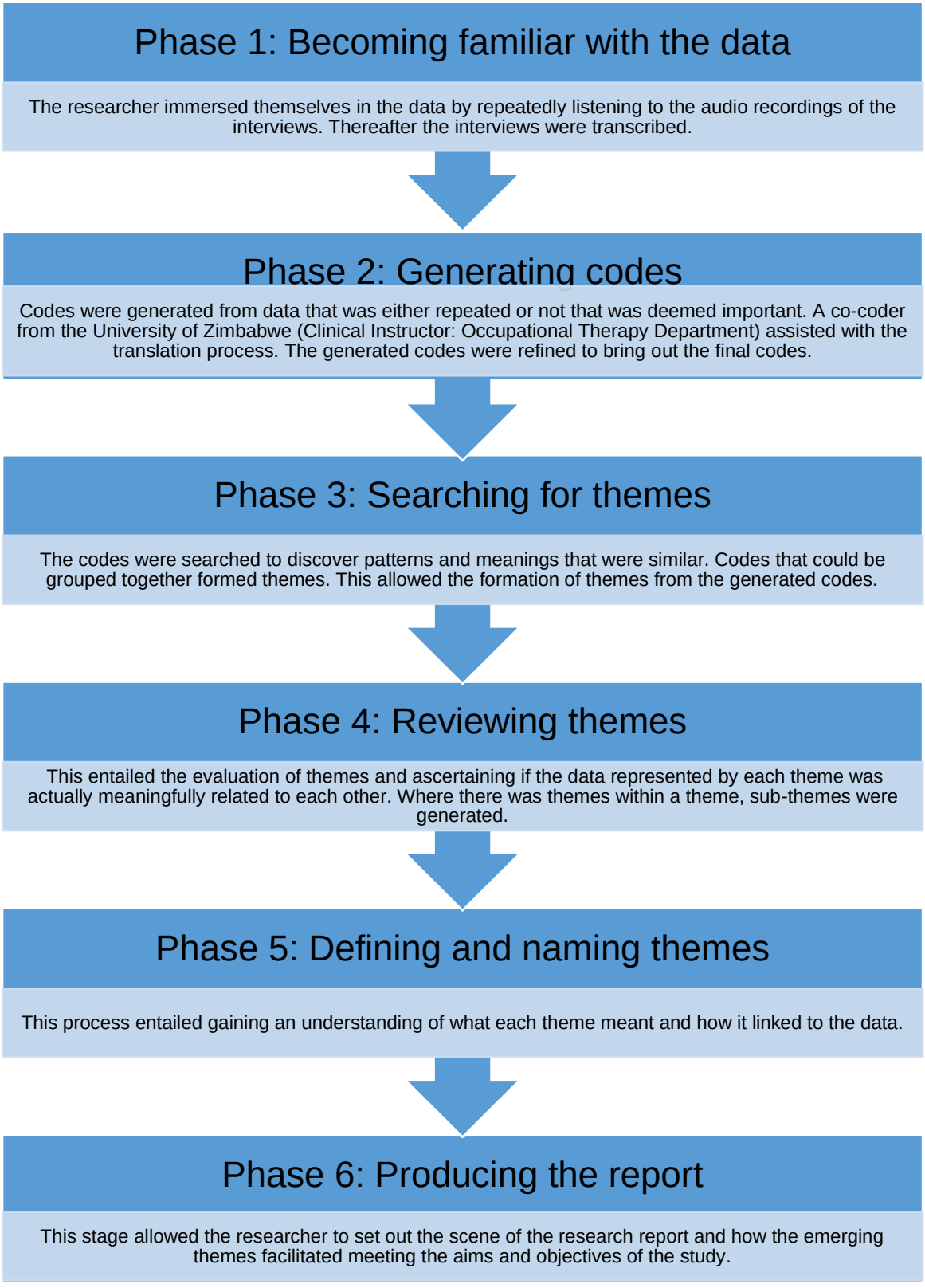

Figure 3.1 Data analysis process

3.9.1 Familiarising self with data

The first phase began with getting to understand the data sets by reading and rereading the transcribed semi-structured interviews (Maguire and Delahunt, 2017). The process of transcribing the interviews also permitted the researcher to familiarise with the data (Braun and Clarke, 2006; Elo and Kyngäs, 2008). During the familiarisation process, the researcher made some rough notes detailing their impressions and the meanings that were ascribed to the extracts (Maguire and Delahunt, 2017; see Appendix H). Transcribing and becoming familiar with the data was done in Shona.

3.9.2 Generating initial codes

The initial codes were derived from important aspects of whole data that were either repeated or not repeated. The coding process allowed sentences, paragraphs of the transcribed data to be labelled with a word or short phrases (Skjott Linneberg and Korsgaard, 2019).The sentences in the transcribed interviews were thoroughly reviewed to generate their meaning allowing important aspects to be labelled accordingly (Skjott Linneberg and Korsgaard, 2019). The short phrases and words in this research were referred to as meaning units (Bengtsson, 2016). This process of coding allowed large quantities of data to be condensed allowing data to be conveniently obtainable through the other stages of the analysis process (Skjott Linneberg and Korsgaard, 2019).The researcher, made conscious evaluations in sorting out relevancy with regards to which meaning units answered the research question, objectives and/or aim (Maguire and Delahunt, 2017; Skjott Linneberg and Korsgaard, 2019). Inductive coding was used to ensure that the codes were reflective of what was in the data through the use of phrases and terms used by the participants themselves (Skjott Linneberg and Korsgaard, 2019).

The coding process was done with the use of the computer software Weft QDA (see Appendix I). Weft QDA allowed relevant meaning units to be assigned a name that could later be used for coding. All potential meaning units or extracts of whole data were assigned a name during coding (Braun and Clarke, 2006). The meaning units were further refined in the second cycle of coding creating condensed meaning units. At this stage the condensed meaning units were back translated to create condensed meaning

units in English. A co-coder was included to check the veracity of the coding and translation process. The co-coder is a clinical instructor at the University of Zimbabwe with extensive knowledge of qualitative research and is fluent in both Shona and English.

The back translation was done by two individuals. The first was given the list of condensed meaning units in Shona to translate, and then the next was given the translated meaning units in English to translate back to Shona. The scripts were then checked by the co-coder and the researcher. Appendix J shows the back translated condensed meaning units. Where differences were noted, the meaning of the words within the context was upheld more than correct use of translated words. After the back translation, initial codes were identified from the condensed meaning units. Table 3.2 shows the process of open coding from precepts of whole data that were the meaning units to the condensed meaning units and the subsequent code.

Table 3.2 Process of inductive coding

Sentences from data that answer research aim/meaning Units	Condensed meaning units	Codes
"The nice thing about OT [occupational therapy] is that as a person you stay focused. You get to organise everything in your day knowing well you will do this and that, under minimal supervision and sometimes with no supervision at all."	You get an opportunity/chance to do your work with reduced supervision Enables independent daily occupation planning	Facilitates independence Facilitates structure

3.9.3 Searching for themes

In this phase the codes that were initially coded were referred to as initial codes. The researcher went over the codes to ascertain how the codes were different or similar to each other to create more refined final codes. The coding process was lengthy and had to be re-done several times. Similar codes were organised into themes (Javadi and Zarea, 2016). Therefore codes that could fit together in one theme were grouped accordingly (Maguire and Delahunt, 2017). Themes arose through interpreting the coded data and creatively assigning overarching names to the groups of coded data (Braun and Clarke,

2019). The data itself , the researchers' theoretical assumptions were part of what aided the generating of the themes (Braun and Clarke, 2019).

3.9.4 Reviewing themes

At this stage an evaluation of the initial process of generating themes was done in two phases to modify and refine the themes (Maguire and Delahunt, 2017). In the first phase, the data inside each theme were evaluated to see if the data were meaningfully related and justifiably fit into that theme (Javadi and Zarea, 2016). An example is when the codes brought about data related to influences of choice of work. This data had the same root meaning, that is influences of choice and could fit in one theme.

The second phase looked at understanding the grouped themes to evaluate whether they were similar or different from each other (Javadi and Zarea, 2016), understanding whether the emerging themes brought out the depth of the data corpus and evaluating whether the themes were contextually logical (Maguire and Delahunt, 2017). Where there was themes within themes, subthemes were generated from the theme (see Table 3.3). An example is the theme on opinions of MHCUs. This theme had two subthemes that fed into it but referred to different things, for example, opinions regarding change: the program and opinions of change related to MHCUs and their productivity needs. The themes were found to be distinct from each other, were an accurate representation of the outcome of the interviews, and answered the aim of the research study.

Table 3.3 Formation of subthemes from themes

Codes	Subthemes	Main themes
Personal influences on choice of work Contextual influences on choice of work Education affecting choice of work	Influences of previous choice of occupation	Influences on choice of occupation
Interest linked to work Meaningful reward	Influences of current choice occupation	

3.9.5 Defining and naming themes

Naming entailed an explanation of what each of the themes means and how the themes enables an understanding of the data corpus (Javadi and Zarea, 2016). This allowed the names given to each theme to be precise and easy to comprehend. An example is the final theme ‘experiences of engagement’ that had to be refined from ‘experiences of engaging in the programme’. This was done because under this theme not all experiences of engagement were confined to the programme and some were experiences of engagement linked to previous productive occupations before hospitalisation.

3.9.6 Producing the report

In this phase, a final account of the analysis together with the write-up of the research was done (Braun and Clarke, 2006). The researcher was able to fully understand their role in the research whilst allowing the actual findings of the research to emerge (Bengtsson, 2016). Therefore, extracts of participants’ actual words were used to report the results. This allowed the participants’ actual words to express what each theme entails. Braun and Clarke (2006) highlight that vivid examples of participants’ extracts should be used to bring out the essence of the point being raised. In this particular write-up, extracts of the participants’ direct words were used.

3.10 TRUSTWORTHINESS

During the thematic analysis process, specific measures were taken to establish trustworthiness. Credibility, dependability and transferability were upheld for this research. To ensure credibility, the researcher had prolonged engagement with the data (Nowell et al., 2017). This permitted the researcher to reflect on the raw data and document their thoughts in a research journal (see Appendix K). Additionally, the researcher have been employed in the institution where the research was done for eight years, and therefore, had prolonged engagement with the participants, ensuring credibility (Korstjens and Moser, 2018). During the data analysis process, the data was analysed by the researcher, the supervisor and the co-coder to ensure triangulation. The co-coder who assisted is a clinical instructor at the University of Zimbabwe, College of Health

Sciences in the Department of Occupational Therapy. This triangulation allowed comparison of the results during online meetings, facilitating the attainment of a suitable agreement. Therefore, the two processes of triangulation and prolonged engagement combined ensured the credibility of the research (Korstjens and Moser, 2018).

To ensure transferability the context and setting where the research was conducted are described in detail allowing the data to have meaning to an outsider (Korstjens and Moser, 2018). The structure of the occupational therapy productive occupations programme, the study setting, together with how MHCUs were admitted in hospital and were attached to the programme was described in detail. To ensure dependability, the research process was consistently guided by Braun and Clarke's (2006) process of data analysis. Lastly, to ensure conformability the researcher was aware of their viewpoints, and assumptions this knowledge allowing these not to interfere with the findings, ensuring the interpretation of the data corpus to be grounded in the data (Hammarberg, Kirkman and De Lacey, 2016; Korstjens and Moser, 2018).

3.11 ETHICAL CONSIDERATIONS

Ethical approval was applied for from the University of Witwatersrand Human Research Ethics Committee. Approval was granted and the Human Research Ethics Committee clearance certificate number is M190946 (see Appendix L). Since this research was conducted outside South Africa, it was necessary to apply for approval at the Medical Research Council of Zimbabwe. Permission was granted and the approval code is MRCZ/B/1849 (see Appendix M). Permission was also applied for at the long-stay mental health institution’s ethics committee and permission was granted (see Appendix N). Participants were informed that being part of the study was voluntary and that they could retract from participating in the study at any time. The consent forms that were used for audio recording and for agreeing to be part of the study are in Appendix G and F and the information sheet is in Appendix E. Participants were given time to read and understand the information sheet and were given time to ask questions so that they understood the focus of the study. Participants who consented to be part of the study were given both consent forms, which they signed to indicate their agreement to be part of the study.

There was no potential harm to the participants; however, the study involved vulnerable groups, and therefore, it was necessary to take further measures to ensure additional protection of their rights (Gordon, 2020). Excluding MHCUs who were directly under the caseload of the researcher was one such additional measure adopted to avoid the potential power imbalance and coercion. The participants' identities were kept anonymous and care was taken to protect their identities. In addition, the participants were assured of confidentiality, emphasising that only the researcher, the supervisor and the co-coder would be able to access the voice recordings of the interviews.

There was scientific, social value and respect of the rights of MHCUs who participated in the research (CIOMS, 2016). Respecting of the rights of MHCUs came about as a result of the need to uphold occupational justice for MHCUs in the long stay mental health institution in order to ascertain that their rights with regards to performance of productive occupations were upheld. The study had social value as it brought out important aspects regarding the care and conditions of treatment for MHCUs who were engaging in the occupational therapy productive occupations program.

3.12 CONCLUSION

This chapter looked in detail at the study design, how data were collected, the analysis framework and the ethical considerations to justify the processes that were followed. There was a detailed discussion of the analysis process that highlighted the back translation process that was pivotal to ensuring that the outcome of the analysis maintained its veracity. This study involved a vulnerable group of people, and therefore, additional precautionary measures were taken to protect their autonomy.

4 RESULTS AND DISCUSSION

4.1 INTRODUCTION

This chapter presents the results and the discussion of the ten semi-structured interviews that were conducted to document the experiences of MHCUs attending a productive occupations programme. The objectives of the study was to explore MHCUs' experiences of their productive occupations before hospitalisation, to explore how MHCUs' productivity needs link to the choice of occupation within the current programme, and to explore MHCUs' experiences of the current productive occupations programme.

As a descriptive qualitative study, this study aimed to understand the experiences of the MHCUs through the meanings that the participants ascribed to their engagement in the productive occupations programme (Bradshaw, Atkinson and Doody, 2017). The interpretation of the experiences is therefore subjective to the participants, and this is further strengthened and supported by verbatim quotes from the participants (Bradshaw, Atkinson and Doody, 2017). In order to elaborately capture the experiences of the participants without losing the meaning, the results section and the discussion section were combined.

Pseudonyms of the participants' choosing were used for confidentiality and to uphold their privacy. Three themes emerged from the data analysis process, namely influences on choice of occupations, experiences of engaging in the programme, and opinions of change (see Table 4.3). Please refer to Figure 3.1 for the data analysis process that was followed to obtain the results. The results and the discussion of the demographics of the participants are presented first, and thereafter, the results and discussion of the semi-structured interviews are done.

4.2 PARTICIPANTS CHARACTERISTICS

This section is divided into two parts: The first looks at the general demographics of the participants, and the second presents the participants' productive occupations through a continuum of prior admission, within the productive occupations programme and after discharge (see Table 4.1).

4.2.1 Demographics of the sample

Table 4.1 shows the demographics of the participants.

