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Occupational Therapists' Perceptions of Routine Outcome Measurement Within Private Psychiatric Settings in South Africa

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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

OCCUPATIONAL THERAPISTS' PERCEPTIONS OF ROUTINE OUTCOME MEASUREMENT WITHIN PRIVATE PSYCHIATRIC SETTINGS IN SOUTH AFRICA

By

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Dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Master of Science in Occupational Therapy.

Johannesburg, 2025

Ethics Clearance Certificate Number: M221159

DECLARATION

I, Priscilla Myburgh, hereby declare that this dissertation is my original work. This submission is made in fulfilment of the requirements for the Master of Science in Occupational Therapy degree at the University of the Witwatersrand, Johannesburg. This work has not been previously submitted for any degree or examination at this university or any other institution.

Signature: 

Date: 08 – 09 – 2025

DEDICATION

I dedicate this study to my husband, whose unwavering belief in me sustained me even on the most challenging days. Your quiet strength, understanding, and humour have been the foundation on which I built this achievement.

And to my mother, whose influence and guidance have shaped who I am today. ‘All that I am or hope to be, I owe to my darling mother.’ – Abraham Lincoln"

ABSTRACT

BACKGROUND: Mental illness affects daily functioning and participation in meaningful occupations, with occupational therapists playing a key role in supporting clients through occupation-based interventions. However, occupational therapists often struggle to define their role and demonstrate effectiveness, particularly in South Africa. Routine Outcome Measurement (ROM) could be beneficial by systematically tracking client outcomes; however, its use in private psychiatric settings in South Africa is currently limited. This study aims to explore occupational therapists' perceptions on ROM implementation in South African private psychiatric settings, addressing a gap in knowledge and informing strategies to improve evidence-based mental health care.
METHODOLOGY: A descriptive qualitative study design was employed to collect data from a sample of 10 occupational therapists working in private psychiatric settings. Semi-structured interviews were conducted over the Zoom platform.
RESULTS: The study revealed four main themes, each with multiple subthemes:
1) Perceived difficulties of implementing routine outcome measurement (ROM) in clinical practice 2) Perceived value of implementing ROM within clinical practice 3) Current trends of measurement in clinical practice 4) Ways of improving the implementation of ROM in clinical practice
CONCLUSION: This study provides valuable insights into the feasibility of implementing ROM in occupational therapy within private psychiatric settings in South Africa. This research further contributes to the advancement of evidence-based practices in mental health care. Future studies should focus on how to incorporate ROM more effectively into clinical practice to ensure the sustainable uptake of ROM.

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LIST OF ABBREVIATIONS

AMPS	Assessment of Motor and Process Skills
AOTA	American Occupational Therapy Association
APOM	Activity Participation Outcome Measure
COPM	Canadian Occupational Performance Measure
EBP	Evidence-based practice
MDT	Multidisciplinary Team
MOHOST	Model of Human Occupation Screening Tool
MDD	Major depressive disorder
NHI	National Health Insurance
NMHPFSP	National Mental Health Policy Framework and Strategic Plan
POPIA	Protection of Personal Information Act
ROM	Routine Outcome Measurement

NOMENCLATURE

Activity participation	The act of engaging in action encompasses an individual's interaction with the world, originating from within oneself, as well as one's relationship with both the self and the external environment. It can also be defined as participation in life situations, occurring when individuals are actively involved in meaningful activities (Van der Reyden et al., 2019; AOTA, 2020).
Evidence-based practice	A decision-making approach that integrates the best available research evidence, clinical expertise, and client preferences to ensure the delivery of effective and high-quality care. It involves systematically reviewing and applying relevant research findings to guide interventions, improve outcomes, and enhance professional practice (Hoffmann et al, 2017).
Outcome	A quantitative and standardised evaluation of change over time, measured at multiple points across key domains of client functioning and well-being. These outcome measures support evidence-based, client-centred practice and enable practitioners to demonstrate meaningful therapeutic impact (Unsworth et al., 2011).
Outcome Measure	A tool or instrument used to assess, track, and evaluate changes in a client's health, function, or well-being resulting from an intervention. It provides objective or subjective data that helps determine the effectiveness of treatment and guide clinical decision-making (Unsworth et al, 2011).
Routine Outcome Measurement	Systematic and regular assessment of changes in a client's functioning and progress toward health goals throughout treatment (Duncan & Murray, 2012).

CHAPTER ONE: INTRODUCTION

1.1 Background of study

Mental health conditions lead to functional limitations that significantly affect the lives of those diagnosed. These limitations often manifest as psychological, emotional, and social disruptions, influencing an individual's thoughts, feelings, and behaviours (AOTA, 2020). Subsequently, individuals may require assistance to engage in desired or essential activities, making it more challenging to meet daily life expectations and fulfill societal roles (de Witt et al., 2021).

Occupational therapists play a crucial role in mental health care, focusing on meaningful daily activities to support the well-being of individuals with mental health conditions (Jafari & Grobelna, 2023). They assist clients in assuming important roles and developing routines that enhance functioning across various settings. With a client-centred approach, occupational therapists personalise interventions to meet individual needs, promoting recovery and reducing the risk of relapse (AOTA, 2020).

What sets occupational therapy apart in mental health care is its holistic approach to care. Therapists examine how mental health conditions affect daily activities and the role of the environment in facilitating participation. By addressing the link between activities, environment, and mental health, they design interventions tailored to personal goals, ultimately enhancing outcomes (Jafari & Grobelna, 2023). Through this comprehensive approach, occupational therapists improve participation in meaningful activities, overall functioning, and equip clients with vital coping strategies and life skills. This makes occupational therapy an essential component of mental health care, fostering independence, recovery, and improved quality of life (Rocamora-Montenegro et al., 2021).

Occupational therapists use evidence-based practice (EBP) to ensure their interventions are grounded in scientifically supported methods while addressing individual needs and contexts (Hoffmann et al., 2017). They combine clinical expertise, research evidence, client preferences, and contextual knowledge to guide decision-

making (Kristensen & Peterson, 2016; Hoffmann et al., 2017).

Key elements of EBP in private practice include specialised expertise in handling complex cases, staying current with research through efficient strategies, flexibility to tailor interventions based on client preferences, and awareness of contextual factors influencing practice decisions (Hoffmann et al., 2017; Jafari & Grobelna, 2023; Kristensen & Peterson, 2016). High-quality evidence is crucial for developing practice guidelines and standards that promote consistent, high-quality care in occupational therapy, while also helping occupational therapists refine and adapt interventions to achieve optimal client outcomes (Hoffmann et al., 2017). This evidence is vital for deepening the understanding of occupational therapy's impact on mental health. However, despite significant growth in mental health occupational therapy research, challenges remain in translating findings into practice.

A comprehensive review of 1,747 studies conducted between 2000 and 2013 revealed that many studies were descriptive and lacked rigorous intervention trials (Hitch et al., 2015). This review highlighted several key research gaps: occupation-focused practice, consumer perspectives on group therapy, factors that enhance engagement in daily activities, and interventions for meaningful occupations in acute inpatient units (Hitch et al., 2015; Jafari & Grobelna, 2023). Despite some progress, only 18% of intervention studies have focused on efficacy for conditions such as depression and schizophrenia (Christie et al., 2023). This limited focus on intervention efficacy indicates the need for more targeted research to build the evidence base for occupational therapy in psychiatric settings. Occupational therapists still require further rigorous studies to establish standardised outcome measures and culturally responsive practices (Hitch et al., 2015). By addressing these research gaps and overcoming implementation barriers, occupational therapists can strengthen the evidence base for their interventions, ultimately leading to improved client outcomes, enhanced professional credibility, and better resource allocation for mental health services.

In South Africa, recent reforms in mental health policy, such as the National Mental Health Policy Framework and Strategic Plan 2023-2030 (NMHPFSP),have

emphasised evidence-based practices and quality assurance in mental health care (South African National Department of Health, 2023a). These reforms align with the broader healthcare changes under the National Health Insurance (NHI) initiative, which aims to reduce disparities between public and private health systems and ensure equal access to intervention for those with mental health conditions. The NMHPFSP and NHI prioritise evidence-based practice, prompting research into evaluating the effectiveness of various interventions. They also advocate for the development of cost-effective, evidence-supported intervention models to be integrated into the NHI service delivery system, ensuring that high-quality mental health care is available to all South Africans (South African National Department of Health, 2023b).

Despite these advancements, occupational therapy in South Africa still faces considerable challenges in contributing to evidence-based practice and demonstrating its impact on mental health. These challenges stem primarily from insufficient evidence (Silaule & Casteleijn, 2021). This highlights the importance of South African occupational therapists engaging in research and actively contributing to the expansion of the evidence base in mental health occupational therapy.

Routine outcome measurement (ROM) provides occupational therapists with a valuable opportunity to generate evidence. It refers to the consistent collection of data that evaluates client outcomes through standardised tools or questionnaires (Carlier & Eeden, 2017). The data collected through ROM can include information on symptoms, functional status, and quality of life. By tracking changes in clients' functioning over time, occupational therapists gain concrete evidence of the effectiveness of their interventions (Aafjes-van Doorn et al., 2022)

Globally, the use of ROM has become increasingly recognised, with studies in the United Kingdom, the United States, Australia, and Europe demonstrating its beneficial effects on clinical monitoring, therapeutic communication, and treatment outcomes (Hitch et al., 2015; Lambert & Harmon, 2018). By enabling clinicians to make informed, data-driven decisions, ROM enhances the quality of care, supports tailored interventions, and allows progress monitoring against benchmarks (Bickman et al.,

2020). It also fosters greater client engagement, strengthens the relationship between clinicians and clients, and contributes to more effective resource allocation and quality improvement within organisations (Boswell et al., 2015). Despite these advantages, several challenges hinder the broader implementation of ROM across various settings.

Clinicians often face practical challenges, such as time constraints, which make it difficult to incorporate the administration, scoring, interpretation, and reporting of ROM into their already demanding schedules (Boswell et al., 2015; Kaiser et al., 2018). Additionally, the financial costs related to the necessary tools, technology, and staff training can be a significant barrier for many organisations (Boswell et al., 2015). Training gaps and a lack of ongoing support also prevent the effective use of ROM, leaving clinicians inadequately prepared to leverage the full potential of these tools (Edbrooke-Childs et al., 2016). Some clinicians question whether standardised measures can truly capture the complexity of mental health treatment (Hall et al., 2013; Kaiser et al., 2018), and there are concerns that ROM data could be misused for punitive performance evaluations rather than promoting improvement (Norman et al., 2014). Ethical issues related to privacy and data collection also contribute to resistance in adopting ROM (Boswell et al., 2015). Additionally, some clinicians may overestimate their ability to assess progress informally, leading them to undervalue the benefits of ROM (Hall et al., 2014).

Most studies addressing these challenges originate from high-income countries, such as the United Kingdom, the United States, and Norway. However, in South Africa, occupational therapy in mental health care faces a clear set of challenges, including resource constraints and a rural-urban divide. Public healthcare facilities, where most occupational therapists work, are often underfunded and lack essential equipment and resources needed for effective interventions (Silaule & Casteleijn, 2021). The uneven distribution of occupational therapists further complicates service delivery, with urban areas, such as Gauteng and the Western Cape, being better equipped, while rural regions, including the Eastern and Northern Cape, experience severe shortages (Ned et al.,2020).

Research on ROM in South Africa has primarily focused on public and rural healthcare settings. Studies have highlighted the development and application of the Activity Participation Outcome Measure (APOM), a contextually appropriate, occupation- based outcome measure (Casteleijn & Graham, 2012). Subsequent research has demonstrated the effectiveness of APOM, showing improvements in outcome domains during hospitalisation in rural public hospitals (Silaule & Casteleijn, 2021). However, one South African study explored correlations between group attendance and improvements in role performance, motivation, and balanced lifestyles in private settings. Despite this, a gap remains in understanding occupational therapists' perceptions of implementing ROM within private mental health facilities (Meyer et al., 2024).

1.2 Problem statement

The implementation of ROM in South African private psychiatric settings faces prominent challenges due to a lack of contextually relevant research. While studies in high-income countries, primarily in public health settings, have explored factors influencing the adoption of ROM, their findings may not be directly applicable to the South African private healthcare context (Rye et al., 2019; Oster et al., 2022). Existing South African research has primarily focused on quantitative evaluations of occupational therapy programs, offering limited insights into the perspectives of occupational therapists themselves (Silaule & Casteleijn, 2021). This lack of qualitative research has resulted in an inadequate understanding of the unique challenges, cultural factors, and barriers to ROM implementation in private psychiatric settings. Without this knowledge, it isn't easy to develop effective, contextually appropriate strategies for enhancing ROM adoption and utilisation in South Africa's mental health services.

1.3 Research question

What are the perceptions of occupational therapists regarding the implementation of routine outcome measurement in private psychiatric settings in South Africa?

1.4 Research aim

To explore the perceptions of occupational therapists on the implementation of routine outcome measurement in private psychiatric settings within South Africa

1.4.1 Objective of the study

To describe occupational therapists' perceptions of routine outcome measurement in private psychiatric settings within South Africa.

1.5 Justification of study

This study is necessary to address the critical knowledge gap regarding the implementation of ROM in South African private psychiatric settings. While global research has identified factors influencing ROM adoption, these insights do not adequately account for the cultural and systemic complexities unique to South Africa (Rye et al., 2019). Furthermore, current South African literature on ROM implementation primarily focuses on public healthcare and rural contexts (Silaule & Casteleijn, 2021), overlooking the specific challenges faced by occupational therapists in private practice. By exploring occupational therapists' perceptions, this study will provide valuable qualitative insights into the barriers and facilitators of ROM implementation. These findings can inform the development of tailored strategies to overcome implementation challenges, enhance clinical practice, and promote evidence-based care in mental health services (Carlier & Eeden, 2017). Additionally, understanding the perceptions of occupational therapists will contribute to the development of culturally relevant ROM tools and processes tailored to the South African context (Oster et al., 2022).

1.6 Significance of the study

This study has substantial implications for improving occupational therapy mental health care delivery in South Africa, particularly by exploring perceptions of ROM implementation in private psychiatric settings. By capturing these perceptions, this study will contribute to the development of tailored strategies for integrating ROM into practice. Subsequently, the study will enhance clinical practice, leading to improved

client outcomes and more efficient resource utilisation (Silaule & Casteleijn, 2021). It also seeks to promote evidence-based practice by addressing the concerns of occupational therapists and fostering buy-in through practical solutions. Furthermore, the study will contribute to the development of culturally appropriate ROM tools and processes that align with South Africa's unique healthcare landscape, ensuring relevance and effectiveness in this context (Rye et al., 2019). The findings are expected to inform evidence-based policy development, offering recommendations for creating supportive frameworks for ROM implementation in private psychiatric settings. Additionally, the study will identify training needs among occupational therapists, advancing professional development to equip them for effective ROM use (Oster et al., 2022). Through a comprehensive exploration of occupational therapists' perceptions regarding ROM, the research will optimise resource allocation and improve cost-effectiveness in mental health care. Ultimately, this will enhance client engagement by developing ROM practices that encourage participation and shared decision-making, thereby improving intervention outcomes (Silaule & Casteleijn, 2021). Overall, this research will fill a significant gap in understanding the implementation of ROM in South Africa’s private psychiatric settings, benefiting both occupational therapists and clients, while advancing occupational therapy practices.

1.7 Organisation of chapters

Chapter 1: Introduction

Chapter 1 provides a comprehensive overview of the study's background, which leads to the identification of the research problem. Additionally, the research question, objectives, and the study aim are presented. Lastly, the researcher outlines the justification and significance of the study.

Chapter 2: Literature review

Chapter 2 provides an overview of the literature on routine outcome measurement (ROM) within occupational therapy, as well as the factors influencing its implementation in practice, drawing on relevant research. It explores the value of integrating ROM into clinical practice and examines the challenges faced by occupational therapists in psychiatric settings, supported by contextually relevant

literature.

Chapter 3: Methodology

Chapter 3 outlines the study design and research methodology, including sample selection, data collection instruments, and research procedures. It also describes the data analysis method and process, as well as the quality control measures implemented throughout the study. The chapter concludes with a discussion of the ethical considerations involved in the research.

Chapter 4: Results and discussion

Chapter 4 presents the research findings and an in-depth discussion of these findings, contextualising them within the framework of existing literature. Key themes are highlighted, with a focus on the specific context of the study and its implications.

Chapter 5: Conclusion

Chapter 5 highlights the study's limitations, provides an evaluation, offers recommendations, and presents the conclusion. It emphasises the study's key outcomes and their relevance within the given context.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This review aims to enhance understanding of the intersection between occupational therapy, mental health care, and outcome measurement in South Africa by synthesising existing literature and identifying gaps in knowledge. The chapter begins with an overview of the state of mental health in South Africa and mental health service delivery, followed by an exploration of the unique contributions of occupational therapy, particularly its role in promoting mental well-being. Furthermore, the review highlights the significance of evidence-based practices in ensuring high-quality care, emphasising the need for standardised and effective outcome measures to support clinical decision-making and service delivery.

The concept of routine outcome measurement (ROM) is then examined, highlighting its role in improving mental health clinical practice and the challenges associated with its implementation. The literature review further discusses the outcome measures currently used by occupational therapists in psychiatric settings, evaluating their relevance and applicability within the South African context. This is followed by an exploration of strategies to facilitate the adoption and effectiveness of ROM in clinical practice.

To ensure a comprehensive review, literature was sourced from databases such as PubMed, CINAHL, Google Scholar, the Cochrane Database of Systematic Reviews, and the American Journal of Occupational Therapy (AJOT). Recognising the limitations of existing research, grey literature was also incorporated to provide a broader perspective on the topic.

2.2 State of mental healthcare in South Africa

Recent studies (Craig et al., 2022; Mukwena & Manyisa, 2022) emphasise South Africa's substantial mental health burden, with at least one in six individuals affected (Bantjes et al., 2019). Additionally, over 40% of people living with HIV in the country also experience a diagnosable mental disorder (Pillay, 2019). Craig et al. (2022) found

that more than 25% of South Africans present with symptoms of depression, with higher prevalence rates recorded in the Northern Cape, Eastern Cape, Western Cape, Gauteng, and Mpumalanga. These findings indicate a widespread and pressing public health concern that requires targeted interventions.

Multiple factors contribute to the increasing prevalence of mental illness in South Africa, including adverse childhood experiences, socio-economic status, race, geographic location, age, marital status, and education levels (Pillay, 2019). Socio-economic disparities play a fundamental role, as Elwell-Sutton et al. (2017) established a correlation between lower socio-economic status and an increased risk of mental disorders. These findings demonstrate the social determinants in shaping mental health outcomes, suggesting that economic hardship exacerbates psychological distress and limits access to adequate care.

Stigma remains an obstacle to mental health treatment and support. Cultural beliefs, misconceptions, and a general lack of awareness contribute to the stigmatisation of mental health conditions, leading to social exclusion and discrimination (Craig et al., 2022). This stigma hampers help-seeking behaviour, thereby widening the treatment gap. Pillay (2019) reports that only approximately a quarter of individuals with mental health conditions receive treatment, leaving the majority without essential care. Addressing stigma through public education and advocacy may therefore help reduce discrimination and encourage more individuals to seek professional assistance.

The mental health crisis is further aggravated by inadequate funding for mental health services. The South African government allocates approximately 5% of its health budget to mental health, with a significant proportion directed toward inpatient care, particularly in specialised psychiatric hospitals (Docrat et al., 2019). This allocation is insufficient to meet the growing demand for mental health services, particularly at the primary healthcare and community levels (Meyer et al., 2019). Greater investment in community-based interventions could enhance early detection and treatment, ultimately leading to improved mental health outcomes.

Given the current state of mental health in South Africa, there is an urgent need for

more accessible and effective mental health services. Expanding resources and support at the primary healthcare and community levels could improve access to timely and appropriate care. Strengthening mental health infrastructure, integrating mental health services into general healthcare, and addressing socio-economic determinants are essential strategies for mitigating the country's mental health burden and ensuring more equitable healthcare access.

2.3 Mental health service delivery in South Africa

The structure of mental health services in South Africa is characterised by a division between public and private healthcare sectors, resulting in disparities in access to care. Public mental health services are designed to be affordable and widely accessible. However, they face challenges such as resource limitations, workforce shortages, and infrastructural constraints. In contrast, private mental health services generally provide higher-quality care but are limited to individuals with medical insurance or sufficient financial resources (Sorsdahl et al., 2023). This section examines the differences in public and private mental health service delivery, focusing on their implications for access to occupational therapy and the effectiveness of mental health interventions.

2.3.1 Public mental health services

In South Africa, public mental health services are delivered through multiple levels of healthcare, including primary and secondary hospitals, outpatient clinics, community health centres, and psychiatric hospitals (Sorsdahl et al., 2023). These services are designed to provide accessible and affordable mental health care, particularly for individuals who cannot afford private treatment (Meyer et al., 2019). However, despite the broad scope of public mental health services, challenges such as resource limitations, workforce shortages, and infrastructural deficits continue to impede their effectiveness.

The distribution of occupational therapists presents a challenge in ensuring equitable access to mental health care. As of 2018, there were 5,180 occupational therapists registered with the Health Professions Council of South Africa (HPCSA), equating to a ratio of 0.9 occupational therapists per 10,000 people (Ned et al., 2020). Although

the profession has experienced an annual growth rate of 7.1% between 2002 and 2018, most occupational therapists are concentrated in urbanised provinces such as Gauteng, Western Cape, and KwaZulu-Natal, leaving rural areas severely under-resourced (Ned et al., 2020) This geographic disparity worsens inequities in mental health service provision, limiting access to rehabilitation and therapeutic interventions for individuals in remote areas.