Table 4.1 Participants' demographics

Name	Age	Gender	Marital status	Number of admissions (date of current admission)	Level of education	Diagnosis
Nicholas	27	M	Single	3 (2014)	Grade 7	Schizophrenia
Brown	52	M	Single	5 (2007)	Grade 3	Schizophrenia
Pangana	35	M	Married	1 (2018)	Grade 7	Schizophrenia
David	43	M	Single	1 (2018)	Grade 7	Substance induced psychosis
Ntantokazi	37	F	Widow	1 (2020)	Grade 4	Schizophrenia
John	39	M	Single	> 10 (2018)	A-Level (Highest level of high school) Certificate in horticulture and agriculture	Substance induced psychosis
Yolanda	34	F	Married	5 (2019)	Grade 7	Schizophrenia
Sharmaine	23	F	Single	2 (2020)	Grade 2	Schizophrenia
Pamela	35	F	Single	1 (2013)	Form 1 (first level of secondary education) Age group: 13/14 year olds	Schizophrenia
Adolance	36	M	Single	9 (2018)	Grade 7	Schizophrenia

Ten participants were interviewed, and most have been diagnosed with schizophrenia. There were six male and four female participants. Most participants were in the age range of 27–39 years, and many had a primary school level of education. During the time of data collection some participants had multiple readmissions while others only had one admission.

The fact that most participants in this study had schizophrenia is not surprising since schizophrenia is a highly prevalent chronic mental disorder (Behrouian et al., 2021). It causes considerable disability in almost all areas of life, including restricting productive occupations (Loh, 2018). As a result, people with this mental disorder are frequently

hospitalised and tend to spend prolonged periods in care institutions (Seeman, 2018). Consequently, people with schizophrenia tend to be institutionalised, excluding them from participating equitably in wider communities (Mueser et al., 2013). It is therefore important that programmes aimed at rehabilitating these MHCUs counter the effects of institutionalisation by emphasising facilitating reengagement in occupations and enabling social inclusion. The occupational therapy productive occupations programme facilitates the engagement of MHCUs in productive occupations, which increases their social participation while preparing them for making a meaningful contribution to their community and for inclusion in their community after discharge.

In their review of horticulture therapy for schizophrenia, Liu et al. (2014) show that over and above the disruptions to the participation in a valued occupation, people with schizophrenia remain homeless for extended periods of time, emphasising the need for long-term care in institutions of care. Falkum et al. (2017) studied vocational rehabilitation for adults with psychotic disorders and show that programmes that target productivity allow a successful transition of engagement in productive occupations from an institution if community support is available. However, in their study, the available support in the occupational therapy programme was institution based, and it is unclear whether there was a successful transition of work roles from the institution to the community. It is therefore necessary to establish the benefit of the programme with regards to continuation of productive occupations at community level after discharge.

Many participants in this study are male, and this reflects the context of where this study took place where more male MHCUs are admitted than females. Even with the limited sample in this study, it is important to mention that schizophrenia is more prevalent among males in early adulthood than among females (Seeman, 2018). Males with schizophrenia experience more negative symptoms, such as low motivation, apathy, poverty of speech and poor grooming (Seeman, 2018). The activities integrated in the occupational therapy productive occupations programme are targeted specifically at promoting function, and thus, eliminating the negative symptoms associated with schizophrenia. Silaule and Casteleijn (2021) highlight that engagement in an occupational therapy programme has positive gains in areas such as motivation, social participation, role performance and self-

esteem. Therefore, engagement in the occupational therapy productive occupations programme is imperative for recovery, and MHCUs need not wait to be symptom free to engage in productive occupations programmes.

Another finding worth noting is the level of education of the participants. Formal employment is highly competitive and heavily relies on a persons' academic qualifications. Most participants in this study only obtained a primary school level of education and some were already out of school between ages of 7 and 13. These findings are similar to findings by Glass et al. (2014), who investigated the impact of livestock assets on mental health symptoms in rural women. Their findings reveal that 68.7% of their participants had no schooling and 15.9% completed primary school education. The lower levels of education attained by the MHCUs reduce their employability, automatically excluding them from gaining entry into the open labour market or formal employment. It is important to prioritise enabling the engagement of the MHCUs into self-employment and skill-based livelihood occupations that do not have specific academic requirements. Therefore, the value of livelihood occupations within vulnerable groups, including MHCUs, is fundamental in circumstances where there is a low educational attainment.

Higher level education is seen as essential for success in the world of productivity and work (Ali and Jalal, 2018). A study by Dickson et al. (2020) on academic achievement and schizophrenia shows that individuals with schizophrenia are less likely to attain higher level education. It is noteworthy that low level education coupled with unemployment further lead to occupational and social exclusion for people with schizophrenia (Hakulinen et al., 2019). A low level of education, however, does not negate the importance of engaging in self-directed livelihood occupations. According to Prainsack and Buyx (2018), work that people do shape their daily lives on a social and community level. Therefore, the occupational therapy productive occupations programme facilitate the participation of MHCUs in self-directed productive occupations to gain financial independence, but more importantly, to promote their social inclusion.

Lastly, the length of stay in hospital was noteworthy. The longest stay in hospital among the participants was 14 years. This participants' hope is to also be part of a community outside the confines of the institution. This is a noted weakness of the occupational

therapy productive occupations program as patients who lack strong social ties with their relatives end up staying longer in the hospital despite their engagement in productive occupations. There is a need to explore possible modifications that the occupational therapy productive occupations program can adopt to assist participants to make the transition back into the community. Lannigan (2014) indicates that regardless of prolonged periods of hospitalisation, human beings still have an innate drive for productivity. Loh (2018) expresses that because schizophrenia has multiple effects on occupational dysfunction, comprehensive rehabilitation is warranted, spanning from the time of hospitalisation and continuing to when the patient is back in the community. The productive occupations programme therefore creates space and opportunity to engage in productive occupations within an institution of care. However, the efforts of occupational therapists in facilitating the engagement of MHCUs in productive occupations should not only be confined to institutions of care. It is of utmost importance that these efforts are also channelled to communities to support the participation of MHCUs in productive occupations within their communities.

4.2.2 Participants' productive occupations

Table 4.2 shows the participants previous productive occupations, current productive occupations and projected productive occupations.

Table 4.2 Participants' productive occupations

Name	Previous productive occupations	Previous productive occupations category	Current productive occupations	Projected productive occupations after discharge	Projected productive occupation category
Nicholas	Herding goats, keeping chickens, working on a piggery farm	Wage-earning labour	Rabbit rearing, keeping free range chickens	Keeping chickens	Wage-earning labour
Brown	Golf caddy	Wage-earning labour	Gardening	Gardening	Livelihood occupations and self-employment

Name	Previous productive occupations	Previous productive occupations category	Current productive occupations	Projected productive occupations after discharge	Projected productive occupation category
Pangana	Weaver and farmer	Livelihood occupation and self-employment	Gardening	Farming and weaving	Livelihood occupations and self-employment
David	Farming, making aluminium pots and pans	Livelihood occupation and self-employment	Barber	Farming and making aluminium pots	Livelihood occupations and self-employment
Ntantokazi	Shop attendant in a tuck shop, domestic worker	Wage-earning labour	Attendant in a tuck shop	Attendant in a tuck shop, a maid in people's houses	Wage-earning labour
John	Farm assistant manager	Wage-earning labour	Attendant in a tuck shop	Farming and selling farm produce	Livelihood occupations and self-employment
Yolanda	Domestic worker	Wage-earning labour	Rabbit rearing, keeping free range chickens	Domestic Worker	Wage-earning labour
Sharmaine	Domestic worker	Wage-earning labour	Preparing food sold in the tuck shop, cleaning and clearing the café environment	Start my own cooking and selling business	Livelihood occupations and self-employment
Pamela	Selling and farming	Livelihood occupation and self-employment	Farming, gardening	Farming and selling farm produce	Livelihood occupations and self-employment
Adolance	Driving and building	Wage-earning labour	Shoe repairs and maintenance of hospital equipment	Driving and building	Wage-earning labour

Most participants showed that they want to engage in self-directed livelihood occupations rather than paid employment. For some participants, the productive occupations they engaged in within the programme was the same as their future productivity goals, however, for some there are differences.

The findings of the study revealed that most participants had a desire to engage in self-directed livelihood occupations after discharge. This is interesting to note considering that some participants were previously in paid employment, such as being domestic workers. It is the researchers' opinion that participation in the occupational therapy productive occupations programme exposed the MHCUs to a variety of activities that enabled them to see the value of self-directed productive occupations. This is important considering that in Zimbabwe there is very limited opportunities for formal employment or wage-earning labour (Chekenya, 2017), leaving self-employment as a viable opportunity for most.

In their survey looking at the involvement of occupational therapists in supporting self-employment, Monareng, Franszsen and Van Biljon (2018) alluded that occupational therapists identify self-employment as a viable opportunity to earn a livelihood for people with disabilities, particularly in areas where there is lack of formal employment. Occupational therapists are encouraged to be cognizant of the realities of populations' contexts in order to provide more meaningful options for engagement in productive occupations for MHCUs (Monareng, Franszsen and Van Biljon, 2018). This emphasises the need to reinforce options that reflect the realities of individual contexts and the complexities of their occupational needs (Asaba et al., 2021).

There was alignment between productive occupations in the current programme and those before hospitalisation for some participants, while for some there was misalignment. It is encouraged that the programme preserves the occupational interests of the participants. However, due to lack of funding for rehabilitation, it is not always possible to create robust rehabilitation programmes (WHO, 2017). Preserving the interests of MHCUs is important, particularly since schizophrenia has a serious impact on motivation (Loh, 2018). The lack of motivation to engage is worse for occupations an individual has no interest in. Adequate funding will ensure that the programme can adapt and include more variety to cater for the diverse needs of MHCUs.

4.3 RESULTS AND DISCUSSION OF THE EMERGING THEMES

The data analysis of this study yielded three main themes that are presented in Table 4.3. The themes are (1) influences on choice of occupation, (2) experiences of engagement

and (3) opinions of MHCUs. The results in this section are be presented and discussed under these themes.

Table 4.3 Emerging themes

Codes	Subthemes	Main themes
Personal influences on choice of work	Influences of previous choice of occupation (obj1)	Influences on choice of occupation
Contextual influences on choice of work		
Education affecting choice of work		
Interest linked to work	Influences of current choice occupation (obj. 2)	
Meaningful reward		
Facilitated self-sustenance	Experiences of engagement in previous work	Experiences of MHCUs
Facilitate skill acquisition		
Facilitates earning a livelihood	Experiences of meaning related to engaging in the programme	
Facilitates exploration of livelihood projects		
Facilitates Health and wellness		
Facilitate engagement		
Facilitates self-care		
Facilitates independence		
Experience of freedom		
Facilitates sense of humanity		
Reduction of relapses		
Facilitates skill strengthening		
Facilitates structure		
Instillation of hope		
Collaborative decision-making		
Facilitation of contentment		
Facilitate socialisation		
Facilitates collective engagement		
Facilitates sustainability	Experiences of learning related to the programme	
Facilitates learning on current livelihood opportunities		
Hope for expansion of the programme	Opinions regarding change: the programme	Opinions of MHCUs regarding engagement in the programme
Hope for diversity		
Hope for adequate resources		
Hope for more community engagement		

Codes	Subthemes	Main themes
Hope for meaningful reward	Opinions of change related to MHCUs and their productivity needs	
Dignity in treatment		
Need for NGOs with supported employment		

4.3.1 Theme 1: Influences on choice of occupation

Various factors were seen influence the participants' choice of previous productive occupations and current activities in the occupational therapy productive occupations programme. This theme is discussed in the following subsection.

4.3.1.1 Influences of choice on previous and current productive occupations

Appreciating the participants' previous productive occupations was vital for this study to fully understand the participants' circumstances before hospitalisation**.** Additionally, it was important to explore the effects of hospitalisation on productive occupations and the hospital stay's influence on current and future productive occupations. The findings revealed that choice of occupations were influenced by personal, contextual and education factors.

Personal influences on choice of productive occupations included interest and personal ability. Some participants showed interest in choosing occupations that reflect what they were doing before hospitalisation. John, who previously worked as an agricultural officer and farm manager and engaged during hospitalisation in the occupational therapy productive occupations programme as a tuck shop attendant, said the following:

> *If there was time, I would have wanted to get an opportunity to have a small garden portion while in hospital… the work that I really liked doing was that of agriculture … this is also what I trained to do in school. (John)*

Adolance previously worked as a driver and a builder and in the occupational therapy productive occupations programme attended the workshop for shoe repairs, and said the following:

Before I was in hospital, I worked as an assistant builder, and then I was a miller. Then I got myself a driver's licence and worked briefly as a driver … but I really liked the building and the driving work more. (Adolance)

David who previously was making aluminium pots and utensils to sell highlighted the following:

I also wish that the making of aluminium utensils was also offered in the program. (David)

An understanding of patients' interest is critical to understand what drives their motivation to engage. MHCUs' interests should be taken in to consideration for productive occupations programmes to remain meaningful and to facilitate full engagement from the participants. Some participants did not have the chance to participate in the type of productive occupations they are interested in. This is concerning as programmes aimed at facilitating productivity among MHCUs run the risk of evoking experiences of meaninglessness and marginalisation when they do not meet the needs, choices and interests of the target population (Asaba et al., 2021). Occupational therapy productive occupations programmes are measured by their meaningfulness, relevancy and responsiveness to the context (AOTA, 2014).

Interest drives the motivation to engage in occupations, making it a critical component for productivity (Ellison and Mullen, 2018). Kielhofner and Burke (1980) highlight that interest leads to engagement in occupation and maintains the continued participation in a chosen occupation. Whatley, Fortune and Williams (2015) found that patients' participation in a gardening productive occupation programme is influenced by their interests. Similarly, Ellingsen-Dalskau et al. (2016) reveal that participants appreciated being afforded the choice to follow their interests.

In addition to interest, the participants identified ability to engage in a productive occupation as another factor that influenced their current choice of occupation. Some participants chose to engage in a productive occupation because they felt they had the ability and skill to do so. These notions were translated into the occupational therapy productive occupations programme as participants viewed themselves as able bodied

and capable of engaging in the programme rather than spending their time in the ward. The participants made the following comments:

> *I chose this type of work because I saw that this was the work I was able to do, working with my hands, than sitting the whole day. (Pamela)*

> *I am a builder and a driver … however, I saw that as a person who had the physique to do some of the types of occupations provided in the programme, I managed to engage in what was provided in the programme. (Adolance)*

In this study, despite the inability of the programme to provide the types of productive occupations some participants identified with, they managed to engage in what was available. The occupational therapy productive occupations programme was seen to help some MHCUs maintain a work identity, while for others it allowed the development of new work roles, thus building competence and self-confidence. In their study of the work identity development in young adults, Liljeholm and Bejerholm (2020) indicated that the development of a work identity is strongly related to the work people do. Similarly, the results in this study, show that the development of a work identity allows an individual to have the foundational basis of building new meaning and valued roles regardless of the illness or periods of hospitalisation.

This does not negate the need of exploring previous productive occupations. For some participants the programme failed to enable MHCUs to maintain their chosen work identities. Some participants were left with 'no choice' but to engage in what was available. Exploring previous work identities in a bid to maintain current or future work identities is therefore important (Blank, Harries and Reynolds, 2015).

Apart from interest and ability, level of education and contextual factors had a bearing on choice of previous occupation. The following comments by the participants illustrate this:

> *I figured since I could not further with education, livelihood projects were the only choice of work that I could do. (David)*

> *Err … my mom was also a MHCU who had been admitted. She passed on before I got a chance to go to Form 1, so I only ended at Grade 7. It pained me that she had*

passed on, and the thing that bothered me was how I was going to get money with my level of education? My uncle then helped in looking for a job for me to work. (Nicholas)

I started off working as a house maid as I saw that there was no other job I could qualify for … though there were other job pursuits, I could not follow those as I did not have the necessary educational requirements. (Sharmaine)

The participants' level of education influenced their choice of previous productive occupations and future productive occupations. This is evident in their statements and indicate that engagement in productive occupations was limited by their educational level, leading to some only being able to engage in self-directed livelihood occupations. Some participants distinctly pointed out that the low level of education came as a result of their family's inability to afford school fees. The interplay between low level of education and poverty was evident. The findings of this study align to what was highlighted by Latif, Aziz and Ahmed, (2016) who revealed that education in combination with contextual factors such as poverty play a critical role in the outcome of one's productive occupations.

Low educational level was shown to be interconnected with other factors such as unemployment and poverty (Lepiéce et al., 2015). Education shapes the trajectory of an individual's life opportunity and is an essential stepping stone for human economic development; however, poverty in LMICs, including Zimbabwe, is a barrier to attaining such education (Marmot, 2008; Funk, Drew and Knapp, 2012). Hakulinen et al. (2019) studied the association between schizophrenia and educational, employment and income status in Denmark, and show that people with schizophrenia are 20 times more likely to be unemployed and six times more unlikely to have secondary or higher education. Therefore, low level education coupled with mental illness creates unfavourable odds for MHCUs to excel in work. It is vital to consider that the above statistics are from a high-income country and that the margins in LMICs may be higher (Funk, Drew and Knapp, 2012; Loh, 2018). Therefore, the planning of an occupational therapy productive occupations programme should be informed by the contexts and backgrounds of the service users in order to bring out services that empower them. Subsequently, the productive occupations programme should enable the engagement of MHCUs in initiating

livelihood occupations within their communities, thus allowing sustainable engagement in productive occupations within the community.

Poverty can be both a determinant and a cause for mental illness, and as a result, persons living with mental disorders are likely to be excluded from participating equitably in education and employment opportunities. Funk et al. (2012) indicate that MHCUs should be supported to engage in livelihood occupations as a development strategy in the community. It is a priority for programmes run in institutions to integrate MHCUs successfully in the community (Cipriani et al., 2018). The occupational therapy programme, however, falls short in this regard as its support is stronger in the institution than in the community because it is institution based and has no follow-through in the community. Additionally, there are no community-based occupational therapist posts (Nhunzvi and Mavindidze, 2016). Silaule and Casteleijn (2021) indicate that MHCUs experience a decline in various areas of functioning, such as role performance and motivation, following discharge into the community. The result of having no community support is entrapping MHCUs in multiple admissions, further excluding them from participating equitably in productive occupations in their communities. It is therefore encouraged to form partnerships with Non-Governmental Organisations (NGOs) to adequately provide assistance within communities that provide support for MHCUs in their communities after discharge.

In conclusion, influences of choice on previous productive occupations were strongly related to the influences of choice on current productive occupations. These influences include interest, poverty, and level of education. Therefore, in the development and planning of services the occupational therapy productive occupations programme should factor in the social determinants of health, such as poverty, lack of education and inequitable employment opportunities, as well as personal attributes, including interests, choices, desires and motivation (Tripathi, Das and Kar, 2019).

4.3.2 Theme 2: Experiences of MHCUs

Two subthemes emerged from this theme to highlight the MHCU's experiences of being engaged in productive occupations. The first subtheme outlines the experiences of

engagement in the previous and current productive occupations and compares them to establish the differences and similarities between the two and explore the considerations for current and future productive occupations. The results are presented and discussed, and thereafter the results of the experiences of current productive occupations are discussed before the conclusion. Lastly, the results of the second subtheme, which is the rewarding experiences related to engagement in the occupational therapy productive occupations programme, are presented and discussed.

4.3.2.1 Experiences of previous and current productive occupations: A comparison

The experiences related to productive occupations that the participants engaged in prior to hospitalisation were explored. The exploration of previous experiences was useful to understand the impact that these have on MHCUs' participation in the current occupational therapy programme. The MHCUs reported that their previous productive occupations were useful to facilitate self-sustenance and skill acquisition.

Firstly, some participants saw engaging in previous productive occupations as a means to self-sustain. Self-sustenance in this study is viewed as gaining an income and how the income is used. By gaining an income, people gain the ability to meet their basic needs, live independently and support themselves and their families (Subramaniam *et al.*, 2020). The participants explained it as follows:

> *The work I used to do, I would buy my zinc sheets and having have made metal buckets from these. With the profit I would be able to live on it. I would buy food and clothes. (David)*
>
> *I used to grow maize. I'd also weave baskets and mats using reeds from the river … I chose to do these jobs because they would bring me money. The produce from the fields we would use for food, helping me to sustain my wife and the family I had. (Pangana)*
>
> *The work I used to do helped me a lot, at my house there …I would buy food, I would by shoes I would buy clothes …, plus I would also get money to come and get my*

medication and come for my review dates, I remember in 2014 I used to do that. (Nicholas)

I would pay my rent, I would also buy food and various other things. (Ntandokazi)

To ensure successful reintegration into communities, it is imperative that MHCUs be engaged in productive occupations, such as livestock rearing and gardening, to enable self-sustenance from the time of admission rather than having these introduced after discharge. The occupational therapy productive occupations programme is, therefore, critical to maintain the self-sustenance skills acquired by MHCUs prior to their hospitalisation. This is important to ensure MHCUs retain these skills during hospitalisation, making them more likely to resume their occupations after discharge. The ability to self-sustain in the community is critical for every adult no matter what their health status. Subramaniam et al. (2020) studied the engagement of young people with mental disorders in productive occupations within their communities and found that productive occupations allow them to meet their day-to-day expenses. Following their diagnoses, MHCUs struggle to achieve full remission, and as a result, they have difficulty engaging in occupations that allow them to meet their daily expenses (Moges et al., 2021). Cipriani et al. (2018) studied the value of horticultural programmes for patients in a long-term adult psychiatry facility and found that one of the end goals of occupational therapy is to develop the skills necessary to facilitate self-sustenance. This is done by facilitating engagement in productive occupations and dispelling the stigma that MHCUs cannot work and are dependent, and therefore, cannot support themselves or their families (Ellison and Mullen, 2018; Subramaniam et al., 2020). Therefore, facilitating the development of skills that foster financial self-sustenance should be the main focus of occupational therapy intervention from the time of admission.

Some participants highlighted that their engagement in the current occupational therapy productive occupations programme is related to a financial reward. They felt that through their participation they gained an incentive. Although this cannot be equated to the income they earned in their previous productive occupations prior to hospitalisation, this monetary reward motivated their engagement in the current occupational therapy programme, as the following comment shows:

At the end of the month we will get something, you get a little something because money is a reward of work done. (Pangana)

The incentive that we get in OT is good, you can supplement some food items that you get from the institution's kitchen, for example, you can buy peanut butter. You can also buy yourself soap and lotion which are other things that may be in short supply in the stores. (John)

The incentive that participants receive in the programme do not only facilitate self-sustenance but it gives MHCUs an opportunity to understand the reward attached to engagement in productive occupations. Additionally, monetary reward was seen as a motivator for engagement. It is important that the context where an occupational therapy programme is implemented take these factors into consideration in order to include elements in the programme that will motivate MHCUs to engage in productive occupations. In a study by Blank (2011), participants indicated that their reason for working was not the money but about feeling appreciated, enjoyment and satisfaction with life. Similarly, Whatley, Fortune and Williams (2015) found that participants' engagement in a programme was not motivated by an incentive but by enabling their social participation and social inclusion. In high-income countries (HICS), the benefits of engagement in productive occupations is seldom linked to receiving a monetary incentive because there are disability grants available (Ellison and Mullen, 2018). However, in LMICs where there are limited opportunities of getting disability grants and where poverty is endemic (WHO, 2020), the benefit of the incentive is valued and may be the motivator for engaging in productive occupations

Lastly, the experiences of engaging in previous productive occupations was related to skill acquisition because MHCUs get an opportunity to learn new skills. The following comment describes this:

The work that I used to do helped to open up my mind. It opens here (pointing to the head). As for me, I didn't go to school but as it is I can count money, I can read and I know a bunch of other things because of that job. (Ntantokazi)

The productive occupations that MHCUs engaged in previously helped develop skills. The participant above worked as a tuck-shop attendant before admission, and she was able to learn different skills, such as identifying money denominations, basic addition and subtraction, giving back change, and reading and writing skills. Although some participants did not get a chance to go to school, engaging in their previous productive occupations allowed them to learn on the job. Engagement in occupational therapy programmes allows the reinforcement of previously gained skills, allowing participants to be confident in their capabilities (Lim, Morris and Craik, 2007). It is imperative for a programme that targets productive occupations within inpatient facilities to align with the MHCUs' previous skills (Cook and Lukersmith, 2010). Therefore, the occupational therapy productive occupations programme facilitates continued participation in previous skills, building on and improving previously gained skills during hospitalisation while also preparing for discharge into previously acquired occupational roles.

Some participants expressed that in the current occupational therapy productive occupations programme they are able to learn new skills. Additionally, they learn various productive occupations that they can potentially do as livelihood occupations after discharge. The following comments by participants clarify their opinions:

> *In the programme you learn such that when you go home you then get to remember what you used to do in the programme. (Pangana)*
>
> *In the programme you end up being able to do something's which you were previously not able to do. Now I know that if I go out of hospital, I will be able to open my own barber. (David)*

Some participants expressed that they gained new skills necessary for them to start productive occupations projects after discharge. However, in the case of David above, there was a mismatch between the productive occupations that he participated in as part of the program and those that he intends to engage in after discharge as can be seen in Table 4.2 under projected productive occupations after discharge. He intends to engage in food gardening and to continue to make aluminium pots and pans, an occupation he was engaging in before he was admitted and he also wants to continue with his plans of opening a barber as well. David, was one participant who had the opportunity to choose

which productive occupation he wanted to be part of in the program and he chose the barbershop though there was gardening which reflected similarities with what he intended to do after discharge.

> *I currently am in the barbershop, I chose this job myself because I wanted to learn barbering. (David)*

It is therefore possible to infer that the productive occupations widened his perspective of the various skills that he can do after discharge.

Some participants found that skill learning through the occupational therapy productive occupations program was fundamental for preparing them for discharge. As is evident in the above quotes, the occupational therapy productive occupations programme provides a platform for MHCUs to learn new skills and occupations. Similarly, Whatley, Fortune and Williams (2015) found that part of the skills learning that happens when participating in their project is through observation. Skills learned include learning how to plant, harvest, prune and organise for a selling day (Whatley, Fortune and Williams, 2015). In addition to learning skills through observation, MHCUs could request more formal learning input when needed. Lim, Morris and Craik (2007) studied the perspectives of MHCUs on occupational therapy and found that occupational therapy programmes are important for patients because they facilitate learning new skills. Estrella et al. (2019) found that participants hoped to have professionals teaching them for some occupations that are available in the inpatient occupational therapy programme, for example, having chefs and carpenters come in for training. Therefore, in as much as the occupational therapy productive occupations programme facilitate skills acquisition, further research is necessary to find out what MHCUs need in regard to skill acquisition to equip them enough to successfully start their productive occupations in the community after discharge.

In conclusion, the experiences of previous productive occupations before hospitalisation resemble the experiences of current productive occupations in the occupational therapy programme. Both the previous productive occupations and the current productive occupations during hospitalisation allow self-sustenance and gaining new skills. There were no marked differences with regards to experiences save that in the current

productive occupations programme participants have a chance to expand their skills. This is highlighted by the fact that some participants learned new occupations that they felt they can pursue after discharge.

4.3.2.2 Rewarding experiences of engagement in the programme

Experiences of engagement looked at the perceived impact that the occupational therapy programme had on the participants in terms of doing and their feelings related to engagement in the programme. Engagement in the occupational therapy productive occupations programme was seen as rewarding to the participants and facilitate the following: Exploration of productive occupations, structure, freedom, independence, sense of humanity, health and wellness, and collective engagement.

Some participants reported that the occupational therapy productive occupations programme exposed them to a variety of occupations, which gave them ideas for occupations they could do after discharge. This is expressed in the following comment:

> *Before I was admitted, I would engage in farming and I was making metal pots, pans and utensils, … in the programme I am involved in the barbershop, and this is something I can earn a livelihood from … If I am discharged, I would like to open my own barbershop. (David)*

> *The work that I am doing now in the programme helps me a lot, I'm learning a lot of things such that if I get an opportunity to be discharged I am sure I will be able to open my own tuckshop. (John)*

Most participants in this study do not have a high educational level. This means that they are unable to compete for skilled work without the requisite academic requirements, leaving them with limited options for productive occupations. Most worked as domestic workers but after engaging in the occupational therapy productive occupations programme, they felt they had an opportunity to engage in self-employment by starting productive occupations in the community, here referred to as a livelihood occupation by the participant. The occupational therapy programme was therefore found to offer a variety of productive occupations that exposed MHCUs to contextually relevant

productive occupations they could potentially engage in within the community. Being aware of the low level education for most MHCUs in the programme, it included occupations that had a low resource input and that can be individually run by the MHCUs in the community. Muñoz et al. (2009) found that engagement in a programme offering a variety of productive roles allows participants to choose and engage in a productive occupation that resonated with their role as workers in the community. Additionally, occupational therapists are encouraged to promote the development of programmes that offer a variety of productive occupations (Iannelli and Wilding, 2007), providing MHCUs with a chance to explore possible productive occupations. Participants in the study were workers before and identified themselves as workers in the future. The occupational therapy productive occupations programme provide different productive occupations that MHCUs can choose from, increasing the probability of successfully setting up their productive occupations in the community.