Adding to this issue is the disproportionate allocation of occupational therapists between the private and public sectors. Approximately 74.8% of occupational therapists are employed in the private sector, serving only 16% of the population, while the remaining 25.2% work in the public sector, which is responsible for 84% of the population (Ned et al., 2020). This disparity intensifies the broader issue of mental health workforce shortages, particularly in undersourced communities, where limited availability of health-care professionals results in more extended client waiting periods, reduced individualised care, and restricted access to specialised therapeutic services (Craig et al., 2022). The shortage of occupational therapists in public health settings not only affects the quality of mental health interventions but also places an increased burden on existing healthcare professionals, contributing to burnout and diminished service delivery (Mapanga et al., 2019). Addressing this imbalance requires targeted policy measures, including incentives to encourage therapists to work in underserved areas, increased investment in training programs, and improved resource distribution to enhance equitable access to care (Ned et al., 2020).

South African occupational therapists are increasingly emigrating to countries such as Canada, the United Kingdom, Australia, the United States, and Portugal, driven by factors including better salaries, improved working conditions, and greater career opportunities abroad (Pillay et al., 2019). Between January 2020 and July 2024, Canada alone issued 7,781 temporary work permits to South African residents, with approximately 600 allocated to healthcare professionals, including occupational therapists (Statista,2023). This migration trend was expected to accelerate, with around 200 healthcare professionals projected to migrate to Canada in 2024 alone. Despite the growing workforce demands in South Africa, particularly within the public

mental health sector, the country faces a net loss of occupational therapists who leave due to challenges such as low pay, limited career progression, and an uncertain healthcare landscape influenced by policies like the National Health Insurance (NHI) scheme. Conversely, South Africa experiences minimal inflow of foreign-trained occupational therapists due to stringent regulatory requirements and community service obligations that act as barriers to immigration in this profession (Health Systems Trust, 2020). This outflow exacerbates the uneven distribution and shortage of occupational therapists in underserved rural and public health sectors, limiting the capacity to deliver equitable mental health rehabilitation services across the country.

The underfunding and resource constraints within the public health sector further weaken the quality and effectiveness of mental health services. As highlighted by Docrat et al. (2019), there is a shortage of mental health professionals, including occupational therapists. Inadequate staffing levels contribute to an overburdened workforce, making it challenging to dedicate sufficient time to each client. Consequently, therapeutic interventions are often insufficient to achieve meaningful mental health outcomes. Additionally, shortages of essential psychiatric medications, particularly for individuals with chronic mental health conditions, disrupt continuity of care and hinder the management of long-term disorders (Pillay et al., 2019). Outdated infrastructure in many public health facilities exacerbates these issues. A study conducted in a public psychiatric facility in Limpopo demonstrated that facilities are ill-equipped to meet the growing demand for mental health services, with inadequate therapeutic resources limiting the scope of occupational therapy interventions (Ghela et al., 2022). These systemic constraints also hinder the implementation of standardised outcome measurement tools, making it challenging to track client progress and evaluate the efficacy of treatments (Silaule & Casteleijn, 2021). The lack of routine outcome measurement procedures restricts the ability to refine therapeutic approaches, potentially resulting in ineffective treatment. Overall, workforce shortages, underfunding, and infrastructural deficiencies not only degrade service quality but also obstruct the ability to accurately assess and improve mental health interventions in the public sector.

The Mental Health Care Act of 2002 and the National Mental Health Policy Framework

and Strategic Plan 2023-2030 (NMHPFSP) are key steps taken by the South African government to improve mental health services (South African National Department of Health, 2023a). These policies focus on providing comprehensive care while protecting the rights of individuals with mental illnesses, with an emphasis on making services accessible to all South Africans (South African National Department of Health, 2023a). The introduction of the National Health Insurance (NHI) in 2019, which became law in 2024, aims to provide universal health coverage, including mental health services, to address disparities between private and public healthcare systems (South African National Department of Health, 2023b).

However, barriers remain despite these efforts. While the NHI is intended to reduce inequalities between private and public healthcare, its success is uncertain. A study conducted by Mukwena and Manyisa (2022) highlighted concerns related to administrative inefficiencies, corruption, and governance problems that could hinder the implementation of universal coverage. These concerns may hinder the NHI from achieving its goal of providing equal access to mental health services, potentially exacerbating existing care gaps. Therefore, while these policy measures have laid the foundation for reform, their success will depend on addressing these ongoing systemic issues.

2.3.2 Private mental health services

Approximately 16% of South Africa's population, roughly 10 million people, have private medical insurance, predominantly comprising formal sector employees and, in some cases, their dependents. The remaining 84% rely on public healthcare services (Mayosi & Benatar, 2014). Despite representing a small minority, the insured population consumes a disproportionate share of healthcare resources. Estimates suggest that while per capita spending in the private sector amounts to roughly R27,000 at current exchange rates, public sector per-user spending is approximately R2,700 to R5,200 This disparity exemplifies the 80/20 Pareto principle in South African healthcare, underscoring stark inequities in resource distribution (Statista, 2023).

Private mental health services, including care provided by practitioners, clinics, and

hospitals, are widely regarded as superior, offering shorter waiting times, access to more specialised professionals, and better facilities (Szabo & Kaliski, 2017). Nevertheless, these services remain prohibitively expensive, accessible primarily to those with insurance or sufficient financial means. Consequently, wealthier individuals benefit from faster and more specialised care, while economically disadvantaged populations face limited access to often overburdened public sector services (Meyer et al., 2019). This entrenched imbalance exacerbates existing inequalities within South Africa's healthcare system.

One of the challenges within South Africa's private healthcare system is the limited coverage for mental health services, including occupational therapy, under medical insurance plans. Mental health conditions are often given less priority compared to physical health conditions within these plans (Affinity Health, 2024). Many medical insurance plans offer minimal coverage for mental health treatment, including conditions like anxiety, depression, and substance use disorders (Craig et al., 2022). Coverage for occupational therapy is often restricted, limiting access to certain professionals or treatment options. Therapy sessions are typically limited, making it challenging to achieve long-term therapeutic progress (Key Health Medical, 2024). Individuals requiring ongoing care may need to utilize their Medical Savings Accounts, which can add further financial pressure (Affinity Health, 2024; Shisana et al., 2024). Despite the inclusion of Prescribed Minimum Benefits, which mandate coverage for mental health conditions, the limited funding available results in occupational therapy being underfunded or neglected in many medical insurance schemes.

This gap between policy and actual insurance coverage highlights a significant issue in service delivery. A factor contributing to this is the lack of solid evidence on the effectiveness of occupational therapy in South Africa's mental health system (Silaule & Casteleijn, 2021). Masango et al. (2024) note that the lack of rigorous research makes it difficult to secure necessary funding. Their review recommends a greater emphasis on evidence-based practice, particularly in mental health, to demonstrate the cost-effectiveness and clinical value of occupational therapy interventions. The lack of strong evidence undermines the profession's ability to secure expanded coverage and

formal recognition within the broader healthcare system. Closing this research gap is crucial for securing greater institutional support and enhancing access to occupational therapy services, ultimately leading to improved mental health outcomes in South Africa.

Addressing these systemic challenges in South Africa's mental health care system is essential to improving the overall mental health of the population. Key actions include ensuring equitable access to quality care, increasing the number of mental health professionals, and reducing the stigma surrounding mental health (Gumede, 2021). The success of initiatives such as the National Health Insurance (NHI) and reforms to medical insurance coverage will be essential to achieving universal access to mental health services and addressing the high burden of mental illness in the country (Mukwena & Manyisa, 2022). The NHI White Paper stresses the importance of using evidence-based, cost-effective strategies in shaping the future of mental health care (South African National Department of Health, 2023b). For occupational therapy to be fully integrated and covered under the NHI, practitioners must provide evidence of the effectiveness of their interventions. This will ensure that occupational therapy is recognised as an essential part of the evidence-based approach the NHI aims to implement (Jejelaye et al., 2019). Generating and presenting legitimate evidence on the impact of occupational therapy is critical not only for improving client outcomes but also for securing broader institutional support and funding for these services.

2.4 Occupational therapy in mental health

The core principle of occupational therapy is that humans are inherently occupational beings, and their health and well-being depend on their participation in meaningful and purposeful activities (Cruz et al., 2023). This principle has evolved from simple activity-based interventions to comprehensive, evidence-based approaches that address complex mental health needs. Occupational therapists in psychiatric settings focus on promoting functional independence, enhancing quality of life, and facilitating community integration through meaningful occupational engagement (Masango et al, 2024).

International and South African studies demonstrate the effectiveness of occupational therapy in mental health care. In the context of global literature, Daaleman et al. (2021) showed that occupational group interventions can improve social functioning, while Christie et al. (2023) found that these interventions enhance functional outcomes and increase participation in daily activities. Other global studies, including those by Ikiugu et al. (2017), Rocamora-Montenegro et al. (2021), and Jafari and Grobelna (2023), further support the role of occupational therapy in improving client outcomes. They highlighted occupational therapy's positive impact on mental health, including improvements in social skills, alleviation of depression and anxiety symptoms, and increased engagement in meaningful activities for adults with severe mental illness. These findings confirm the value of occupational therapy in enhancing mental health and promoting overall well-being.

While the literature on the effectiveness of occupational therapy in mental health is limited, several studies from South Africa offer valuable insights. Bryant et al. (2016) demonstrated the effectiveness of two occupational therapy group programs in improving social functioning among clients with major depressive disorder (MDD), highlighting the role of occupational therapy in enhancing social skills in this population. Similarly, a study by Silaule & Casteleijn (2021) reported improvements in mood, self-esteem, and balanced lifestyle, indicating the effectiveness of occupational therapy in acute mental health care within a public psychiatric setting. Meyer et al. (2024) provided additional evidence, demonstrating that occupational therapy groups have a positive impact on activity participation and mental health outcomes for individuals with major depressive disorder (MDD) in acute settings. These findings support the value of occupational therapy in managing mental health conditions and verify its role in improving mental health outcomes.

The evidence demonstrating the effectiveness of occupational therapy in mental health care needs to expand. The evidence base for occupational therapy in mental health presents a complex picture. While some interventions show promise, particularly in areas such as supported employment and return-to-work programs (Masango et al., 2024), occupational therapy faces challenges in establishing

widespread empirical support. García-Gestal et al. (2024) argued that the profession has not fully capitalised on creating more evidence, particularly in acute psychiatric settings where occupational therapy services remain underutilised and often misunderstood.

In addition to the need for more evidence to demonstrate the effectiveness of occupational therapy, the shortage of professionals in mental health settings is a concern. Recent American workforce data reveals a troubling statistic: only 2.2% of occupational therapists work in behavioural health settings (Read et al., 2024). This is similarly an issue in South Africa (Ned et al., 2020). Given the high burden of mental illness in South Africa, this limited workforce is particularly concerning. As the demand for mental health services continues to rise, especially with increasing rates of mental health disorders, there will not be enough occupational therapists to meet the growing need for care. This shortage highlights the urgent need for increased investment in workforce expansion, training, and awareness to ensure that occupational therapy can play a pivotal role in addressing mental health challenges nationwide.