Participants felt that being part of the productive occupations programme allows them to engage in 'doing' various occupations, which facilitate gaining structure in their lives. The following comments show this:

> *We won't spent the whole day seated in the ward, sleeping, doing nothing. (Nicholas)*

> *The nice thing about this programme is that you get to know daily living, you get to know that you are supposed to bath, you need to eat, you also need to work. (John)*

The focus of the occupational therapy productive occupations programme is to facilitate engagement in productivity. However, latent benefits goes beyond productivity and bring structure to the participants' lives. The occupational therapy productive occupations programme breaks the ward routine facilitating not only engagement in productivity but also in other occupations that participants find meaningful, such as self-care and social integration. Casteleijn et al. (2012) found that participants who are attending an occupational therapy programme are able to live a balanced life in an inpatient mental health facility, and as a result, they advocated to have the programme offered during the weekend as well. When MHCUs lose structure in their daily occupations, they lose the interaction between the self and the world (Sutton, Hocking and Smythe, 2012), and this

results in days spent unproductively, a situation typically found in the ward. According to the WFOT (2018), the environment is the ‘crucible’ where the doing of occupations is facilitated, enabled and developed. This study found that in the crucible of the occupational therapy productive occupations programme, participants feel the impact of the programme providing them with structure and motivation to engage in occupations beyond productivity. Therefore, occupational therapists are encouraged to harness the environment and adapt and use it to facilitate the ‘doing’ of occupations that are valued by MHCUs.

Engagement in the occupational therapy productive occupations programme was associated with feelings of freedom. The occupational therapy programme used a treatment mall approach where participants have to leave their wards and meet other MHCU who participate in the programme in the occupational therapy departments. Some participants found this experience liberating because it allows them to experience the freedom to engage in other occupations outside of the ward, as the following comment shows:

> *I personally see that this programme helps me, if I look at staying in the ward, that does not make me happy … But when I move around and see different things, it’s better than when we are closed in and locked inside. But when we come for OT, we become a bit free, you feel the breeze, you see other people, and that makes me happy. (Ntantokazi)*

The ward environment is seen to be limiting the participants freedom, as it is considered separated from the outside world, where the participant here highlights as being ‘locked away. This however, is standard for many ward environments where time and activity structure within the ward is often constant. The occupational therapy productive occupations programme, through its use of the treatment mall approach, allows MHCUs to demonstrate a level of freedom by creating an environment that resembles the community with regards to promoting independence and choice. This is because some treatment malls contain areas with classrooms, recreational spaces, a hall, dining areas, salons and a library (Ballard, 2008), preparing MHCUs for community living. Funk and Drew (2017) highlight that recovery from mental illness is about freedom and

independence, and this is better experienced outside the confines of the hospital where an individual is free to move around and make choices about their occupations. Similarly, participants in a study by Oyelade and Nkosi-Mafutha (2021) understood that being in hospital entailed that certain privileges were taken away however they hoped to have a variety of occupations that they could engage whilst being admitted. The occupational therapy programme therefore, becomes fundamentally placed allowing MHCUs' self-direction and their ability to make choices about the occupations they want to engage in therapy (Sutton, Hocking and Smythe, 2012).

Closely linked to experiences of freedom, participants also felt that coming to the programme facilitate feelings of independence. Some participants valued the state of having to engage in occupations without constant supervision and assistance, and this allows them to become more responsible. The following comment illustrates this:

> *This programme is good because as a person, you become focused … you are able to plan your work and you know that today I'm doing this and that and that, while you are under minimum supervision, and at times without supervision at all. (John)*

The findings of this study highlight that the occupational therapy productive occupations programme allows MHCUs to build competence in independent living skills which are crucial for discharge preparation. The main aim of occupational therapy intervention is to facilitate the development of skills that promote independence in the participation within occupations (WFOT, 2017a), ultimately facilitating community living. A study by Lannigan (2014) on the perspectives of MHCUs on a vocational programme found that for the participants being ill is associated with losing their independence, while Matthews et al. (2015) highlight that recovery is associated with the ability to independently plan and accomplish daily tasks. Additionally, Cipriani et al. (2018) indicate that their gardening programme improves the level of independence and promote community living for their participants. The occupational therapy productive occupations programme, similar to other rehabilitation programmes, has the same effect for the participants, allowing them to re-gain independence (Oyelade and Nkosi-Mafutha, 2021).

Some participants felt that engagement in the occupational therapy productive occupations programme facilitated a sense of humanity. Engagement in productivity was

related to feeling normal, and participants were able to compare themselves with other people in their community. The following comment shows that engagement in the occupational therapy productive occupations programme elicited feelings of being like other people:

> *The programme helps me because you see, rather than just sitting in the ward there is no joy in that … but coming to the OT programme you get an opportunity to work and you get that feeling that I am also human same as other people. (Ntantokazi)*

It is not surprising, therefore, that for MHCUs in this study the opportunity to engage in productive occupations elicited feelings of being human. Within institutions of care, such as the long-stay institution where this study took place, there is a risk of having limited opportunity for engagement in occupations as most institutions do not have programmes that provide opportunities to participate in various occupations. This results in MHCUs losing the sense of what it is to be human. The occupational therapy productive occupations programme is seen to provide an opportunity for MHCUs to have an equitable chance of engaging in productive occupations. Subsequently facilitating feelings of being like other humans and being able to work, provide and engage in meaningful occupations. Blank et al. (2015) highlights that through engagement in work occupations participants in their study felt identified as equivalent citizens. Humans have used occupations to make sense of the world around them (Yerxa, 2000). People with mental illness, however, feel that within communities they are identified first by their illness (Rebeiro and Cook, 1999) and not as people who, like others, can engage in various occupations. Hence, they are excluded from engaging in occupations once people identify them as having a mental illness (Subramaniam et al., 2020). The occupational therapy productive occupations programme becomes important as it provides an opportunity to for MHCUs to work and engage in meaningful occupations despite the presence of mental illness.

Some participants highlighted that engagement in the occupational therapy productive occupations programme facilitated their health and wellness. This was expressed firstly as improvements in physical health and wellness. Participants expressed that their bodies were strengthened through regular physical activity from engaging in productive

occupations. Secondly, it was expresses as improved mental health, which included gains in emotional, psychological and social wellbeing. Lastly, it was expressed as contributions towards recovery from mental illness. This is expressed in the following comments:

> *This work that we do keeps our bodies strong … if you are just seated and doing nothing, you get tired such that you don't feel like doing anything. (Pamela)*

> *I see the OT programme as a very good thing because without it … I don't see things being okay, because you continuously feel ill and you have these relapses, but when you come to OT it's rare that one would relapse. (John)*

Some of the participants said that being idle and not engaging in an occupation is associated with ill health and apathy. Through facilitating, structure and self-sufficiency, the occupational therapy productive occupations programmes contributes to the health and wellness of MHCUs. Estrella et al. (2019) highlight that participants' mental health and wellness improved as a result of engagement in an occupation therapy programme. Mental health and wellness gains constitute feelings of happiness, self-sufficiency, less stress, increased motivation and feelings of being in control of one's emotions (Estrella et al., 2019). Apart from improved mental health, other studies show that engagement in an occupation is associated with reduced relapses. Argentzell, Håkansson and Eklund, (2010) show that moving from a state of doing nothing to having something to routinely do, such as engage in productive occupations, minimises relapses. Therefore productive occupations facilitate economic stability, personal and social identity, connectedness and a chance to make a meaningful contribution to societies (Subramaniam et al., 2020).

In the occupational therapy productive occupations programme, participants were involved in different projects, for example, gardening, a barbershop, a café, and arts and crafts. However, participants often felt that they had a mutually beneficial relationship with regards to accomplishment of tasks despite their involvement in different projects by helping each other during times when one group had a greater workload and vice-versa. Therefore, engagement in the occupational therapy productive occupations programme facilitates collective participation. The following comment describes this:

So sometimes we have people working in the garden, and us we tend mainly to the animals, so those guys at the garden may not have a lot of work you see, so they come to help us to look for rabbit feed and feeding the animals, and as for us we also help them if we see that they have a lot of work in the garden, we will go and help them. (Pamela)

The occupational therapy programme promotes a culture where participants feel that they can accomplish tasks through collective participation. Participants in the programme have a shared experience of having a mental illness, being admitted in a long-stay institution and being participants in a productive occupations programme. These similarities may provide a sense of belonging, which brings them together in spite of the different projects they are involved in. Participants feel they are in a community that they identified with and where they have a supportive social network. Smidl, Mitchell and Creighton (2017) highlight that through engaging in the occupation together, participants are able to identify with the group and form new relations by accomplishing tasks as a collective. Leufstadius, Gunnarsson and Eklund, (2014) highlights that programmes that foster a sense of belonging are critical and should be supported. It is therefore important for occupational therapist to understand the dynamics of collective participation within groups and how this can be used to promote a supportive network for MHCUs at an individual level. These dynamics may include feelings of empowerment and self-confidence, motivating individuals to take up a role in society and find supportive networks (Leufstadius, Gunnarsson and Eklund, 2014).

To conclude, participants in the study expressed that engagement in the productive occupations programme was rewarding, facilitating the exploration of productive occupations, structure, freedom, independence, sense of humanity, health and wellness, and collective engagement. Participants felt that the programme offers a variety of productive occupations that widen their options for successfully engaging in productive occupations in the community after discharge. Additionally, apart from participants realising the benefits of the occupational therapy productive occupations programme while being admitted, for example, giving routine and contributing to their health and wellness, they also see the benefits of the programme extending beyond hospitalisation.

Providing hope for a better quality of life for the participants as a result of the increased opportunity to set up productive occupations in the community.

4.3.3 Theme 3: Opinions of MHCUs regarding engagement in the programme

This theme presents the opinions of the participants about the occupational therapy productive occupations. The opinions reflects areas where the participants provided suggestions on what they felt should change and be modified in the occupational therapy productive occupations programme. Some of these suggestions focus on changes that need to occur in the programme itself and others focusses on changes for the MHCUs themselves, their productivity needs and the effects this will have on their lives. This theme is represented under the following two subthemes: Opinions of change regarding the programme, and opinions of change related to MHCUs and their productivity needs.

4.3.3.1 Opinions of change regarding the programme

The participants' highlighted areas they hoped would change in the occupational therapy productive occupations programme. Their suggestions included advocating for the expansion of the programme, more resources and more community engagement. Some participants requested the expansion of the occupational therapy productive occupations programme. They felt that the programme has the capacity to grow and include other projects that are not currently offered in the programme. Additionally, participants felt that some of the projects in the programme could be expanded, for example, the gardening project can include an herb garden in addition to vegetables. The following comments discuss this:

> *The programme is good, but when you look at the tuck-shop, there is very few items selling from there. We want the tuck-shop to be full. Those people in the café can add more to what they currently do. The can even start making sadza (thick maize porridge) or rice for lunch …. (Ntantokazi)*

> *We would want more gardens. If we plant more vegetables, we get to sell more and we also get to receive more money as a result. (Brown)*

The hope of having the programme expand may be because the participants see the value in the programme. As can be seen above, more production in the occupational therapy productive occupations programme means an increased incentive for work done by the MHCUs. Similarly, MHCUs attending an occupational therapy programme at an inpatient facility found that the value of engagement in the programme included enabling meaningful engagement, wellness, skill learning and empowerment (Estrella et al., 2019). It is possible that with expansion, the programme can go beyond operating in the confines of the institution and that satellite community occupational therapy productive occupations programmes can be set up. Such an expansion will give MHCUs the opportunity to contribute meaningfully to the community (WHO, 2013). An analysis by Kidia et al. (2017) of Zimbabwe's mental health systems indicate to the need for the expansion of rehabilitation facilities. Rehabilitation programmes, however, are often poorly funded and the financial resources to expand programmes may not be available. This has serious implications that not only limit the potential benefits that the occupational therapy productive occupations programme have for MHCUs but also limits their meaningful engagement, which influences their recovery. It is therefore important that occupational therapists think innovatively regarding MHCUs' needs for programme expansion, and where necessary, advocate for the involvement of partner mental health organisations that can provide funding to scale up occupational therapy programmes (Estrella et al., 2019). Additionally, occupational therapists should strive to demonstrate the effects of the services they offer in order to attract funders to support the expansion of their programmes, especially in resource constrained environments (Silaule and Casteleijn, 2021).

The participants also felt that they need more community engagement by expanding the occupational therapy productive occupations programme. The participants highlighted the need to improve their customer base through selling their produce at a more communal place, such as the local market place, instead of only selling to customers in the long-stay institution. This can facilitate social inclusion through engagement in the occupational therapy productive occupations programme. The following comments raises this concern:

Another thing which we need to change is when we now harvest our vegetables, we need to sell it at the market place. (Ntandokazi)

The long-stay institution is separated from the rest of the community and their target market for their products from various projects in the programme are staff members and other patients in the institution. This is a problem because the programme only allows socialisation with other people with mental illness and not with the wider community. This further perpetuates the cycle of social isolation and exclusion that has affected MHCUs for years (Coakley and Bryze, 2018). Whatley, Fortune and Williams (2015) found that participants can make social connections not only with other MHCUs but also with visitors to market stalls, which resulted in social inclusion in the wider society. The occupational therapists facilitating the productive occupations programme can explore the possibility of linking with the community, for example, having an open market day weekly where the community is invited into the institution to buy products and produce from the different projects. Alternatively, they can explore the possibility of MHCUs having their own stall at the community market place. This will help MHCUs initiate contact with the wider community, which could facilitate better community reintegration after discharge (Morato, Aparecida and Lussi, 2015). The additional benefits of this may include increased social support from the community and dissipating the stigma in the community around MHCUs viewed as people who are unable to engage in productive occupations (Abayneh et al., 2017). More community engagement will give MHCUs more social contact and develop the necessary social skills needed for recovery (Morato, Aparecida and Lussi, 2015).

4.3.3.2 Opinions of change related to MHCUs and their productivity needs

Some participants raised opinions about the programme that have a direct impact on their lives while participating in the productive occupations programmes. These opinions were hope for a more meaningful reward, hope for dignity in treatment, and hope for supported employment.

Most participants in the occupational therapy productive occupations programme hoped for a more meaningful reward than the monthly incentive they currently receive. The following comments discusses this:

We hope that the money that we get as incentives be increased from what we are currently getting. (Pamela)

One of the things that I plead for is that we hope to have the money that we get be raised so that it can buy something meaningful as things are continually rising because of inflation … it would be good to also get something substantial after your work, something you can point to and say, 'I got this item when I worked on such a day'. (Adolance)

The incentive that MHCUs are getting was to motivate engagement. However, since participants expressed concern over the low incentive, the motivation for MHCUs to continue in the program can be affected. This results in the reduction in number of MHCUs who actually want to be a part of the productive occupations programme and those who would benefit from the programme. Muñoz et al. (2009) state that an incentive is used to acknowledge participants who effectively demonstrate acceptable work habits and personal responsibility. In view of this, the more meaningful the reward, the greater the probability of having participants establish the habits necessary for sustainable productive roles in the community.

There is very high inflation in Zimbabwe where the occupational therapy productive occupations programme is operating in (Kidia et al., 2017), resulting in the diminishing value of the incentive that MHCUs participating in the programme are getting. It is important therefore for the occupational therapy productive occupation programme to incorporate a more meaningful reward system to enable motivation and reinforce skills learned. This can be done through non-monetary incentives where possible, for example, getting a substantial amount of money that can be accumulated in the form of tokens. The tokens can be kept and when they reach a certain number, for example, three tokens, the individual gets an opportunity to buy some of what they will need to start a livelihood project once they are discharged. This will help MHCUs face less disruptions with regards to continued participation in productive occupations in the community.

The second opinion raised by some participants was the hope to be treated with dignity. It can be inferred that the treatment that some of the participants receive while engaging

in the programme make them feel stigmatised by the people who are supposed to help them. The following comments explains this:

> *There is need for more programmes like, for example, the rehabilitation technicians, that they can have programmes for training organised for them on how to treat and handle MHCUs with dignity, together with training to avoid MHCUs being considered as people who do not know what they are doing once they are admitted. (John)*

The stigmatisation of MHCUs by members of the mental health care team raises a serious concern. The occupational therapy productive occupations programme is meant to facilitate the MHCUs' occupational identity and prepare them for engagement in productive occupations following discharge. Stigma within the health care system counteracts the gains made to the self-esteem and empowerment of MHCUs, impeding skill development and confidence to engage in productive occupations after discharge. It is evident from the above comment that MHCUs also face stigma within the health system (Lawn, 2015). The dire implications of such treatment must be acknowledged as this can affect the identity and self-esteem of MHCUs and disempower them (Abayneh et al., 2017). The implications of stigma in health care systems result in the perpetuation of discriminatory practices against MHCUs, obstructing them from having any say in their treatment as they are seen as not having anything meaningful to contribute (Samudre et al., 2016). Being viewed as worthless by the people who should help you generates poor self-esteem, low confidence and no hope for the future (Funk, Drew and Knapp, 2012). Additionally, if stigma is present in the health care system, it will be difficult to alleviate it in the community. Neumann et al. (2009) highlight that it is necessary to practise and teach empathy amongst ourselves as mental health professionals, abating stigma in the process. It is necessary to upskill the knowledge base of rehabilitation technicians who are a part of the programme to enable appropriate handling of MHCUs.

Lastly some participants hoped for assistance in setting up productive occupations after discharge from the hospital. Participants were concerned about the decreased opportunity of engaging in productive occupations in the community and hoped for supported employment opportunities. Lack of start-up capital or start-up kits were noted

as potential barriers that could hinder setting up a productive occupations project in the community. The following comments focus on this:

> *If I get help, I wish to be helped with money so that I can buy one hair clippers so I continue with what I'm currently doing here in hospital. (David)*

Mental health care users expressed the need to be supported in setting up either self-directed productive occupations or paid productive occupations within the community. Occupational therapists are encouraged to continue their services post-discharge, especially for individuals who wish to continue their productive occupations in the community (Machingura and Lloyd, 2017). This will allow carryover of skills acquired in the occupational therapy productive occupations programme into the community. However, in LMICs, opportunities that support the engagement of MHCUs in productive occupations within the community are unavailable or limited for the targeted population (Chimara, Van Niekerk and Van Biljon, 2021). Without support, MHCUs struggle to engage in productive occupations post-discharge (Machingura and Lloyd, 2017). The WHO (2011) advocates for community based rehabilitation programmes because they lead to greater participation for MHCUs. The implications of not having supporting services to engage in productive occupations in the community perpetuate the vulnerability of MHCUs and increases the already existing barriers to engagement in productive occupations within the community, resulting in increased exclusion and poverty for MHCUs (WHO, 2011).

Zimbabwe's mental health policy recognises the need of various specialised rehabilitation services to offer support in the community for MHCUs, such as day centres and vocational training centres (Ministry of Health and Child Care [MoHCC], 2004). Mlambo et al. (2014) propose that occupational therapists work closely with centres that are currently supporting MHCUs in the community to empower them and facilitate their engagement in sustainable productive occupations. Therefore, occupational therapists in the programme can work with organisations already operating in the community to make their services accessible post-discharge. This will help support the engagement of MHCUs in productive occupations within the community.

In summary participants expressed opinions with regards to the occupational therapy productive occupations programme, including areas they felt needed to change for them to benefit optimally from the programme. Some areas of concern were community support, dignified treatment and expansion of the programme. The results show that community engagement is lacking in the programme. This is despite the MHCUs acknowledging this as a core element to help them setting up and sustaining engagement in productive occupations in the community. There is a need for occupational therapists to advocate for more funding to ensure programme expansion and the procurement of the required tools and materials.

4.4 SUMMARY

Findings from the demographics yielded important aspects, namely, the prominent diagnosis of schizophrenia, low educational level and the future goals of MHCUs with regards to productive occupations. Three major themes were identified in this study, namely influences on choice of occupation, experiences of engagement, and opinions of MHCUs regarding engagement in the programme.

Most of the participants have previously engaged in paid productive occupations as domestic workers, and they indicated their need to engage in self-directed productive occupations to earn a livelihood in the community after discharge. Their educational level does not allow them to compete on the open labour market and engagement in the productive occupations programme inspired them to opt for self-directed productive occupations.

The first theme indicated that personal, contextual and educational factors impact the influences of choice of occupation. Personal factors included interests and personal ability. It is evident from the findings that the occupational therapy productive occupations programme needs to reflect the interests of MHCUs. Additionally, it was indicated that the occupational therapy productive occupations programme facilitated the engagement of MHCUs in occupations that they are able to do as a result of their previous engagement in productive occupations, thus maintaining their work identity. Low educational level is interconnected with other contextual factors, such as poverty and unemployment, and are

important social determinants of health, which can be barriers to engagement in occupation. As a result, occupational therapists must be mindful of the determinants of health to facilitate equitable opportunity for engagement in productive occupations for MHCUs.

The theme experiences of MHCUs provided a comparison of the experiences of previous and current productive occupations and the rewarding experiences of engagement related to the occupational therapy productive occupations programme. Comparing the participants previous experiences of engagement before admission to their experiences of engagement in the occupational therapy productive occupations programme indicated that engagement facilitated skill acquisition and self-sustenance. MHCUs indicated that engagement in the occupational therapy productive occupations programme was associated with experiences that are rewarding, facilitating the exploration of productive occupations, structure, independence, sense of humanity, health and wellness and collective engagement.

Through engagement in the occupational therapy productive occupations programme participants have the opportunity to explore various occupations that they could potentially engage in within the community, allowing them to identify productive occupations that resonate with their future productive roles within society. The purpose of the occupational therapy productive occupations programme was to promote engagement in productive occupations, and participants were able to experience increased motivation to take part in other occupations, such as self-care and social participation. The occupational therapy productive occupations programme created an environment that simulated the community environment, promoting freedom and competence in independent living skills necessary for discharge. The value of the occupational therapy productive occupations programme goes beyond facilitating productivity and allows MHCUs to experience improved mental health and reduced relapses.

The last theme, the opinions of MHCUs participating in the occupational therapy productive occupations programme, was further classified into opinions of change related to the programme and opinions of change related to MHCUs and their needs. Opinions

of change related to the programme included hope for expansion of the programme, hope for more resources in the programme, and hope for more community engagement. The subtheme opinions of change related to MHCUs and their productivity needs, and yielded the hope for meaningful reward, hope to be treated with dignity and hope for supported employment. These opinions were raised by the participants so that they could benefit from the occupational therapy productive occupations programme. These themes strengthen the notion that MHCUs have critical input for the development, planning and evaluation of occupational therapy programmes

5 CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY OF THE FINDINGS

The aim of this study was to explore the experiences of MHCUs attending an occupational therapy productive occupations programme in a long-stay mental health institution. An exploration into MHCUs' previous productive occupations allowed an understanding into the participants' life circumstances before admission. Understanding the experiences in the occupational therapy productive occupations programmes revealed MHCUs' views, opinions and goals for future productivity roles. This chapter presents the limitations, evaluation, recommendations, and conclusion of the study.

5.2 LIMITATIONS

The research was a descriptive qualitative study that used thematic analysis with purposive sampling. The sampling method limited the level of random selection of the participants. This meant that there was a possibility of bias during the selection process. To overcome this, an equal number of males and females were selected. However, due to the discharge of patients, some identified participants were not able to participate and six males and four females ended up participating in the study. Additionally, to reduce bias, the selection process was done by other occupational therapists who are in charge of some of the occupational therapy departments and are part of the productive occupations programme. Throughout, this process was verified by the supervisor.

Patients who were directly under the supervision of the researcher was necessary as a result of the power imbalance that could come into play and result in possible coercion of the participants.

5.3 STRENGTHS OF THE STUDY

The results of the study may be transferable to facilities with similar characteristics to where the study took place. Occupational therapy in Zimbabwe, as with most LMICs has few published studies hence this research contributes to the body of knowledge of occupational therapy research in psychiatry.

5.4 CRITICAL EVALUATION OF THE STUDY

The exploration into MHCUs experiences needed an understanding of previous engagement into productive roles to elucidate the progression of these roles from the community to admission as well as projected future roles to bring out the impact of the occupational therapy productive occupations programme. The descriptive qualitative study was an ideal study design as it allowed participants to relate either past or current situations as well as to describe their preferences for the future. The semi-structured interviews were done in Shona, a language in which the participants could express themselves well and the researcher's first language. As a result, the participants were able to elaborately relay their experiences to the researcher. The data analysis was done in Shona. Given that the co-coder is also a native Shona speaker, it added to the rigour of the analysis process and reduced the probability of losing the actual meaning of the participants' views and opinions.

The researcher worked in one of the occupational therapy departments in the productive occupations programmes. The researcher did not select MHCUs who were directly under her supervision as this would have resulted in uneven power dynamics and limit the freedom of the MHCUs to express themselves. Therefore, only MHCUs from other occupational therapy departments were selected.

The study provided a platform where MHCUs could express their experiences, views and opinions about an occupational therapy productive occupations programme they attend. MHCUs often do not have the opportunity to have their voice heard, especially regarding planning, development and evaluation of programmes. This study sought to give MHCUs an opportunity to contribute to the evaluation of a productive occupations programme, and they found it empowering. As the researcher had established a rapport with the participants, the participants felt free to express themselves, which yielded rich information. Additionally, this expands the knowledge base of the benefits of the participation in productive occupations for MHCUs in low resource settings.

The results of the study had a high number of MHCUs with a low educational level. Despite the small sample size, this expounds the realities of the determinants of health in

LMICs for vulnerable populations. As a result of the specifics of the context in which this study took place, transferability of the results may be applicable to institutions with similar contexts. Therefore, the results of this study adds important highlights to the body of knowledge on the impact of life circumstances on engagement in occupations in LMICs.

In the study, community reintegration came out strongly where MHCUs pointed to the need to continue with their productive roles post-discharge. Continuation with productive roles is confounded by the multiple admissions that was an evident for most of the participants. This research did not go into detail to explore the reasons for the multiple admission and their views on how to mitigate this. However, readmissions are one of the quality indicators of mental healthcare services. In addition readmissions are capable of disrupting the continued engagement in productive occupations within the community for MHCUs. In the communities where MHCUs are coming from there are limited support services for MHCUs which results in admissions which could otherwise be avoidable whilst allowing the MHCUs to continue in the community. The researcher was aware of the need for support services, which should not only include community occupational therapy services but also other team members beyond the medical multidisciplinary team. Mental health care users need to be supported with other services like supported housing when they are well enough to be discharged but have no home to go to. The availability of these services will not only enable them to engage in productive occupations in the community but have a positive effect on avoiding multiple admissions for MHCUs.

5.5 RECOMMENDATIONS

This study showed that most MHCUs had a low educational level and are likely to fall into poverty. Additionally, once in the community, their educational level and economic status mean that they have less opportunities to engage in occupations. The lack of engagement in occupations, such as productive occupations, further lead MHCUs into a vicious cycle of poverty. Furthermore, the open labour market is saturated and it is necessary to direct funds to help MHCUs upskill to enable them to start self-directed productive occupations in the community. Prioritising these opportunities for educating MHCUs to start their own productive occupations will allow them to equitably engage in sustainable productive occupations in the community. Reducing the probability of MHCUs falling into poverty.

In Zimbabwe, there is a general lack of psychosocial rehabilitative services that respond to the broad needs of MHCUs, for example, the lack of supported employment for MHCUs. Vocational rehabilitation services as well as other services directed towards providing support for MHCUs to establish livelihood occupations in the community are important to ensure continued engagement in productivity after discharge. Ideally, the support should include services such as start-up kits for setting up self-directed productive occupations in the community, work skills, work etiquette, and support for mental health issues that can be addressed in the community. These services are essential for MHCUs to facilitate community reintegration; however, they are currently unavailable. Occupational therapists must advocate to have these services available for MHCUs to successfully engage in productive occupations in the community. Future studies should investigate if the occupational therapy productive occupations programme can effectively benefit MHCUs to participate in productive occupations within the community and the various support services needed to facilitate that.

Occupational therapists are well positioned to facilitate self-employment for MHCUs, including helping them start their self-directed productive occupations within the community. There is an urgent need to explore the possibility of having partnerships between occupational therapists and institutions or non-governmental organisations to fast track the development and accessibility of these service for MHCUs. It is important to acknowledge that some occupational therapists may not be prepared to facilitate self-employment opportunities or even livelihood occupations for MHCUs. Therefore, it is necessary to explore opportunities to upskill occupational therapists in this area. This can be done by integrating training in undergraduate curriculum and ensuring the availability of training workshops for occupational therapists.

Stigma from healthcare professional was identified as having dire consequences for MHCUs. MHCUs already face problems with communities and struggle to prove that they are capable of participating equally in various occupations. However, having to meet with stigma in an environment in which the source of stigma is the one who is supposed to push boundaries for MHCUs to engage in productive occupations results in MHCUs losing self-esteem and confidence and the ability to see themselves as people who can

engage in productive occupations in the community. For some, just disclosing that they have a mental disorder could make them lose their job or limit their chances of being considered for a job. Training mental health care professionals on the quality rights of MHCUs should be a requirement. Training can be strengthened by making MHCUs on higher levels of recovery to be part of the trainers as they can better relate their experience of being stigmatised.

This study's methodology gave a voice to MHCUs and an opportunity to have their experiences, opinions, views and suggestions respected. This allowed them to contribute to the evaluation of the programme in order for the service to remain responsive. MHCUs should be given opportunities to evaluate the services they receive. Monthly evaluation meetings where MHCUs get to anonymously fill in evaluation forms can be incorporated as part of evaluation strategies.

Lastly, there is a pertinent need to finance priority areas such as the rehabilitation of MHCUs and to target development areas that include their engagement in productive occupations. Funding should be directed towards ensuring there are adequate tools and equipment for MHCUs to engage in their various productive occupations, allowing MHCUs to derive the most benefit from the mentioned programmes. Additionally, facilitating the expansion of the programmes so that MHCUs can derive the maximum benefit from the programme and the giving of meaningful rewards or incentives for work done in the programme.

5.6 CONCLUSION

The study aimed to explore the experiences of MHCUs attending an occupational therapy productive occupations programme. Overall, the findings yielded insightful information on the value of incorporating the experiences of MHCUs into the planning, development and evaluation of occupational therapy programmes together with the value of the impact of life circumstances. Additionally, the findings pointed to the benefits of engagement in productive occupations for MHCUs regardless of the context they find themselves in.

Incorporating the experiences, views and opinions of MHCUs means respecting their choices and upholding the person-centred approach. MHCUs are people who can make

a meaningful contribution to the mental health team. The valuable input from MHCUs in this study is crucial as this forms a basis on which mental health programmes, such as the occupational therapy productive occupations programme, can be evaluated and strengthened.