While occupational therapy's potential in mental health care is widely acknowledged, the gap in evidence remains problematic. Without substantial investment in high-quality research (Christie et al., 2023; Pretorius & Franzsen, 2023) and standardised outcome measures (Kearns et al., 2021a), occupational therapy risks being marginalised in mental health service delivery, particularly as healthcare systems increasingly emphasise evidence-based interventions and cost-effectiveness (Mayosi & Benatar, 2014). This predicament is especially pertinent in South Africa, where the implementation of the National Health Insurance (NHI) system demands clear evidence of intervention effectiveness and value for money (South African National Department of Health, 2023b).

The way forward requires a dual approach, strengthening the evidence base through rigorous research while simultaneously advocating for the unique value of occupational therapy in mental health care. This includes developing standardised outcome measures that capture the profession's holistic impact, conducting more

randomised controlled trials, and better documenting cost-effectiveness across diverse healthcare settings. Only through such comprehensive efforts can occupational therapy secure its position as an essential component of mental health care delivery and ensure its inclusion in future healthcare policy and funding decisions.

2.5 Evidence-based practice and occupational therapy in mental health

Evidence-based practice (EBP) plays a key role in occupational therapy within mental health by integrating the best available research, clinical expertise, and client preferences to inform treatment decisions (Ikiugu et al., 2017). The benefits of EBP in psychiatry include improved client outcomes through interventions grounded in evidence, enhanced professional credibility within multidisciplinary mental health teams, and optimal allocation of healthcare resources, such as time, funding, and personnel, to maximise treatment effectiveness. This efficient use of resources ensures that clients receive the most appropriate and cost-effective care. Additionally, EBP promotes continuous professional growth, as practitioners are encouraged to stay current with the latest research, ultimately enhancing the quality of mental health services (Cruz et al., 2023).

To effectively contribute to evidence-based practice (EBP), occupational therapists engage in a range of activities. These include accessing research databases, attending professional development events, collecting and analysing client data, collaborating on research projects, participating in journal clubs and mentorship programs, referring to clinical guidelines, using digital tools, and engaging in reflective practices (Christie et al., 2021; Faija et al., 2022). The American Occupational Therapy Association (AOTA, 2020) and other studies emphasize the importance of these activities in promoting an evidence-informed approach to clinical practice (Kirsh et al., 2019; Daaleman et al., 2021; Read et al., 2024).

Despite the importance of these efforts, challenges remain both globally and within the South African context. These include the lack of high-quality evidence for specific occupational therapy interventions, particularly in the area of mental health, which

makes it difficult to validate their effectiveness and justify their inclusion in treatment (Legg et al., 2017; Silaule & Casteleijn, 2021). Another barrier is the difficulty in translating research findings into practice, as many practitioners face constraints such as limited time, resources, and access to ongoing professional development (Daaleman et al., 2021; Jafari & Grobelna, 2023). Additionally, balancing standardised treatment protocols with the need for individualised care remains a persistent concern, particularly when addressing the diverse needs of clients with mental health conditions (Cruz et al., 2023). In South Africa, these issues are further aggravated by the scarcity of resources, underfunding in public healthcare, and the inequality between private and public sector service provision, which often leaves lower-income populations without adequate access to mental health services (Silaule & Casteleijn, 2021; Mayosi & Benatar, 2014). These barriers hinder the full integration of evidence-based practice in occupational therapy, particularly within the context of mental health care, limiting the profession's ability to demonstrate its value and effectiveness in improving client outcomes (Ikiugu et al., 2017).

2.6 Routine Outcome Measurement

Routine outcome measurement (ROM) has gained importance in mental health services, including occupational therapy, as a fundamental bridge between clinical practice and research (AOTA, 2020). It involves the consistent use of standardised tools to gather data and track progress throughout treatment. According to Barkham et al. (2023), ROM has evolved from a simple measurement technique to a comprehensive framework for enhancing and understanding mental health interventions. For occupational therapists, ROM provides an essential means to monitor changes in activity participation over time, offering valuable insights into the effectiveness of interventions (Tse et al., 2023).

In occupational therapy, the use of ROM is required to provide empirical evidence of intervention effectiveness (Pretorius & Fransen, 2023). Without sufficient empirical support, occupational therapy in mental health may struggle to gain full recognition, making it more challenging to secure adequate funding, insurance coverage, and policy support (Silaule & Casteleijn, 2021). This lack of recognition could restrict access to occupational therapy services, worsening existing disparities in mental health care.

Although ROM is essential as evidence to support the effectiveness of occupational therapy in mental health, the evidence base in South Africa remains limited. In contrast, it has been successfully integrated into mental health occupational therapy in several developed countries—including the United Kingdom, Canada, Australia, and the United States—where it is supported by well-established policies, procedures, and funding frameworks (Meyer et al., 2024). This is not yet the case in South Africa. A study by Brinker et al. (2017) demonstrated that only 41% of occupational therapists working in adult psychiatric settings implement ROM. Despite its proven success, the rate of implementation remains low.

With the upcoming implementation of the National Health Insurance (NHI) in South Africa, healthcare interventions will likely be evaluated based on demonstrated outcomes and cost-effectiveness. As the country transitions toward a more integrated and sustainable healthcare system, adopting ROM will be crucial for ensuring that occupational therapy services can demonstrate their value and secure the necessary resources for continued practice and expansion.

2.7 Relevance of implementing routine outcome measurement in clinical practice.

Implementing routine outcome measurement (ROM) in clinical practice is essential for enhancing treatment effectiveness, ensuring accountability, and promoting evidence-based decision-making (AOTA, 2020). Without systematic outcome measurement, occupational therapy risks being undervalued in mental health care, limiting its ability to secure funding, justify its role in multidisciplinary teams, and demonstrate its unique contributions to client recovery.

The tracking of client outcomes and the assessment of treatment effectiveness are fundamentally supported through ROM, enabling therapists to monitor progress systematically and adjust interventions accordingly (Aafjes-van Doorn et al., 2022). By regularly evaluating client progress, occupational therapists can identify trends, detect areas for improvement, and make informed decisions about treatment adjustments. This approach enhances clinical practice, optimises interventions, reduces the risk of

adverse outcomes, and fosters continuous improvement in client care (Waldron et al., 2018; Faija et al., 2022).

Similarly, research by Rye et al. (2019) and Thapa Baigain et al. (2023) shows ROM's ability to improve treatment outcomes by reducing treatment failures, enhancing responsiveness, and ensuring interventions meet the client's specific needs. Beyond clinical benefits, outcome measurement promotes transparency and accountability, strengthening the case for securing resources and funding to deliver high-quality services (Boswell et al., 2015). In an era of increasing healthcare scrutiny, occupational therapy must embrace ROM to maintain credibility, expand its influence, and protect its position in psychiatric settings.

The concept of client-centred care is a foundational element in occupational therapy, emphasising active client involvement, personalised care, and collaboration between clients and healthcare providers (AOTA, 2020). An effective tool for fostering client engagement is ROM, which incorporates patient-reported outcome measures. Research by Boswell et al. (2015) and Solstad et al. (2019) indicates that involving clients in tracking their progress through ROM enhances their investment in therapy, reinforcing the principles of client-centred practice (Law et al., 2014; Casteleijn & Graham, 2012). In the absence of ROM, occupational therapists may struggle to demonstrate the tangible benefits of client-centred interventions, making it harder to justify their role in mental health services.

Additionally, ROM strengthens the therapeutic relationship by facilitating open communication between clients and occupational therapists, encouraging transparency and collaboration. This fosters a stronger therapeutic alliance, which is crucial for the success of interventions (Solstad et al., 2019). Finally, client-centred ROM has been linked to increased client satisfaction, with studies showing that clients who are actively involved in their care report higher satisfaction with therapy services, as their goals and preferences are more likely to be met, resulting in a more favourable therapeutic experience (Solstad et al., 2019). The implication is clear—without ROM, occupational therapy risks being less effective, less client-centred, and ultimately less

impactful within mental health care.

Routine outcome measurement plays a vital role in fostering collaboration and enhancing communication within multidisciplinary healthcare teams (Waldron et al., 2018). By integrating ROM into clinical practice, teams can adopt a structured, data-driven approach to evaluating client progress and making informed treatment decisions (Boswell et al., 2015). The use of objective outcome data promotes transparency among team members, reducing reliance on subjective clinical impressions, which may be inconsistent or biased. This structured approach facilitates shared decision-making, ensuring that interventions are adjusted based on measurable outcomes rather than intuition or habitual practice. (Waldron et al., 2018). For occupational therapists, ROM serves as a powerful tool to enhance interdisciplinary communication, advocate for evidence- based interventions, and ultimately improve client outcomes.

Lastly, recent cost-effectiveness studies have reinforced the economic value of occupational therapy interventions in mental health. Barkham et al. (2023) and Gelkopf et al. (2022) argue that while the implementation of ROM incurs initial costs, it ultimately leads to better outcomes, including improved efficiency, more effective treatment, and better resource allocation. Although these studies are not specific to occupational therapy, they highlight the broader impact of ROM on the sustainability of mental health care. In contrast, Dineen et al. (2020) emphasise the long-term cost savings associated with occupational therapy interventions, particularly in improving functional outcomes, reducing disability, preventing unemployment, and enhancing overall quality of life. Additionally, Johanson et al. (2023) provide evidence that occupational therapy return-to-work interventions are cost-effective, primarily when implemented early in the recovery process. However, most occupational therapy-specific findings on cost-effectiveness originate from high-income countries and do not adequately address the financial implications of ROM specifically. This indicates a gap in the literature—without clear evidence on the cost-effectiveness of ROM in occupational therapy, its widespread adoption may be hindered, particularly in resource-constrained settings.

In conclusion, ROM is an essential tool for enhancing occupational therapy's effectiveness, accountability, and client-centred approach in mental health care. By systematically tracking client progress, ROM enables occupational therapists to make evidence-based decisions, improve interventions, and ensure better treatment outcomes. Beyond clinical benefits, ROM strengthens the therapeutic alliance, increases client engagement, and supports transparency within multidisciplinary teams. Additionally, while cost-effectiveness studies highlight the economic value of occupational therapy interventions, there remains a gap in research explicitly addressing the financial benefits of ROM in occupational therapy. Without this evidence, securing funding and justifying its implementation may be challenging. Therefore, further research is needed to establish the long-term impact of ROM on cost savings and service efficiency within occupational therapy, ensuring its sustainable integration into mental health practice.

2.8 Barriers to the implementation of routine outcome measurement within clinical practice

Implementing routine outcome measurement (ROM) in clinical practice presents several barriers that hinder its effective adoption, despite its potential benefits for improving client care and service efficiency. The challenges associated with ROM implementation are multifaceted, including resource limitations, training gaps, technological barriers, and communication issues. These barriers impact occupational therapy, particularly in mental health settings, where therapists are already managing heavy caseloads and administrative burdens.

2.8.1 Resource and practical challenges

A key barrier to ROM implementation in clinical settings is the shortage of resources, including time, finances, and administrative support. Previous studies have consistently highlighted these practical challenges as obstacles. Boswell et al. (2015) and Waldron et al. (2018) identify time constraints and administrative burdens as

significant barriers to the integration of ROM. Occupational therapists, especially in private practice, often manage large caseloads, leaving little time to focus on the time-consuming tasks associated with ROM, such as selecting appropriate outcome measures, administering outcome measures, and analysing results (Sonsbeek et al., 2021). Davenport and Underhill (2023) further emphasize that ROM implementation is often viewed as an additional workload that competes with direct client care, leading to the de-prioritisation of ROM despite its potential benefits for treatment outcomes.

Financial constraints also pose a challenge, especially for smaller practices. The initial costs of ROM, such as the purchase of technology and staff training, can be prohibitive (Lambert et al., 2018). Boswell et al. (2015) note that ongoing costs, including software updates and continued training, further exacerbate these financial pressures. In resource-constrained settings, particularly in mental health care, the benefits of ROM may not be immediately apparent, which can make it difficult to justify continued investment in its implementation. Additionally, insufficient funding for ongoing training and technological updates poses a threat to the sustainability of ROM adoption (McAleavey et al., 2024). As a result, occupational therapists may struggle to stay current with advancements in ROM practices, which undermines the quality of client care and limits the effectiveness of ROM in improving therapeutic outcomes.

2.8.2 Training and professional development

Effective ROM implementation requires occupational therapists to have specialised training in outcome measurement principles, data interpretation, and the practical application of ROM (Carlier & Eeden, 2017). However, gaps in training and professional development opportunities hinder the adoption of ROM (Boswell et al., 2015). McAleavey et al. (2024) emphasise that insufficient training compromises clinicians' ability to effectively use ROM tools, resulting in inconsistent application and diminished impact on client care. Edbrooke-Childs et al. (2016) suggest that limited professional development opportunities prevent therapists from staying current with new ROM practices, further worsening the challenges of implementation.

The rapid pace of change in ROM practices, including the development of new outcome measures and interpretation methods, adds to the pressure on occupational therapists. Lonita et al. (2016) note that staying up to date with these advancements can be overwhelming, particularly for practitioners already facing heavy workloads. Escudero-Escudero et al. (2020) highlight that the constant need for professional development can lead to burnout, particularly in mental health settings where occupational therapists are already balancing client care and administrative responsibilities. This adds further strain to an already overburdened workforce, potentially decreasing job satisfaction and the quality of care provided to clients.

2.8.3 Technological and systemic barriers

Anderson et al. (2024) address the technological barriers that complicate the integration of ROM into existing workflows. Many occupational therapy practices rely on outdated or incompatible electronic health record systems, making it challenging to incorporate ROM tools seamlessly. Concerns regarding data privacy and security further complicate ROM adoption, as organisations must ensure compliance with stringent privacy regulations, such as HIPAA in the U.S. or the Protection of Personal Information Act (POPIA) in South Africa (Bausewein et al., 2018). These technological and regulatory challenges can delay or prevent the successful implementation of ROM, particularly in settings that lack the necessary resources or expertise to address these issues.

2.8.4 Communication and Interdisciplinary Collaboration

Effective interdisciplinary collaboration is essential for the successful implementation of ROM. However, communication barriers often impede progress. Lampis and Rocca (2024) identify several challenges that contribute to these barriers, including inconsistent terminology, lack of standardised measurement approaches, limited cross-departmental communication, and variability in professional perspectives. A lack of consensus on the importance and application of ROM among different healthcare disciplines further complicates its implementation (Boswell et al., 2015). These challenges are compounded by the absence of standardised protocols for ROM,

leading to fragmented and inconsistent implementation across healthcare settings. Aafjes-van Doorn and de Jong (2022) note that such inconsistency can lead to confusion among clinicians, ultimately reducing the effectiveness of ROM.

To overcome these barriers, effective communication strategies and standardised protocols are essential. Barkham et al. (2023) emphasise that clear communication is necessary for ensuring that ROM is utilised uniformly across healthcare settings. Interdisciplinary collaboration, however, is often hindered by differences in professional perspectives and practices, as noted by Steihaug et al. (2018). Therefore, fostering a shared understanding of ROM's importance and ensuring effective communication between disciplines is vital for successful ROM integration.

2.8.5 Systemic and organisational challenges

Systemic factors, such as poor usability and the lack of integration with existing workflows, also affect ROM use. Lambert et al. (2018) emphasise the importance of selecting appropriate measurement tools and ensuring that ROM systems are user-friendly to avoid resistance from clinicians. When ROM tools are challenging to use or disrupt established clinical processes, clinicians are less likely to embrace them, thereby reducing their potential impact. Uncoordinated and inconsistent practices delay standardised methods, negatively impacting the integration of evidence-based treatment (Mackrill & Sørensen, 2020).

Inadequate administrative support and poor training are also concerns relating to ROM implementation. In order to address these obstacles, organisations must provide comprehensive training to clinicians and offer adequate support to streamline the integration of ROM. (Lambert et al., 2018). Leadership plays a key role in securing resources and fostering a supportive environment for ROM use (Kwan et al., 2020). By improving administrative support and providing training, organisations can enhance ROM implementation and ultimately improve client outcomes.

In conclusion, several factors negatively impact the implementation of ROM, including

resource constraints, technological limitations, training gaps, and communication problems. These barriers affect the ability of occupational therapists, especially in mental health settings, to implement and effectively integrate ROM into their practice. Overcoming these concerns requires coordinated efforts at the individual, team, and organisational levels. By addressing issues such as time constraints, financial pressures, and inconsistent communication, occupational therapists can more effectively integrate ROM into their practice, ultimately enhancing client care and service efficiency. Furthermore, prioritising training, providing necessary resources, and promoting interdisciplinary collaboration will be required for the successful utilisation of ROM in occupational therapy.

2.9 Occupational therapy outcome measures in mental health care.

A systematic review in Ireland by Kearns et al. (2021b) examined outcome measures for occupational therapy in mental health. Only eight of the twenty identified measures were suitable for psychiatric settings. The most frequently used tools included the Canadian Occupational Performance Measure (COPM) and the Assessment of Motor and Process Skills (AMPS). While several occupational therapy outcome measures in Ireland support recovery-oriented health services, these tools are not specifically tailored to mental health care. As a result, the measures implemented may not fully address the unique needs of mental health practice. Outcome measures supported in the literature and utilized in mental health occupational therapy are addressed below.

2.9.1 The Canadian Occupational Performance Measure (COPM)

The Canadian Occupational Performance Measure (COPM) is a client-centred outcome measure that captures how individuals perceive their performance in everyday tasks. It was developed in 1991 by the Canadian Association of Occupational Therapy (CAOT) and has become a valuable tool used in over 40 countries (Law et al., 2014). The COPM evaluates performance and satisfaction in self-care, productivity, and leisure activities (Law et al., 2005). While several studies highlighted its effectiveness in goal setting, treatment planning, and tracking outcomes over time (Carswell et al., 2004), it has been criticised for some of its drawbacks. Firstly, it

requires clients to have sufficient cognitive abilities for self-assessment, making it unsuitable for those with cognitive impairments (Phipps & Richardson, 2007). Additionally, its Canadian origins may limit its applicability in culturally diverse settings, such as South Africa (Casteleijn & Graham, 2012). Since the outcome measure relies on subjective perceptions, it may not consistently capture subtle changes in occupational performance (McColl et al., 2000). Its semi-structured format and lack of standardisation in administration raise concerns about the consistency of results and the time it takes to complete (Cusick et al., 2006). Despite this criticism, ongoing research and adaptation efforts are necessary to enhance the relevance of the COPM in various contexts and improve its effectiveness in clinical practice (Nieuwenhuizen et al., 2014).

2.9.2 The Assessment of Motor and Process Skills (AMPS)

The AMPS, developed by Fisher and Merritt in 1986, is widely accepted in occupational therapy for its emphasis on observing and assessing how individuals perform instrumental activities of daily living (IADLs) (Fisher, 2001). Its goal is to provide a reliable measure of a person's ability to carry out everyday tasks effectively and independently within their environment. Simultaneously, clinicians recognise it as an effective tool for identifying subtle changes in motor and process skills over time. The AMPS is widely criticised for its limitation in addressing essential client factors in mental health, such as self-esteem, cognition, volition, and mood (Hitch, 2007). Clinicians reported various difficulties with the AMPS, including the time required to complete it, difficulties initiating its implementation, challenges with the overall application in clinical settings, and its limited flexibility across different contexts (Chard, 2000). Although some occupational therapists in South Africa are trained to implement the AMPS, its use in psychiatric settings is still relatively rare (Casteleijn & Graham, 2012). Its oversimplified approach disregards important client factors, therefore making it inappropriate for measuring activity participation in psychiatric settings (Hitch, 2007; Casteleijn & Graham, 2012).

2.9.3 Activity Participation Outcome Measurement (APOM)

In response to the need for better outcome measurement in mental health within South Africa, the Activity Participation Outcome Measure (APOM) was developed by Professor Daleen Casteleijn (Casteleijn, 2010). This outcome measure aims to track functional changes in activity participation, focusing on enabling clients to move from dependence to independence. The APOM enables occupational therapists to observe and analyse clients' behaviours over time, allowing them to monitor progress or setbacks. Grounded in the Vona du Toit Model of Creative Ability (VdTMoCA), the APOM comprises eight domains of activity participation, including process skills, communication and interaction skills, life skills, role performance, balanced lifestyle, motivation, self-esteem, and affect (Casteleijn & Graham, 2012). These domains align with fundamental principles of occupational therapy, providing a thorough framework for evaluating client outcomes.

The APOM has strong validity and reliability. It effectively tracks changes in clients with traumatic brain injuries and those with mental illness receiving psychiatric treatment in rural areas (Camp et al., 2020; Silaule & Casteleijn, 2021). Its psychometric properties make it a valuable resource for assessing shifts in activity participation. While initially designed for mental health contexts, the APOM's comprehensive approach allows for its use in various settings, including neurological rehabilitation. It has proven effective in measuring activity participation and assisting treatment planning and goal setting (Casteleijn, 2010). The development of the APOM involved contributions from clinicians and clients, ensuring the tool is centred around the client and meets their needs (Casteleijn, 2010). This collaborative approach enhances the tool's relevance and acceptance in clinical practice. The APOM, with its robust psychometric properties and client-centred design, represents a promising tool to address these gaps and improve the integration of outcome measurement in psychiatric practice.

Outcome measurement plays a vital role in occupational therapy for mental health, yet existing tools often lack specificity for psychiatric settings. While measures like the COPM and AMPS offer valuable insights, they have limitations in the context of mental health. Although APOM is a promising tool, the ongoing limited implementation of

ROM in general has resulted in limited evidence. These limitations highlight the need for proactive and strategic solutions.

2.10 Strategies to enhance routine outcome measurement implementation

The practical implementation of routine outcome measurement (ROM) in clinical practice is imperative for the success of ROM initiatives, especially in mental health settings where evidence-based practices are essential (Bear et al., 2021). To successfully integrate ROM, several strategies must be employed, including resource allocation, stakeholder engagement, clear policies and procedures, effective leadership, continuous monitoring and evaluation, and optimal use of collected data.