Life circumstances may act as an advantage or a disadvantage in the outcome of the health and wellness of an individual. Social determinants such as education, poverty, and employment status can ultimately affect the ability of an individual to engage in productive occupations. This study showed that is necessary to make key changes, such as offering support and development opportunities for MHCUs who would have been disadvantaged as a result of previous life circumstances, to support their engagement in productive occupations.

In conclusion, engagement in productive occupations was rewarding to the participants and is associated with profound benefits that contribute to their recovery, health and wellbeing.

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APPENDICES

Appendix A: Productive occupations offered in the occupational therapy department

	Arts and crafts	Gardening/animal husbandry	Shoe repairs and equipment repair	Barbershop	Tuck-shop	Café
Occupational therapy department 1	*	*				*
Occupational therapy department 2				*	*	
Occupational therapy department 3	*	*				
Occupational therapy department 4			*			
Occupational therapy department 5		*				

Appendix B: Brief mental status exam checklist

Brief Mental Status Exam Checklist

<table>
<tr><td>1. Appearance</td><td colspan="2">casual dress, normal grooming and hygiene
other (describe):</td></tr>
<tr><td>2. Attitude</td><td colspan="2">calm and cooperative
other (describe):</td></tr>
<tr><td>3. Behaviour</td><td colspan="2">no unusual movements or psychomotor changes
other (describe):</td></tr>
<tr><td>4. Speech</td><td colspan="2">normal rate/tone/volume w/out pressure
other (describe):</td></tr>
<tr><td>5. Affect</td><td colspan="2">reactive and mood congruent normal range
labile depressed
tearful constricted
blunted flat
other (describe):</td></tr>
<tr><td>6. Mood</td><td colspan="2">Euthymic anxious
irritable depressed
elevated
other (describe):</td></tr>
<tr><td>7. Thought Processes</td><td colspan="2">goal-directed and logical Disorganised
other (describe):</td></tr>
<tr><td rowspan="2">8. Thought Content</td><td>Suicidal ideation:
None active passive
If active: yes no
Plan
Intent
Means</td><td>Homicidal ideation:
None active passive
If active: yes no
Plan
Intent
Means</td></tr>
<tr><td colspan="2">Phobias
Delusions
Compulsions and obsessions
other (describe):</td></tr>
<tr><td>9. Perception</td><td colspan="2">no hallucinations or delusions during interview
other (describe):</td></tr>
<tr><td>10. Orientation</td><td colspan="2">Oriented: time place person self
other (describe):</td></tr>
<tr><td>11. Memory/ Concentration</td><td colspan="2">Short term intact Long-term intact
other (describe): distractible/ inattentive</td></tr>
<tr><td>12. Insight/Judgement</td><td colspan="2">Good fair poor</td></tr>
</table>

Appendix C: Demographic questionnaire

Patients' ID ……

Age ……

Gender ……

Marital status ……

Diagnosis ……

Date of Admission ……

Number of Admissions……

Level of Education ……

Address (only location and city)

……

Which work related activities were you engaging in before admission?

……

……

……

……

What are your interests and preferences regarding work?

……

……

……

What work activities would you like to engage in after discharge?

……

……

……

Appendix D: Interview guide

1. Could you please tell me about your past activities that helped you to earn a living before you were admitted?

- What influenced your choice
- Would you have hoped to engage in something different
- To what extend did the occupation assist in meeting your survival needs

2. Could you tell me about your current work activities in the productive occupations programme?

- What was guided you into making that choice for the productive occupation you are engaging in

3. What are your experiences concerning the current productive occupations programme?

- What are the positive aspects of this programme?
- What are the negative aspects of the programme?
- What are your views on the way services are rendered
- What can be done to improve?
- What can be changed, adapted or modified?

4. To what extend is the programme meeting your needs and expectations to become a person who is able to earn a living after discharge?

5. After discharge what do you wish to do for you to earn a living?

- Is the programme helping you to do that
- In your opinion what can be done to help

Appendix E: Participant information sheet

PARTICIPANT INFORMATION SHEET

Good Day

My name is Amelia Ruth Chiringa and I am currently enrolled in the Masters of Occupational Therapy (Psychiatry) Course with the University of Witwatersrand in Johannesburg, South Africa. As part of my studies, I am expected to undertake a research project. The project is entitled “experiences of MHCUs attending a productive occupations programme”. This study aims to explore the experiences of clients who are currently part of the productive occupations programme regarding their satisfaction and the ability of this programme to meet their needs.

As a participant in the occupational therapy productive occupations programme, I am inviting you to take part in this study. Participation is entirely voluntary and even if you do agree to participate, you may subsequently withdraw at any time, without having to give a reason. You will continue to receive the same medical attention whether or not you agree to participate.

If you agree to take part in this study an interview will be done which will be approximately one and a half hours long at a convenient place and time that you and the researcher will agree to. These interviews will be recorded using a digital voice recorder. There is no risk in taking part in this exercise. There is no immediate personal benefit, but we hope your reported experiences may help to improve the treatment of future patients.

Information that you provide will be confidential and anonymous, as questions that will result in loss of anonymity will be avoided during the interview and participants will be

referred to as participant 1….up to 10. The institution's name will be identifiable in the final research report and the department will only be referred to as the occupational therapy department. During this process, all information will be kept between the student and their supervisor. Upon completion, the results will be available on request.

Researcher	Supervisor
Chiringa Amelia Ruth (+263774333032)	Olindah Silaule (+27 11 717 3701)
Ingutsheni Central Hospital	Witwatersrand University
Zimbabwe	South Africa

Appendix F: Participant consent sheet

PARTICIPANT CONSENT SHEET

Experiences of mental health care users attending an occupational therapy productive occupations programme

1. I have been given the Participants information sheet which explains the processes and nature of this study.

2. I have been given enough time to read and I have understood the contents therein in the language that I understand.

3. I have been given time to ask questions that I wanted to ask and the answers I received were reasonable and satisfactory.

I believe I fully understand why the research is being done and what the intended outcomes are.

4. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time.

5. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained.

6. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study I am free to speak to any of these contacts.

Contact details:

Amelia Chiringa, Principal Investigator, telephone no. +263774333032, or by e-mail at chiringaamelia@gmail.com,

Olindah Silaule, Supervisor, on telephone no. +27 11 717 3701, or by e-mail at olindah.silaule@wits.ac.za

Professor C.B. Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.

Ms. Z Ndlovu or Mr. Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of Participant: _____

Date: _____

Place: _____

Signature or mark _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Appendix G: Participant consent sheet for audio recording

PARTICIPANT CONSENT SHEET FOR AUDIO RECORDING

Experiences of mental health care users attending an occupational therapy productive occupations programme

I hereby consent to audio recording of the interview,

I understand that:

- The recording will be stored in a personal computer protected by a password protected with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed,
- The recordings will be erased within either:

(a) two (2) years of the publication of the research findings, or

(b) six (6) years, if no publications arise from this research

- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg and Medical Research Council of Zimbabwe
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Name of Participant: _____

Date: _____

Place: _____

Signature or mark _____

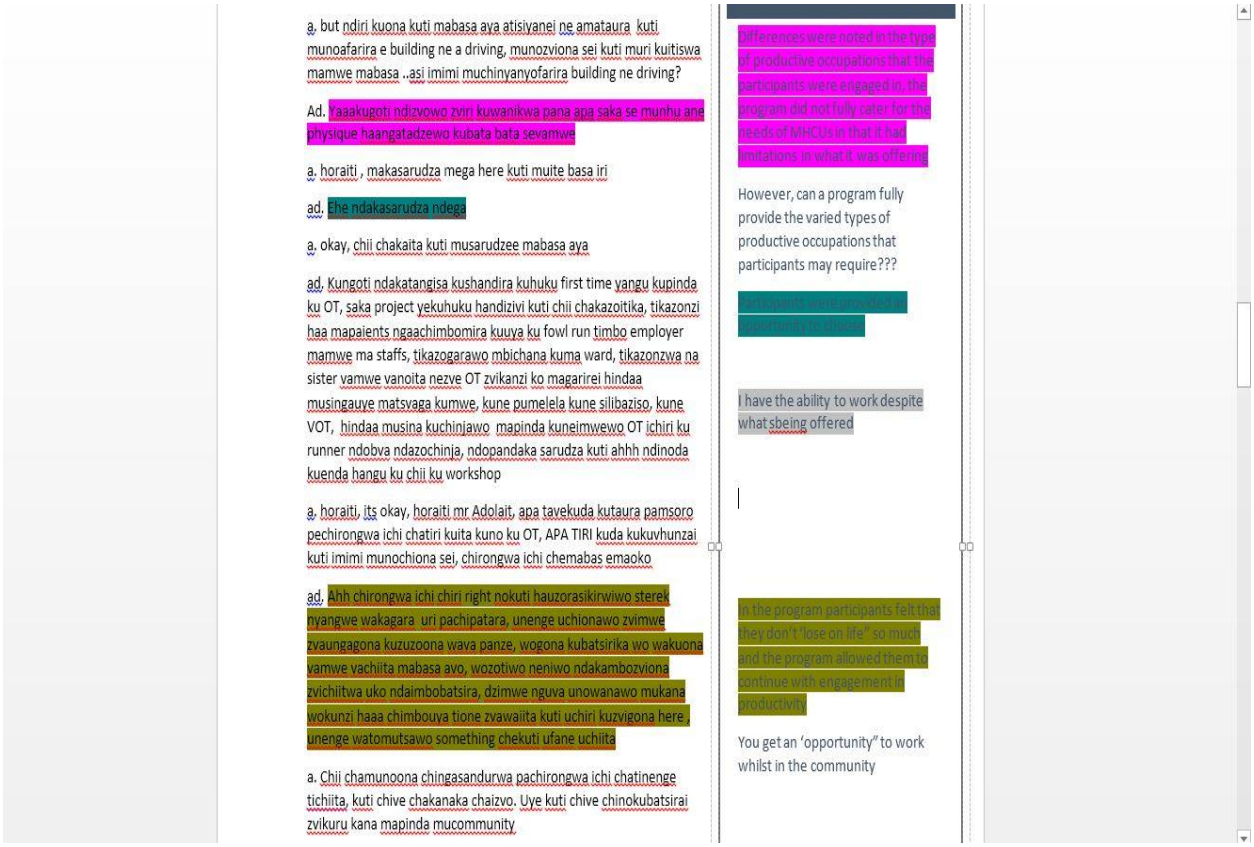
Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Appendix H: Rough note-taking on transcribed data



a. but ndiri kuona kuti mabasa aya atisiyanei ne amataura kuti munoafarira e building ne a driving, munozviona sei kuti muri kuitiswa mamwe mabasa ..asi imimi muchinyanyofarira building ne driving?

Ad. Yaaakugoti ndizvowo zviri kuwanikwa pana apa saka se munhu ane physique haangatadzewo kubata bata sevamwe

a. horaiti , makasarudza mega here kuti muite basa iri

ad. Ehe ndakasarudza ndega

a. okay, chii chakaita kuti musarudzee mabasa aya

ad. Kungoti ndakatangisa kushandira kuhuku first time yangu kupinda ku OT, saka project yekuhuku handizivi kuti chii chakazoitika, tikazonzi haa mapaients ngaachimbomira kuuya ku fowl run timbo employer mamwe ma staffs, tikazogarawo mbichana kuma ward, tikazonzwa na sister vamwe vanoita nezve OT zvikanzi ko magarirei hindaa musingauye matsvaga kumwe, kune pumelela kune silibaziso, kune VOT, hindaa musina kuchinjawo mapinda kuneimwewo OT ichiri ku runner ndobva ndazochinja, ndopandaka sarudza kuti ahhh ndinoda kuenda hangu ku chii ku workshop

a. horaiti, its okay, horaiti mr Adolait, apa tavekuda kutaura pamsoro pechirongwa ichi chatiri kuita kuno ku OT, APA TIRI kuda kukuvhunzai kuti imimi munochiona sei, chirongwa ichi chemabas emaoko

ad. Ahh chirongwa ichi chiri right nokuti hauzorasikirwiwo sterek nyangwe wakagara uri pachipatara, unenge uchionawo zvimwe zvaungagona kuzuzoona wava panze, wogona kubatsirika wo wakuona vamwe vachiita mabasa avo, wozotiwo neniwo ndakambozviona zvichiitwa uko ndaimbobatsira, dzimwe nguva unowanawo mukana wokunzi haaa chimbouya tione zvawaiita kuti uchiri kuzvigona here , unenge watomutsawo something chekuti ufane uchiita

a. Chii chamunoona chingasandurwa pachirongwa ichi chatinenge tichiita, kuti chive chakanaka chaizvo. Uye kuti chive chinokubatsirai zvikuru kana mapinda mucommunity

Differences were noted in the type of productive occupations that the participants were engaged in, the program did not fully cater for the needs of MHCUs in that it had limitations in what it was offering

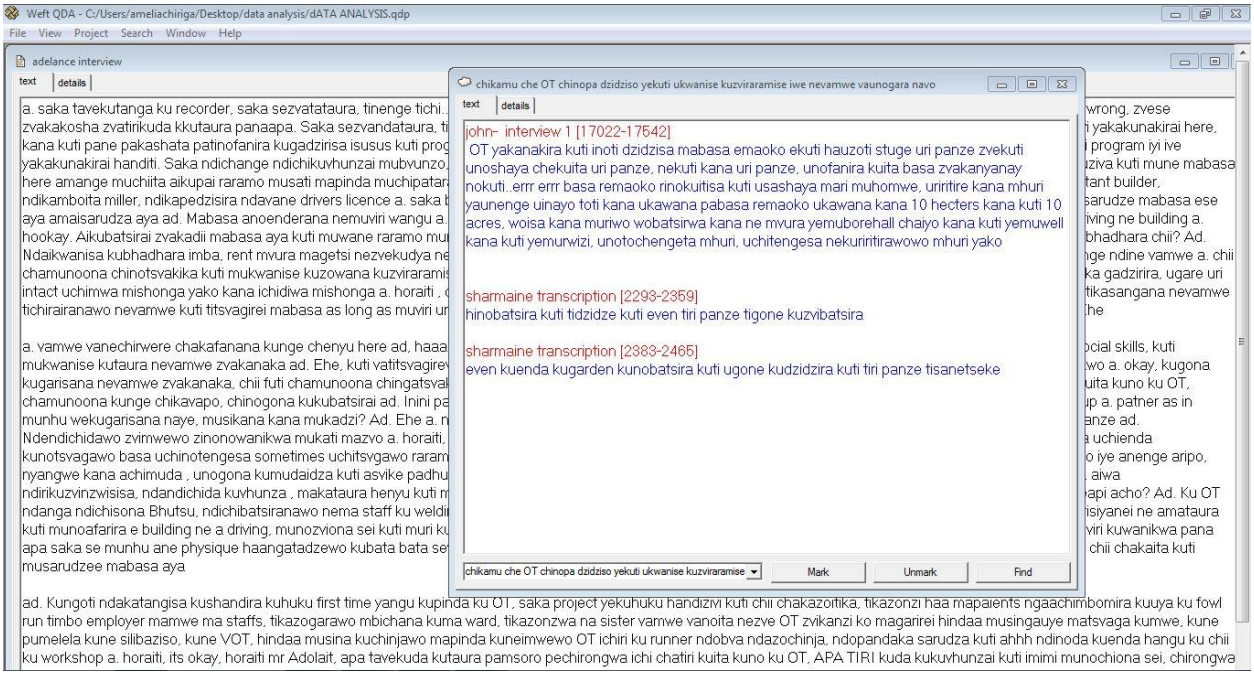
However, can a program fully provide the varied types of productive occupations that participants may require???

I have the ability to work despite what sbeing offered

In the program participants felt that they don't "lose on life" so much and the program allowed them to continue with engagement in productivity

You get an 'opportunity" to work whilst in the community

Appendix I: Open coding in Weft QDA



Appendix J: Back translation of condensed meaning units

Condensed meaning units	English translation	Back translation
Kunyanya kufarira basa randaiita rekurima ndisati ndapinda muchipatara	Interest in farming which I used to do before hospitalisation	Zvekurima zvandaifarira ndisati ndapinda muchipatara
Kuwana mari yekupota uchitenga zvikwanisiro zvinombopota zvichishaikwa pachipatara	Getting money to essentials which are sometimes not available in the hospital	Kuwana mari yekutenga zvakakosha zvekushandisa zvinokwanisa kunge zvisimo muchipatara
Chikamu che OT [occupational therapist] chinobatsira kuti kupera kwemwedzi unowanawo mari	The OT programme helps in that at the end of the month you get some money	Mabasa eku OT anobatsira kuti pakupera kwemwedzi unowana mari
Unowana dzidziso yekuti panze pechipatara pakambomitra sei uye vanhu varikurarama sei	You learn about what is currently happening outside the hospital and what people are doing to sustain themselves	Unodzidza zvirikuitika panze pechipatara ne zvirikuita vanhu kuti vazviriritire
Unowana dzidziso yekuti uzokwanisa kutanga pundutso yako wabuda muchipatara	You get information/education on how to start your own business/ livelihood project after discharge	Unowana ruzivo/ dzidziso pamusoro pekutanga mabasa ekuzviriritira mushure mukenge wabuda muchipatara
Chikamu chee OT chinopa dzidziso yekuti ukwanise kuzviraramisa iwe nevaunogara navo	The OT programme teaches us ways of sustaining ourselves and the people we live with	Mabasa e OT anotidzidzisa nzira dzekuzviriritira nevanhu vatigere navo
Chikamu che OT unodzidzira kushanda uchiri muchipatara	The OT programme teaches us to work while we are in hospital	Mabasa eku OT anotidzidzisa kushanda tiri muchipatara
Chikamu chinondipa mukana wekudzidza mabasa akasiyana	the OT programme gives me an opportunity to learn different work projects	Chikamu che OT chinondiwanisa mukana wekudzidza mabasa akasiyana siyana atingaite kuti tizozviriritira
basa reku OT rinokudzidzisawo kugeza kudya nekugona kuzviriritira iwe munhu	The work we do in the OT programme also helps us with bathing, feeding and insights us on our own personal care	Chikamu che OT chinotibatsira zve kuti tigone kuzviitira zvakafanana nekuzvigeza, kudya nekuzvichengetedza
Chikamu che OT chinopa mazano ekukwanisa kuzoita mari wabuda muchipatara	The OT programme gives me ideas on money generating projects that I can do after discharge	Chikamu che OT chinotibatsira neruzivo rwemabasa ekuwana/ekuzvitsvagira mari andingakwanisa kuita mushure mekunge ndabuda muchipatara
Chikamu che OT chinondipa kuvhurika pfungwa kumabasa akasiyana siyana anogona kuitwa nemunhu abuda panze	The OT programme opens my mind up to different livelihood opportunities that one can do after discharge	Mabasa ekuOT anovhura pfungwa dzangu kumabasa ekuzviriritira akasiyana siyana anokwanisa kuitwa nemunhu abuda muchipatara
Chikamu che OTchinobatsira kuti munhu hauzotamburi nenhamo	The OT programme helps in that you then will not suffer in poverty	Chikamu che OT chinobatsira kuti munhu usazotambura
Unowana batsiro yekuti munhu asaramba achipinda muchipatara	You get help to reduce readmission and relapses	Unowana rubatsiro/ruzivo rwekudzivirira kuramba uchidzoka muchipatara

Unowana mukana wekushanda basa usina anokutarira	You get an opportunity/chance to do your work with reduced supervision	Unowana mukana wekuita basa usina kurindirwa
Kuuya kumabasa ekuchikamu che OT kunokupa kusununguka kubva mukusungika kwe mu ward	Coming for the OT programme gives you freedom from the next to “imprisonment” feeling that is there in the ward	Kuuya ku Ot kunotisunungura kubva muhu gari hwemuward hwatinonzwa kunge hwakafanana nehwekujere
Shuviro yekuti dai mari yatinowana ku OT yati wedzerei	It is our hope/wish that the money/incentive that we get be increased	Ishuviro yedu kuti mari yatinowana ikwanise kuwedzerwa
Shuviro yekuti tiwane incentive inobatikawo kana tashanda, isiri yemari chete	It is our hope that we get a reward which is not only monetary	Tinoshuvira kuwana zvisiri mari
shuviro yekuti tiwane maorganisations anotipa support tava mucommunity kuti tigone kuwana mabasa	It is our hope that we get organisations which support us to get jobs once we are in the community	Itarisiro yedu kuti tiwane zvikamu zvinotibatsira kuti tiwane mabasa tava munharaunda dzatinogara
Shuviro yekuti ma rehabilitation technicians vawane dzidziso yekubata varwere vepfungwa zvakanaka	We wish/hope that rehabilitation technicians get help in handling mental health patients	Tinotarisirs kuti marehabilitation technician akwanise kunatsurudza mashandiro avanoita nevarwere vepfungwa
Shuviro yekuti kuchikamu che OT ndiitewo mabasa andaiita ndisati ndapinda muchipatara	It is my hope/wish that I do work activities in the OT programme, that I used to do before I was admitted	Itarisiro yangu yekuti ku OT ndikwanise kuita mabasa andaiita ndisati ndapinda muchipatara
Kusawana mukana wakakwana wekupiwa sarudzo pamabasa	I did not get enough opportunity/options to be able to choose among the available projects	Handina kuwana mukana wakakwana wekuti ndisarudze zvandinoda kuita pamabasa akanga aripo
Chikamu che OT handina kupiwa sarudzo yekuti mabasa aripo ndeapi kuti andibatsire kuita sarudzo yebasa randingada kuita	In the OT programme I was not given an opportunity to choose among the projects which were there to help me in making a choice regarding which work project I wanted to do	Handina kupiwa mukana wekuita sarudzo yebasa randaida kuita pamabasa akanga aripo
Shuviro yekuti dei tawana hembe dzekushandisa pamabasa atinoita dzakafanira	It is my hope/wish that we get suitable clothing to use as we engage in the work projects	Tinoshuwira kuwana zvipfeko/nhumbi dzebasa dzakafanirana nebasa
Shuviro yekuti chikamu chemabasa chiwedzere kukura kubva pachiyero chidiki chichienda pachiyero chihombe	We wish/hope that the OT programme as a whole increase from a small scale to a large scale project	Tinoshuwira kuti mabasa e OT awedzere kukura kubva pachiyero chidiki zvichienda pachiyero chikuru
Shuviro yekuti nguva yatinotora tiri kuchikamu che OT ive inowedzera	We wish/hope that the time we spend in the OT programme be increased	Tinoshuwira kuti nguwa yatinoshanda tiri ku OT iwedzerwa
Shuviro yekuti zvinoshandiswa pamabasa emaoko zvive zvakakwana	We wish/hope that we have adequate tools and materials to use	Tinoshuwira kuva nezvekushandisa kumabasa atinonga tichiita zvakakwana
Shuviro yekuti mabasa atirikuita ku Ot ava anovandudzwa	It is our hope/wish that the work that we do at OT diversify	Ishuwiro yedu kuti mabasa eku OT ave anowedzeredzwa ave akasiyana siyana

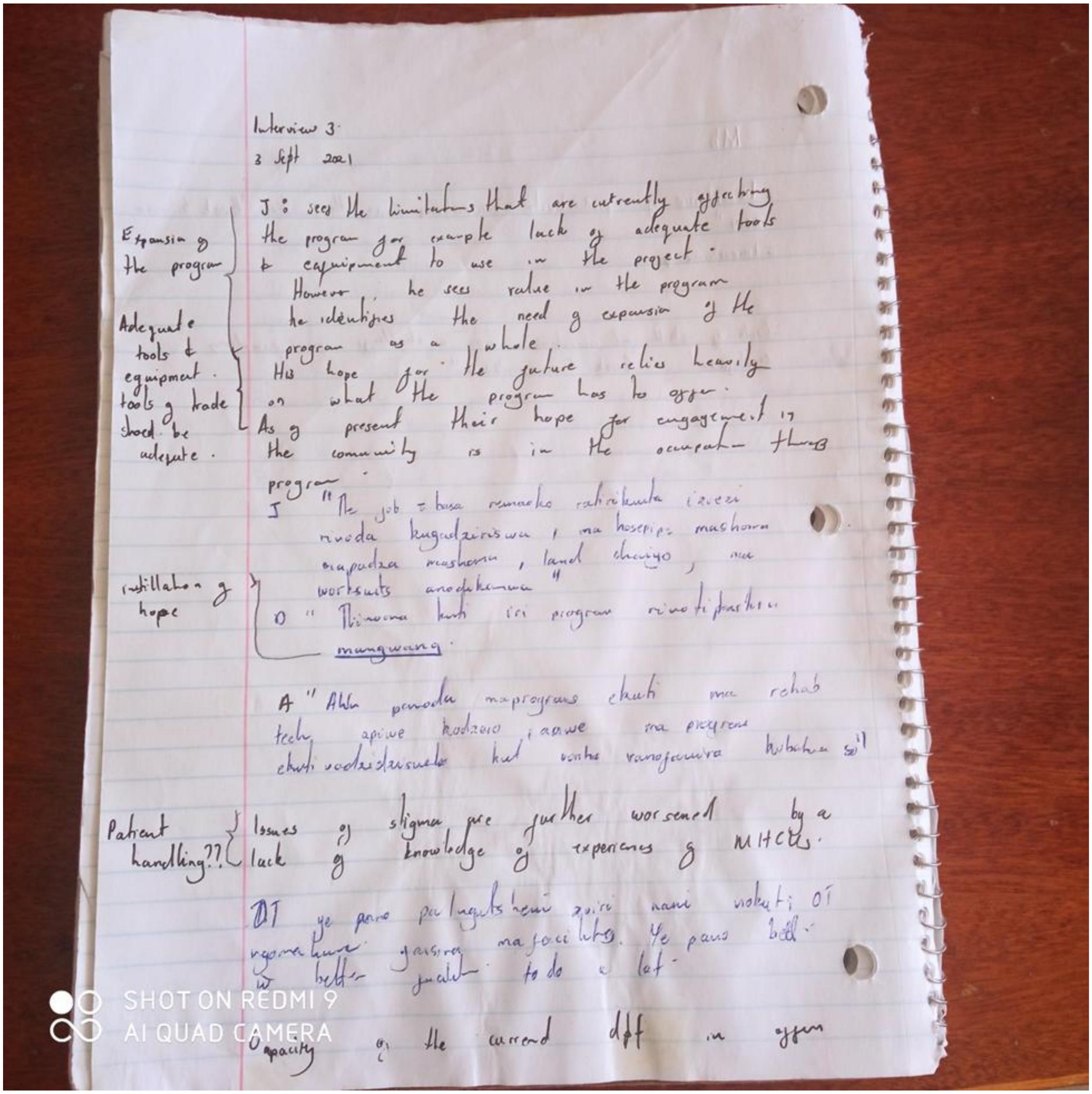
Shuviro yekuti dai mabasa anowanikwa kuchikamu che OT awedzera kusanganisira mamwe asipo	It is our hope/wish that the projects that are found in the OT programme be increased to include some which are currently not being offered	Tinotarisira kuti ku OT kuwedzerwe mamwe mabasa akasiyana nearikuitwa parizvino
Chikamu che OT chinondipa kuronga zvinhu zvandichaita nezuva	The OT programme allows me to plan my daily activities	Chikamu che OT chinondibatsira kuti ndikwanise kuronga zvandinoda kuita pazuva
Nguva yatinopinda muchikamu yakatinakira	The time we start our work projects is good	Nguva dzatinotanga mabasa kuchikamu che OT dzakafanira
Basa randinoita kuchikamu rinondipa utano pamuviri	The work that I do at OT contributes to good health to my body	Mabasa atinoita kuOT anoita kuti tive nehutano
Chikamu che OT chinokupa kuvhurika pfungwa kumabasa akasiyana siyana anogona kuitwa nemunhu abuda muchipatara	The OT programme opens my mind up to different livelihood projects that one can do after discharge	Chikamu cheOT chinovhura pfungwa dzangu mukuona mabasa akasiyana siyana ekuzviriritira angaitwe mushure mekunge wabuda muchipatara
Sarudzo yebasa raiitwa munhu asati apinda muchipatara rakasarudzwa nezvaiitika munharaunda	The choice of job/work one was doing before admission was determined by what was happening within the community	Sarudzo yemabasa yaiitwa nemunhu asati apinda muchipatara yaifambirana nezvaiitwa munharaunda
Basa ratinoita rinoenderana nezvatinokwanisa kuita	The work that we do matches our abilities/skills	Mabasa atinoita anoenderana nezvatinokwanisa
Basa randinoita kuchikamu che OT rinondipa utano pamuviri	The work that I do at OT contributes to good health to my body	Mabasa atinoita kuOT anoita kuti tive nehutano
Kuuya kumabasa ekuchikamu che OT kunokupa kusununguka kubva mukusungika kwe mu ward	Coming for the OT programme gives you freedom from the next to “imprisonment” feeling that is there in the ward	Kuuya ku Ot kunotisunungura kubva muhu gari hwemuward hwatinonzwa kunge hwakafanana nehwekujere
Kuuya kuchikamu che OT kunondibatsira nokuti handizofunganyi zvakanyanya	Coming to the OT programme helps me in that I do not excessively worry	Kuenda ku OT kunoderedza kufunganya
Chikamu chemabasa atinoita chinondipa kuti ndinziwo ndiri munhu pane vamwe vanhu	The OT programme gives me the feeling of being considered a human being among others	Chikamu che OT chinoita kuti ndivewo munhu pane vamwe vanhu
Unowana mukana wekuwna chekuita uchiri muchipatara	You get an opportunity to engage in doing while in hospital	Unowana mukana wekuwana zvekuita uchiri muchipatara
Chikamu chemabasa chinobatsira kuti tisaswera takavata kuma ward pasina zvatinoita	The OT programme helps me not to spend the whole day sleeping in the ward doing nothing	Chikamu che OT chinondibatsira kuti ndisapedze zuwa ndakarara pasina zvandirikuita
Basa randinoita kuchikamu che OT rinobatsira kuti ndigare ndakasimba pamuviri	The work that I do in the OT programme keeps me in good health	Chikamu che OT chinoita kuti ndigare ndaakasimba pamuviri
Chirongwa chemabasa chakanakira kuti haurasikirwe nezvirikuitika panze pechipatara kunyangwe uchiri muchipatara	The OT programme is good because you get a glimpse of what is happening within communities while still admitted	Chikamu che OT chinondibatsira kuti ndizive zvirikuitika kunze kunyange ndichiri muchipatar
Mari yatinowana ku OT inotikurudzira pakushanda kwedu	The money that we get at OT motivates us when we work	Mari yatinowana tiri ku OT inoita kuti tinzwe kuda kushanda