2.10.1 Allocating resources for effective ROM integration

For ROM to be effectively integrated into clinical practice, it is essential to allocate sufficient resources, particularly in terms of time and personnel. Implementing ROM involves various time-consuming tasks, such as administering assessments, analysing results, interpreting data, and incorporating these findings into treatment plans. These tasks mustn't be viewed as administrative burdens, but rather as integral to clinical care. This further promotes a culture of engagement with ROM (Cooper et al., 2019).

Allocated time for ROM activities has been shown to improve clinician engagement and consistent use of outcome data (Mellor-Clark et al., 2014; Cooper et al., 2019) While both studies are from the United Kingdom and within the discipline of psychology, Boswell et al, (2015) assert its relevance to other allied health professions including occupational therapy. Without structured time, ROM risks being reduced to a superficial process rather than a valuable clinical tool. Therefore, allocating specific time blocks for ROM tasks can help occupational therapists develop proficiency and integrate the data meaningfully into their decision-making (Meyer et al., 2019). The initial time investment in ROM pays off by leading to more efficient treatment planning and improved clinical outcomes, as it enhances the overall quality of care.

2.10.2 Training and education for ROM proficiency

Ongoing training and education are fundamental for integrating ROM into clinical practice. While the theoretical benefits of ROM are well-established, translating these principles into everyday practice requires structured learning and professional development (McAleavey et al., 2024). Adequate training ensures that occupational therapists are familiar with the technical aspects of ROM and are also capable of interpreting data effectively and using it to inform treatment decisions.

Effective ROM training programs should encompass a range of competencies, including technical proficiency and outcome measures, as well as the interpretation of data for informed clinical decision-making (Boswell et al., 2015). Clinician confidence is a crucial factor in the successful implementation of ROM. When clinicians feel competent in using outcome measures, they are more likely to consistently incorporate them into their practice (Edbrooke-Childs et al., 2016). Without adequate confidence, ROM may be perceived as a burdensome task rather than a tool for improving client care.

Ongoing professional development is crucial for keeping occupational therapists up to date on advancements in ROM. Al-Omary et al. (2024) highlighted the value of integrating artificial intelligence and advanced analytics into treatment planning for continuous learning opportunities. This leads clinicians to promote a culture where ROM is viewed as a fundamental part of clinical care.

By consistently refining their ROM skills, occupational therapists can more effectively assess client progress and adjust treatment plans, resulting in improved outcomes. Integrating ROM into the organisational culture helps overcome resistance, positioning it as a valuable tool that aligns with recovery-oriented practices. As technology continues to evolve, ROM will become an increasingly powerful resource for supporting mental health recovery and promoting functional independence.

2.10.3 Leveraging technology: streamlining ROM processes

Technology is increasingly playing a pivotal role in streamlining ROM processes, from data collection to analysis and feedback (Lyon et al., 2016). Integrating ROM into electronic health records can modernise the process, making data collection and analysis more efficient and clinically relevant. Additionally, digital platforms can enhance the accuracy of assessments, improve client engagement, and support better intervention planning (Birken et al., 2022).

However, integrating technology into ROM processes presents several concerns, including overcoming clinician resistance and ensuring that the technology aligns with clinical workflows (Tancreti, 2022). Success depends on providing specialised training, ongoing support, and regular evaluations of the technology's effectiveness. Therefore, technology should support, not undermine, therapeutic relationships and occupation-based interventions.

Future directions for technology in ROM could include the use of remote assessments and advanced analytics to track client progress more accurately, offering a more holistic and client-centred approach to therapy (Al-Omary et al., 2024). The systematic integration of technology through pilot programs, comprehensive staff training, and continuous quality assurance can help overcome these challenges and improve ROM's efficiency and effectiveness in mental health occupational therapy.

2.10.4 Organisational support: leadership and management's role in ROM implementation

Organisational leadership plays a fundamental role in the successful implementation of ROM. For ROM to be adequate, leadership must demonstrate a visible commitment by aligning it with broader organisational goals and mental health recovery frameworks (Boswell et al., 2015). Leaders should actively review ROM data and ensure that adequate resources, including protected time for ROM activities, are allocated to support implementation (Lambert & Harmon, 2018). In addition to leadership, a supportive organisational culture is key to the success of ROM. Open communication, team collaboration, and integrating ROM in discussions can increase engagement and

demonstrate its value in treatment outcomes (Unsworth, 2011). Therefore, embedding ROM within quality improvement initiatives allows for ongoing monitoring and refinement of treatment interventions, ensuring that ROM continues to be a valuable part of occupational therapy

2.10.5 Addressing the shortage of occupation-based assessments in mental health

Occupation-based assessments are essential in mental health, where conditions impact performance and participation. Standardised, occupation-based outcome measures are necessary for monitoring treatment progress and ensuring evidence-based practice (Casteleijn, 2010). However, in many settings, particularly in private psychiatric practice, there is a lack of suitable assessments that fully capture the complexities of mental health recovery (Silaule & Casteleijn, 2021).

The introduction of tools like the Activity Participation Outcome Measure (APOM) is an important step toward bridging this gap, though their routine use remains inconsistent (Meyer et al., 2024). To address these challenges, occupational therapy in mental health requires the development of more standardised, occupation-based tools that are both reliable and relevant to diverse clinical contexts (Casteleijn & Graham, 2012).

Incorporating client feedback into the outcome measurement process can further improve the relevance of ROM tools. As noted by Duncan and Murray (2012), engaging clients in the selection and application of these measures ensures that they are not only clinically helpful but also align with client-centred practice. This is particularly relevant in occupational therapy, as it provides transparency and ownership among both therapists and clients (AOTA, 2020). By involving clients in the ROM process, clients feel empowered and engaged in their recovery. This involvement not only increases client satisfaction, as they see their input directly influencing their therapy, but also reduces resistance to ROM. Solstad et al. (2019) noted that when clients understand the value of ROM and see it as a tool to personalise their care, they are more likely to embrace the process, leading to more effective therapy outcomes and a stronger therapeutic relationship. Additionally, real- time

feedback enables occupational therapists to adapt interventions promptly, ensuring that care remains responsive and personalised (Casteleijn & Graham, 2012). This continuous dialogue strengthens the occupational therapist's ability to make informed decisions about interventions. Engaging clients in the process not only promotes positive client experiences but also improves overall outcomes in occupational therapy.

The successful implementation of ROM in mental health occupational therapy relies on several interconnected factors: resource allocation, training, technological integration, organisational support, and the development of occupation-based assessments. By addressing these factors holistically, organisations can ensure that ROM becomes an integral part of clinical practice. The ongoing development of standardised, occupation-based tools, combined with leadership commitment and clinician training, will help create a more effective, evidence-based mental health service, ultimately enhancing client outcomes and supporting the broader goals of occupational therapy.

2.11 Conclusion

This literature review has examined mental healthcare in South Africa, with particular focus on the role of occupational therapy and outcome measurement. Several key themes emerge from this analysis that warrant attention.

The review reveals disparities in mental health service delivery between the public and private sectors in South Africa. Recent policy initiatives, such as the National Health Insurance and the National Mental Health Policy Framework and Strategic Plan 2023-2030, show promise in addressing these inequalities. The severe shortage of occupational therapists, particularly in public and rural settings, continues to limit access to essential mental health services for much of the population.

The evidence supporting the effectiveness of occupational therapy in mental health settings, although promising, remains limited within the South African context. This research gap poses challenges for securing expanded coverage and recognition

within healthcare systems, particularly in private sector insurance schemes. The review demonstrates the need for more robust, context-specific research to demonstrate the value and cost-effectiveness of occupational therapy interventions in mental health care.

The literature reveals systemic challenges in implementing ROM in clinical practice. These barriers include resource constraints, inadequate training, technological limitations, and communication difficulties across healthcare disciplines. Addressing these obstacles is required to improve service delivery and demonstrate the effectiveness of occupational therapy interventions.

Moving forward, there is a clear need for increased investment in mental health services, particularly in expanding the occupational therapy workforce and supporting research initiatives. Future studies should focus on developing and validating culturally appropriate outcome measures, implementing effective ROM systems, and generating evidence for occupational therapy interventions within the South African context. Such efforts will be crucial to advancing this field and ensuring accessible mental health care for all South Africans.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology used in this study. In this section, a description of the study's design, sample size, and selection process is highlighted. Thereafter, the specific procedures implemented to address the research question, along with the measurement tools, are described. Lastly, ethical considerations applied to the study are explained.

3.2 Study design

This study employed a qualitative descriptive design to explore occupational therapists' perceptions of the implementation of ROM in private psychiatric settings within South Africa. This design offered a clear and pragmatic approach for gaining insights into participants' perceptions, enabling the generation of findings based on their own words and ensuring direct, unfiltered responses (Doyle et al., 2020). The flexibility inherent in this design facilitated purposive sampling to select participants and the use of semi-structured interviews as the method of data collection (Etikan & Bapatope, 2019).

The semi-structured interview questions were carefully developed to capture a comprehensive understanding of the topic. These questions focused on participants' general attitudes and practices regarding ROM, as well as their experiences with its implementation. The interviews explored both the practical and philosophical challenges and successes of ROM use, along with participants' suggestions for improving its adoption in occupational therapy practice within private psychiatric settings. This approach provided a rich understanding of the factors influencing ROM implementation and yielded actionable insights for enhancing its integration into practice (Kim et al., 2017).

3.3 Study population

As this study focused on the implementation of ROM in private psychiatric settings, the study population consisted of occupational therapists actively working within these settings. As occupational therapists with lived experience in private psychiatric settings, they were well positioned to offer key insights. Their expertise enabled an in- depth exploration of their experiences with ROM, including the challenges they faced and the opportunities they identified to improve ROM uptake. This focus is significant as the dynamics and demands of private psychiatric settings differ from those in public services, necessitating a tailored understanding of ROM implementation in this context.

3.4 Sampling

A purposive sampling strategy was employed to select participants based on specific eligibility criteria. Participants were required to have at least five years of experience working in private psychiatric settings to ensure they could provide informed and relevant perceptions (Creswell and Poth, 2018). The Institute for Occupational Therapists in Private Practice (INSTOPP), a professional organisation in South Africa that supports occupational therapists in private practice, was used as the recruitment platform. This made INSTOPP an appropriate choice for accessing a targeted population of occupational therapists with relevant expertise.

Before recruitment began, permission was obtained from the chairperson of INSTOPP to distribute invitations to its members (Appendix A). The researcher-created invitations outlined the study's purpose, participation requirements, and logistical details. The invitations also included the researcher’s contact information, allowing potential participants to express their interest and willingness to participate directly.
The sample size of ten participants, excluding the participant involved in the pilot study, was sufficient to achieve data saturation. The pilot participant was deliberately excluded to preserve objectivity and minimise potential bias. This was evident in the richness and depth of the data collected, as well as the repetition of themes in subsequent interviews (Creswell and Poth, 2018). Occupational therapists in the researcher’s setting were excluded to minimise bias and enhance objectivity. This minimised the chance of

participants feeling pressured to share specific responses or being concerned that their input might be recognised or associated with them in their professional environment. This approach maintained anonymity and created a safe space for participants to share their honest insights without fear of repercussions, thereby upholding ethical standards and fostering trust in the research process (Subedi, 2025).

Limiting the researcher's familiarity with participants' specific work contexts helped ensure objectivity during data collection and analysis, thereby strengthening the study's reliability (Malterud, 2016). This approach aligned with best practices in qualitative research by prioritising ethical rigor and methodological transparency while ensuring that participants provided insightful data to address the research question effectively.

3.5 Eligibility criteria

Eligible participants will include occupational therapists who are currently working in private psychiatric settings across any province in South Africa and have a minimum of five years' experience in such settings. Occupational therapists who are employed within the same facility or organisation as the researcher will be excluded from participation to avoid potential conflicts of interest or bias.

3.6 Instruments used for data collection

The instruments used for data collection in this study include a demographic questionnaire and an interview guide, each designed to gather specific types of information relevant to the research objective.

3.6.1 Demographic questionnaire

A demographic questionnaire (Appendix B) was used to gather information about the participants' age, gender, ethnicity, and the institution from which they obtained their degrees and/or other qualifications. Additionally, the number of years of practice in private psychiatric settings was acquired. This information was crucial for the researcher to gain an understanding of the participants, their backgrounds, and experiences, to determine the impact this would have on their perceptions of routine

outcome measurement in occupational therapy.

3.6.2 Interview guide

The researcher used an interview guide to conduct successful interviews and provide structure to the interview process (Kallio et al., 2016). The primary and probing questions in the guide ensured that the researcher systematically investigated specific aspects of ROM implementation, including perceptions, experiences, challenges, and support needs. This focus helped gather comprehensive insights while minimising irrelevant discussions, and using standardised questions allowed for uniformity in data collection across the ten participants, ensuring consistency that was vital for comparing responses and identifying themes related to ROM implementation. Employing probing questions enabled the researcher to delve deeper into participants' perceptions and uncover perceptions that may not have emerged from the broader questions (Bearman, 2019).

The interview guide directly targeted the practical aspects of ROM, including the frequency of use, criteria for application, and support requirements. This aligns with current research findings, which emphasize the importance of barriers such as time constraints, technological issues, and clinical attitudes in improving ROM adoption (Kallio et al., 2016). The effectiveness of ROM depends on integrating feedback into therapy to enhance outcomes. Similarly, the interview guide's structured approach ensured the researcher gathered actionable data to inform strategies for improving ROM implementation. By asking participants about their advice for occupational therapists and their perceived support needs, the guide fostered critical reflection on systemic improvements necessary for successful ROM adoption.

In summary, the interview guide provided a structured framework that helped the researcher systematically explore the complex topic of ROM implementation while addressing both theoretical and practical dimensions. It therefore ensured high-quality data collection that can inform evidence-based recommendations to enhance mental health practices (Bearman, 2019). Refer to Appendix (C) for the interview guide.

3.7 Pilot study

Following approval from the School of Therapeutic Sciences and the acquisition of ethical clearance by the University of Witwatersrand's Human Research Ethics Committee (clearance number: M221159) (Appendix D), an exploratory interview was conducted to test the interview guide, refine the questions, and evaluate the interview process (e.g., timing, flow and clarity of questions) (Majid et al., 2017). The researcher's employer was chosen as the pilot participant as she has worked for 13 years as an occupational therapist in a private psychiatric setting and owns a private practice. The pilot participant met the eligibility criteria but was excluded from the primary data collection group. She is the researcher's current employer, and her inclusion could raise concerns about objectivity, bias, and ethical issues related to power dynamics and voluntary participation (Malmqvist et al., 2019).

The research process began by obtaining informed consent from the participants, which included providing detailed information about the study's purpose, confidentiality, and the voluntary nature of participation (Appendix E & F). An invitation link to the Microsoft Teams meeting, the initial selected platform, was sent to the participant ahead of the scheduled meeting time. Upon attempting to access the meeting, the researcher encountered login issues. As a result, the researcher was only able to join the interview as a guest. A total of fifteen minutes was spent trying to resolve access issues with the original meeting link before successfully connecting with the pilot participant.

Once the researcher successfully established contact with the pilot participant, the purpose of the study was clearly explained to them. The participant was reassured that the primary objective of the exploratory interview was to evaluate and refine the interview format, rather than to collect data for inclusion in the final study. This clarification helped set expectations and ensured the participant felt comfortable contributing constructive feedback without concern for how their responses might influence the main research findings.

The exploratory interview was conducted successfully, lasting approximately 30 minutes. The pilot participant responded to the questions without apparent difficulty. However, during the post-interview reflection, the participant provided valuable

feedback, suggesting modifications to three probing questions that could potentially confuse participants whose first language is not English. It is essential to note that English was chosen as the preferred language for conducting the interviews to ensure consistency across all participants. Additionally, English is commonly used as the primary language in many professional settings, making it an appropriate and practical choice for this study. The pilot participant further validated the effectiveness of the interview guide in addressing the research question.

Based on the pilot study results, the researcher chose to use Zoom instead of Microsoft Teams to prevent technical issues that might cause delays during the main study. The following probing questions were further adjusted and checked by the researcher to avoid potential confusion during the main study.

1. **Initial question:** What are your views on ROM within private psychiatric settings?
   Adapted question: What are your thoughts on the use of ROM in private psychiatric settings
2. **Initial question:** What informs your views on ROM?
   Adapted question: What factors influence your approach to ROM in your setting?
3. **Initial question:** How do you decide which clients need ROM within your setting?
   Adapted question: What criteria do you use to determine which clients require ROM in your setting?

In summary, the pilot study enhanced the quality and efficiency of the primary research by identifying and addressing potential issues before full-scale implementation. Refer to (Appendix C) for the interview guide.

3.8 Data collection procedure

Participants who expressed their willingness to participate in the study were contacted by the researcher via email or WhatsApp, ensuring compliance with the Protection of Personal Information Act (POPIA). Upon receiving confirmation of their interest, the researcher provided an information sheet (Appendix G), a demographic questionnaire (Appendix B), and two informed consent forms—one for participation in the study and

another for video recording the interviews (Appendix E & F). Once participants completed and returned all required documentation via email, appointments were scheduled using either WhatsApp or email, depending on their preference. The availability of both the participants and the researcher was negotiated, and specific meeting times that suited both parties were confirmed.

The ten interviews were conducted in May 2023, with two or three interviews conducted per week. The interviews were conducted on the Zoom platform, which enabled both audio and video recordings. On average, the interviews lasted approximately 30 minutes. The researcher used the interview guide while conducting the semi-structured interviews. The main questions were asked of all participants, and probing questions were asked depending on their responses. The researcher asked probing questions when further clarification or elaboration was needed to understand the participants' perceptions fully.

The decision to conclude interviews was informed by a combination of factors, including participant engagement, data completeness, and the researcher's judgment of when the interview had reached its natural conclusion. Verbal and non-verbal signals from participants, such as giving shorter, less detailed responses or indicating they had shared all relevant information, helped signal when they were ready to end the interview. Additionally, signs of fatigue or disinterest, such as changes in body language or facial expressions, further suggested it was time to conclude. Once all key questions had been addressed, the researcher asked the participant for any final thoughts or additional points they wished to share.

In the context of this study, video recordings provided particularly valuable insights into the perceptions of occupational therapists. By observing participants' emotional responses—such as signs of frustration, enthusiasm, or hesitation—the researcher was able to identify areas where occupational therapists felt confident or uncertain about using ROM in their practice. For instance, a therapist might have expressed positive feelings about ROM's potential but exhibited signs of frustration when discussing challenges related to its implementation. These visual cues, when combined with the interview content, enabled the researcher to gain a deeper understanding of the emotional and psychological factors influencing occupational therapists' perceptions of ROM implementation (Lau and Bratby, 2023). The

researcher recorded these non-verbal communications in their diary, which facilitated the review and incorporation of these observations during the data analysis process.

After all the interviews were conducted, the files were uploaded to Descript, an advanced AI transcription application. The transcription process took place over two months, June and July of 2023. The researcher then reviewed the transcriptions while watching the video recordings, making necessary adaptations before commencing with data analysis. This meticulous process ensured a comprehensive understanding of the collected data and laid a solid foundation for subsequent analysis.

3.9 Data analysis

In this study, a reflexive inductive thematic analysis was used to identify, analyse, and report on the patterns emerging from the data (Braun and Clarke, 2006; 2019). This allowed the researcher to identify patterns and themes directly from the data, without relying on pre-set theories. It involved closely examining participants' views, thoughts, and beliefs, which naturally revealed valuable insights. The researcher followed Braun and Clarke's six phases: familiarising yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

These six phases are flexible and adaptive, allowing the researcher to revisit earlier stages as new insights emerge. This flexibility enabled the researcher to refine codes, adjust themes, and move back and forth between phases, ensuring the analysis remained closely tied to the data. It accommodated unexpected findings and complexities, allowing for a more adaptable approach. This approach is particularly valuable in qualitative research, where meaning-making is an evolving process, and researchers must remain open to refining their interpretations as they engage with the data (Braun and Clarke, 2019). By revisiting these phases as needed, the researcher gained a deep understanding of the data and developed a model that demonstrated how the themes were interconnected, directly addressing the main research question. This inductive method was particularly effective for exploring the complex experiences of participants, ensuring that the final analysis closely reflected their perspectives (Braun and Clarke, 2019).

The following is a detailed explanation of the steps taken in the data analysis for this

study, following the guidelines outlined by Braun and Clarke (2019). It is worth mentioning that the researcher and research supervisor held regular online meetings throughout the data analysis process. These collaborative discussions contributed to the rigor and validity of the analysis by offering critical feedback and confirming that the findings were closely tied to the data.

3.9.1 Familiarising oneself with data:

The initial phase of the thematic analysis aimed to gain an in-depth understanding of the data by reading and rereading the transcribed semi-structured interviews. This assisted the researcher in familiarising herself with the dataset (Braun & Clarke, 2019). At this stage, the researcher watched the videos several times, taking notes to record participants' impressions and document their interpretations of the video clips (Braun & Clarke, 2019).