Sarudzo yebasa kuchikamu che OT yakaitwa kuburikidza nekufarira basa iroro	The choice of work activities in the programme was chosen as a result of an interest in that particular work activity	Sarudzo yebasa yakaitwa maererano nekufarira kwandinoita mhando yebasa
Basa randaimboita ndaikwanisa kuzviriritira naro	I used to sustain myself with the work that I was doing	Ndaizviriritira nebasa randaiita
Basa randaimboita raindipa kuvhurika pfungwa	The work that I used to do opened up my mind	Basa randaiita rakavhura pfungwa dzangu
Basa raiitwa munhu astai apinda uchipatara raibatsira kuwana raramo yakakwana	The work I was doing before I was admitted helped me to adequately sustain myself	Basa randaiita ndistai ndapinda muchipatara rakabatsira kuti ndive neupenyu huri nani
Basa randirikuita ku OT rakafanana nebasa randaimboita ndisati ndapinda muchipatara	The work that I am doing at OT is the same work that I used to do before I was admitted	Basa randiri kuita ku OT rakafanana nerandaiita ndisati ndapinda muchipatara
Basa randirikuita ku OT ndinorifarira nokuti ndairiita ndisati ndapinda muchipatara	I enjoy/ have interest in the work that I do at OT because I used to do it before hospitalisation	Ndinofarira basa randirikuita ku OT nokuti ndaiiriita ndisati ndapinda muchipatara
Takagara pasi tikaonesana pamsoro pemabasa ataikwanisa kuzoita kuchikamu	We sat down and collaborated/discussed on the work that we wanted to do in the OT programme	Takagara pasi tikaonesana pamsoro pemabasa ataida kuti tiite kuchikamu che OT
Basa rekuchikamu che OT rakanaka kana zvinhu zvichifamba	The work that we do is good if things move according to the intended plan	Basa ratinoita rakanaka kana zvinhu zvikagfamba maererano neurongwa
Shuviro yekuti chikamu chemabasa chive chinobatana nevepanze pechipatara kuti zvinotengeswa zvitengwe nechiero chakakwirira	it is my wish/hope that the OT programme form ties with the community outside the hospital to increase the market so that sales also increase	Ishuviro yangu kuti chikamu che OT chibatane nenharaunda panze pechipatara kuti pawedzerwe vanhu vanokwanisa kutenga
Shuviro yekuti tinoita mabasa emaoko tiri panze pechipatara		
Shuviro yekuti chikamu chindibatsire kutangisa pundutso munharaunda	It is my hope/wish that the OT programme helps me to start my own livelihood project in the community	Ishuviro yangu kuti chikamu che OT chindibatsire kutanga bhindauko ringandipa pundutso munharaunda
Shuviro yekuti chikamu che OT chitibatsire kuti t enderere mberi tizonokwanisa kutangisa dzedu munharaunda	It is my hope, my wish that the OT programme helps us to go on further so that we are able to start our own livelihood projects within the community	Ishuviro yedu kuti tienderere mberi tinoita mabab emaoko tabuda muchipatara
Chikamu che OTchinotipa tariro yemangwana akajeka	The OT programme gives me hope for a brighter tomorrow	Chikamu che OT chinotibatsira kuti tive ne tariro muupenyu
shUviro yekuti tiwane maorganisations anotipa support tava mcommunity kuti tigone kuwana mabasa	It is my hope/wish that we get organisations within the community that give us support in the community so that we can be able to access jobs	Ishuviro yekuwana zvikamu zviri kunze kwechipatara zvinotibatsira kuwana mabasa mushure mekunge tabuda muchipatara
Basa rekuchikamu parizvino harina batsiro yairi kutipa to bridge the gap ye unemployment	The OT programme as it is now has no help in helping us to bridge the unemployment gap	Parizvino, chikamu ichi hachisi kutibatsira kuti tiwane mabasa tabuda muchipatara

Zvakakosha kuti uwane kurudziro kune varimunharaunda kuti ugone kuzviraramisa	It is important that we get support from the people within the community so that you are able to sustain yourself	Zvakakosha kuti tiwane kurudziro kuvagarai vemunharaunda kuti tikwanise kuzviririrtira
Zvakatikoshera kuti tiwane batsiro yekuti tizowana mabasa tabuda muchipatara	It is important to us that we get help for us to get jobs after we leave hospital	Zvakakosha kuti tiwane batsiro yekuti tiwane mabasa tabuda muchipatara
Sarudzo yemabasa andaimboiyta yainderana nechiero chedzidzo chandakasvika	The choices I made for my previous work occupations was shaped by the level of education that I attained	Sarudzo yandakaita yemabasa yaienderarana ne chikamu chedzidzo chandakasvika
Chikamu che OT chinondipa mukana wekusangana nevamwe vanhu	The OT programme gives me an opportunity/chance to engage and socialise with others	Chikamu che OT chinondibatsira kuwadzana nevamwe
Sarudo yebasa rakaitwa kuburikidza nekuti ndirowo basa raaikwanisa kuita	The choice of work that I used to do was as a result of me being able to do that job	Sarudzo yebasa yaienderana nezvandinofarira
Sarudzo yebasa randirikuita kuchikamu rakasaudwa pamabasa iwayowo anga aripo	The choice of work that I chose in the OT programme was chosen among the available options presented to us	Sarudzo yangu pabasa randirikuita kuchikamu rakangobvawo pamabasa akange aripo
Ndakasarudza ndega basa randaida kuita kuchikamu	I chose for myself the work project I wanted to do in the OT programme	Ndakasarudza ndega basa randaida kuita kuchikamu che OT ndega
Basa randirikuita kuchikamu che OTrakafanana nebasa randichada kuzoita ndabuda muchipatara	The work that I'm doing in the OT programme is the same as the work that I would want to do after discharge from the hospital	Basa randirikuita ku OT rakafana nerandichazoda kuita ndabuda muchipatara
Dzimwe nguva tinoita mushandira pamwe pamabasa atinenge tichiita kuchikamu	At times we work together as a group/collective as we engage in the work we do within the work programme	Dzimwe nguva tinoshanda pamwechete nevamwe
Shuviro yekuti vanhu vanouya kuchikamu che OT vave vanowedzera	It is our hope/wish that the people who come for the OT programme come in their numbers	Tinoshuwira kuti vanhu vanouya ku POT vave valkawanda
Zvakakosha kuti uve nekunzwisisa urwere hwako	It is important to understand your illness	Zvakakosha kuti ndinzwisise chirwere change
Kuwana munhu wekuroorana naye zvakakosha kuti ndizovawo munhu anozvozviraramisa ndabuda muchipatara	For me getting a life partner is important to enable me to be a person who can sustain myself after discharge	Kwandiri zvakakosha kuwana munhunwekugarisana naye muhupenyu
Chirongwa hachizadzikisi zvishuwiro zvangu nokuti mabasa aripi akasiyana neangu chaiwo	The programme does not really satisfy my hopes/wishes because the work activities that are there are different from my own	Chikamu hachizadzikisi tariro yangu nokuti mabasa aripo akasiyana neangu andinoda kuzoita
Basa randiri kuita kuchikamu rakasiyana nerandinoda kuzoita ndabuda muchipatara	The work that I do in the programme is different from the work that I would want to do after discharge	Basa randirikuita kuchikamu rakasiyananerandichazoda kuita ndabuda muchipatara
Basa randirikuita kuchikamu rakasiyana nebasa randaimboita ndisati ndapinda muchipatara	The work that I do in the programme is different from the work I used to do before I was admitted	Basa randirikuita parizvino muchikamu rakasiyana nerandaimboita kudhara ndisati ndapinda muchipatara

shuviro yekuti ndiitewo mabasa ari formal asi kurwara ndiko kwakaita ndiite abasa emaoko	It was my hope/wish to get into formal employment but the mental illness shifted my choice to livelihood work opportunities instead	Yaivewo tariro yangu kuti ndiitewo mabasa ekuti ndinokwanisa
Lockdown ichatikanganisa kuti tivewo vanhu vanozviraramisa tabuda	We for-see the effects of the lockdown disadvantaging us in becoming people who are able to sustain themselves after discharge	Tinoona kukanganisa kwe Lockdown kuti ichawedzera kukanganisa kuti tivewo vanhu vanogna kuzvibatsira tabuda muchipatara

Appendix K: Documented thoughts in research journal


Interview 3
3 Sept 2021

Expansion of the program
Adequate tools & equipment. Tools of trade should be adequate.

J: sees the limitations that are currently affecting the program for example lack of adequate tools & equipment to use in the project.
However, he sees value in the program he identifies the need of expansion of the program as a whole.
His hope for the future relies heavily on what the program has to offer.
As of present their hope for engagement in the community is in the occupation through program.

Instillation of hope

Patient handling?? Issues of stigma are further worsened by a lack of knowledge of experiences of MHCUs.

capacity of the current dpf in offer

productive occupations as compared to another. However the fact that a participant is "pointing out" that the current dpt has a better capacity. One issue is the dpt being compared has no O.Is ∴ The value that the input of occ. Therapy brings to the patient is subtly viewed by patients.

Addnl tools. There are limitations that are associated with the use in the progra

To "do" is important { It feels that the value of that a person in society does heavily relies on what they are doing as part of productive occupations. Engagement in the productive occupations is therefore seen to facilitate recovery.

Engaging in productive occ facilit recovery { challenging notions we say one should get better to be able to participate in work oriented occupations. rather - One should engage in work oriented activities to become better.

Interview 4

The value of the program in enabling MHClic to start something in the communities in which they reside.

Appendix L: Approval Human Research Ethics Committee

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

Office of the Deputy Vice-Chancellor (Research & Post Graduate Affairs)

TO: Ms AR Chiringa
School of Therapeutic Sciences
Department of Occupational Therapy
Medical School
University

E-mail: chiringaamelia@gmail.com

CC: Supervisor: Ms O Silaule <Olindah.Silaule@wits.ac.za>
and <HREC-Medical.ResearchOffice@wits.ac.za>

FROM: Iain Burns
Human Research Ethics Committee (Medical)
Tel: 011 717 1252

E-mail: Iain.Burns@wits.ac.za

DATE: 2020/01/29

REF: *R14/49*

PROTOCOL NO: **M190946** *(This is your ethics application study reference number. Please quote this reference number in all correspondence relating to this study)*

PROJECT TITLE: *Experiences of mental health care users attending an occupational therapy productive occupations programme at Ingutsheni Central Hospital in Zimbabwe*

Please find attached the Clearance Certificate for the above project. I hope it goes well and that an article in a recognized publication comes out of it. This will reflect well on your professional standing and contribute to the Government funding of the University.

MSWorks2000/Iain0007/Clearscan.wps

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Ms AR Chiringa

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M190946

NAME: (Principal Investigator)	Ms AR Chiringa
DEPARTMENT:	School of Therapeutic Sciences Department of Occupational Therapy Medical School University
PROJECT TITLE:	Experiences of mental health care users attending an occupational therapy productive occupations programme at Ingutsheni Central Hospital in Zimbabwe
DATE CONSIDERED:	2019/09/27
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Ms O Silaule
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	2020/01/29

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the 3rd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to submit details to the Committee. I **agree to submit a yearly progress report**. When a funder requires annual re-certification, the application date will be one year after the date whon the study was initially reviewed. In this case, the study was initially reviewed in **September** and will therefore reports and re-certification will be due early in the month of **September** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature _____ Date _____

PLEASE QUOTE THE CLEARANCE CERTIFICATE NUMBER IN ALL ENQUIRIES

Appendix M: Approval Medical Research Ethics Council Zimbabwe

Telephone 791792/791193
Telefax (263) - 242 - 790715
E-mail mrcz@mrcz.org.zw
Website http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazowe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

MRCZ/B/1849 **06 January, 2020**

Amelia Ruth Chiringa
Ingutsheni Central Hospital
23rd Avenue Corner Birmingham Road
Belmont
Bulawayo

RE: - Experiences of mental health care users attending an occupational therapy productive occupations program

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review: -

1. Completed MRCZ 101 new application form
2. Study protocol
3. Data collection tools

- **APPROVAL NUMBER** : **MRCZ/B/1849**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING** : **EXPEDITED**
- **APPROVAL DATE** : **06 January, 2020**
- **EXPIRATION DATE** : **05 January, 2021**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (0242) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.
- In addition to this approval, all clinical trials involving drugs, devices and biologics (including other studies focusing on registered drugs) require approval of Medicines Control Authority of Zimbabwe (MCAZ) before commencement.

Yours Faithfully

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
20[illegible]-01-06
APPROVED
P.O. BOX CY 573 CAUSEWAY HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix N: Institutional approval

Telephone: 466463 – 5/ 472420
463411-3

Telegraphic Address
"MEDICUS", Bulawayo
Fax: 473966
Telex:

ZIMBABWE

REFERENCE:

Ingutsheni Central Hospital
P.O. Box 8363
Belmont
BULAWAYO
Zimbabwe

08 November 2019

Ms Amelia Ruth Chiringa
Occupational Therapist
Ingutsheni Central Hospital

RE: REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH STUDY AT INGUTSHENI CENTRAL HOSPITAL

The above subject matter refers.

I am pleased to inform you have been granted permission to conduct your research.

Your topic is: **An investigation on the experiences of mental health care users attending an Occupational Therapy productive occupations program at Ingutsheni Central Hospital.**

Wishing you all the best in your learning endeavours.

Thank you

CLINICAL DIRECTOR
INGUTSHENI CENTRAL HOSPITAL
8 NOV 2019
P.O. BOX 8363, BELMONT
BULAWAYO, ZIMBABWE

Dr W Ranga
Clinical Director
For: CHIEF EXECUTIVE OFFICER

Appendix O: Language editing certificate

WORDPLAY EDITING
Copy Editor and Proofreader
Email: karien.hurter@gmail.com
Tel: 071 104 9484
Website: http://wordplayediting.net/

29 March 2022

To Whom It May Concern:

This letter is to confirm that *Experiences of Mental Health Care Users Attending an Occupational Therapy Productive Occupations Programme* by Amelia Ruth Chiringa was edited by a professional language practitioner. It requires further work by the author in response to my suggested edits. I cannot be held responsible for what the author does from this point onward.

Regards,

Karien Hurter