3.9.2 Generating initial codes:

The researcher coded parts of the data that were meaningful or important to the research question, regardless of whether the idea or theme appeared frequently or only once. This emphasises the inclusiveness of the coding process, capturing both recurring and unique elements in the data. Sentences and paragraphs of the transcribed data were labelled with concise words, phrases, or paragraphs. Each of these labels was referred to as a unit of meaning, representing the smallest segments of data that could be interpreted in a meaningful way; these units ultimately served as the building blocks when developing themes (Saunders et al., 2023). Through this process, large volumes of data were condensed for ease of access in subsequent analysis stages. Once the initial codes were labelled, the researcher reviewed them to grasp the essence of each label, thereby attributing meaning to each. The researcher further discerned relevance by evaluating which data addressed the research question, objective, and/or aims. Inductive coding was employed to ensure that the codes accurately reflected the data, using phrases and terms directly cited by the participants themselves (Skjott Linneberg & Korsgaard, 2019). The potential meaning units were labelled and later refined in the second coding stage. This process involved creating condensed meaning units and reducing the data into smaller, manageable segments while still maintaining the meaning and data content (Dawadi, 2020). The

coding process was conducted using NVivo, a computer-assisted qualitative data analysis software (CAQDAS). The use of NVivo enhanced the researcher's data management capabilities as it provided a structured approach through which the data could be handled. The software's capabilities enabled the researcher to create and manage codes or themes, making it easier to identify patterns, relationships, and emerging insights within the data. This approach facilitated a deeper exploration of the data, ensuring that the patterns and relationships within the interviews were comprehensively and accurately captured, ultimately supporting the analysis and interpretation process (Fallin, 2019).

Table 3.2 illustrates the researcher's process of moving from raw interview data to refined conceptual understanding: starting with full meaning units, summarising them into concise condensed meaning units, and finally translating those into initial codes.

Table 3.1. Process followed in generating the initial codes

Meaning units	Because I think also a big thing is, you actually have to sit down and put the data into the computer and that takes quite long, especially if you need to do 12 at a time. Oh, it's, it's, yeah, it's, it's not practical
Condensed meaning units	• High patient volume impacts ROM implementation feasibility • Data entry for multiple clients is time-intensive • Current ROM process is impractical for daily clinical use
Initial codes	• Insufficient time for routine outcome measure implementation in clinical practice • Time-consuming nature of conducting and documenting outcome measures • Time constraints render ROM implementation idealistic rather than practical • High patient load hinders effective ROM integration Data entry process for

	• ROM is burdensome and impractical

3.9.3 Searching for themes:

During this phase, the researcher revisited the initial codes to identify patterns and differences, leading to the generation of final codes through a careful review of the dataset. Similar codes were grouped, while distinct ones were placed in separate categories. As the researcher analysed the data, distinct themes started to emerge, each given a descriptive name that reflected its content. Both the data itself and the researcher's theoretical assumptions played a key role in shaping the generation of themes. The first theme that emerged focused on critiques of ROM implementation. Similar challenges were combined, while those that differed were categorised separately.

3.9.4 Reviewing themes:

The process of reviewing and refining themes was a pivotal stage in ensuring the rigor, coherence, and validity of the final analysis. This phase involved a critical evaluation of the themes related to the initial codes, individual data extracts, and the dataset as a whole. The researcher carefully examined whether each theme was adequately supported by evidence and whether it accurately captured meaningful patterns within the data. Themes that lacked sufficient support or overlapped with others were either removed, merged, or condensed to enhance their clarity and distinctiveness. This refinement ensured that each theme represented a unique and coherent aspect of the participants' perceptions.

Subthemes were developed by closely reviewing grouped themes and identifying patterns within them. This process provided a more detailed understanding of the data, allowing for a layered interpretation that captured both broader themes and specific variations within them.

The following examples illustrate the processes followed. In theme one, ‘perceived difficulties of implementing ROM in clinical practice’, several refinements were made. Subthemes were consolidated and renamed, such as merging “increased workload associated with ROM implementation” into “time-consuming nature of ROM,”

renaming “lack of consistency and standardisation of ROM” to “diverse perspectives on routine outcome measurement,” and clarifying “adaptations to current systems” as “putting systems in place.” In theme two, ‘value of routine outcome measurement for occupational therapists in mental health’, subthemes were also consolidated, and new ones were created. The terms ‘Significance of ROM’ and ‘perceived value of ROM’ were merged due to their similarities, while new subthemes such as ‘value of generating evidence’ and ‘making a valuable contribution’ were introduced. These refinements demonstrate a thoughtful and systematic approach to thematic analysis, ensuring the final themes and subthemes accurately represent the data while maintaining clarity and distinction.

Table 3.2 Formation of themes from subthemes

Subthemes	Main themes
Time-consuming nature of ROM	Perceived difficulties implementing routine outcome measurement in clinical practice
Cost implications of ROM implementation	
Health system factors affecting the implementation of ROM	
Limited accessibility to appropriate outcome measures	
Difference in opinions regarding ROM	

3.9.5 Defining and naming themes:

At this stage, the researcher refined the themes to ensure clarity, assigning them clear and concise names that effectively captured their essence. This helped distinguish the themes from the codes, as they are broader and more abstract. Appropriate names

were provided for each theme ensuring they are informative and provide immediate insight into the content of each theme (Braun & Clarke, 2019).

For example, the initial theme name of theme one was changed from "Difficulties of implementing ROM in clinical practice" to "Perceived difficulties of implementing ROM in clinical practice" to reflect participants' perspectives better.

3.9.6 Producing report:

The final stage of Braun and Clarke's thematic analysis involved writing up the data analysis. In this step, the researcher focused on letting the actual findings come from the data by including quotes from participants. This is detailed in Chapter 4: results and discussion. Braun and Clarke (2019) emphasise the importance of including quotes to make the report more authentic, accurately reflect participants' experiences, and increase transparency, allowing readers to see how themes and interpretations were formed. Including these quotes also added to the report's credibility, as they served as examples for the themes identified and provided evidence to support the interpretations, thus enhancing the validity and reliability of the findings (Saunders et al., 2023).

3.10 Trustworthiness

The researcher employed various strategies namely credibility, dependability, confirmability, transferability and authenticity to ensure the findings were trustworthy and that the interpretations accurately represented the data collected from participants.

The study's credibility was strengthened through peer debriefing, which involved the researcher's supervisor reviewing both the raw data and the transcriptions. This process allowed the supervisor to offer an outside perspective on how the data was interpreted, providing valuable feedback on the analysis and helping to identify any potential biases or areas of ambiguity. By engaging in this collaborative review, the researcher was able to refine their interpretations and ensure that the findings were consistent with the data (Korstjens & Moser, 2018).

Dependability was ensured by following a consistent interview protocol throughout the study. Each participant was asked the same set of questions in the same order, adhering strictly to the pre-established interview guide. This structured approach helped maintain uniformity in data collection, reducing the potential for variation in how information was gathered. By ensuring that every participant had the same experience during the interview, the researcher was able to minimise inconsistencies and increase the reliability of the data (Johnson et al., 2020).

Conformability was ensured by the researcher using a detailed diary to document interpretations of the non-verbal responses. This record explained the reasoning behind including or excluding these cues in the analysis, ensuring transparency and reducing bias. By reflecting on the possible meanings of non-verbal cues, the researcher maintained objectivity and created an audit trail for others to follow (Ahmed, 2024).

Transferability was enhanced by offering detailed and rich descriptions of both the study's setting and the participants involved. By thoroughly describing the context in which the research took place, the researcher gave a clear picture of the study's circumstances. Detailed characteristics of the participants were included to enable readers to assess how the findings might relate to different groups or settings. This helps other researchers to determine whether the conclusions drawn from the study can be applied or transferred to similar contexts or populations, thereby increasing the study's external validity. By providing enough context, the researcher ensured that informed judgments can be made about the relevance and applicability of the findings beyond the specific sample or setting under investigation (Johnson et al., 2020). Authenticity was achieved by carefully analysing and presenting the different perspectives and values expressed by participants. The researcher made a conscious effort to ensure that all viewpoints, whether similar or differing, were represented fairly and accurately—the final report aimed to accurately reflect the range of views, rather than favouring one over another. By doing so, the researcher maintained an accurate representation of the participants' lived experiences, allowing for a more comprehensive understanding of the topic (Korstjens & Moser, 2018).

3.11 Ethical considerations

This study adhered to ethical guidelines and data protection measures to ensure participant safety, confidentiality, and the integrity of the research process (Mohd Arifin, 2018). Ethical approval was obtained from the University of the Witwatersrand's Human Research Ethics Committee (clearance number: M221159), ensuring that the research was conducted by established ethical standards. Participants were protected from harm and treated fairly and respectfully throughout the study.

Informed consent was obtained from all participants, who provided both verbal and written permission before participation (Appendices E & F). They were also provided with an information sheet (Appendix G) that outlined key details, including the purpose and procedures of the study, their right to withdraw at any time without consequences, the voluntary nature of their participation, potential risks and benefits associated with the study, and the measures taken to ensure confidentiality. This ensured that participants were fully informed and able to make a voluntary decision regarding their involvement.

The selection of participants was based on predetermined eligibility criteria, and all participants were treated respectfully, without bias, and with sensitivity to their rights and dignity throughout the research process.

To safeguard participant confidentiality, data protection measures were implemented. Personal information and transcribed data were stored on an encrypted cloud service, specifically Google Drive. During analysis, data was further secured through encryption within NVivo software. Video recordings were saved on a password-protected computer and backed up on the university’s secure cloud storage. Access to all data was restricted to the primary researcher and research supervisor.

Upon completion of the study, all data were transferred to the Department of Occupational Therapy’s digital research repository and will be archived in the university library for two years following the student’s graduation, ensuring long-term preservation while maintaining security.

By following these ethical procedures and implementing rigorous data management practices, this study ensured the protection of participants' rights while upholding the

integrity of the research.

3.12 Conclusion

This chapter described the qualitative descriptive design, purposive sampling, and semi-structured interviews used to explore occupational therapists' perceptions of ROM in private psychiatric settings in South Africa—strategies selected for their clarity, flexibility, and ability to capture practitioners' lived experiences. It outlined the data-collection tools, methods and analysis used to identify patterns and themes.

The chapter also addressed the study's rigor—credibility, dependability, confirmability, transferability, and authenticity—as well as detailed ethical considerations and robust data-management procedures. The following chapter will present the study's findings and their interpretation.

CHAPTER 4: RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the results and discussion of the ten semi-structured interviews conducted to document occupational therapists' perceptions of the implementation of routine outcome measurement (ROM). As a descriptive qualitative study, this research aimed to explore the perceptions of occupational therapists regarding the implementation of ROM in private psychiatric settings. The objective of the study was to describe the perceptions of occupational therapists on the implementation of ROM in private psychiatric settings. Given that perceptions are inherently subjective, verbatim quotes from participants were used to provide direct insights into their thoughts and feelings about the implementation of ROM, ensuring their voices are accurately represented in the study's findings.

To capture the participants' perceptions comprehensively without losing their meaning, the results and discussion sections were integrated. Pseudonyms, such as "participant" followed by a number (e.g., participant 1, participant 2, etc.), were used to protect participants' identities while allowing for apparent reference to individual responses.

Four themes emerged from the data analysis process, namely the perceived difficulties of implementing ROM into clinical practice, the perceived value of implementing ROM within occupational therapy, current trends in measurement in clinical practice, and ways to improve the implementation of ROM in clinical practice (see Table 4.1). The results and discussion of the demographics of the participants are presented first, followed by the results and discussion of the semi-structured interviews.

4.2 Demographics of the participants

Table 4.1 presents the relevant demographics of the participants, followed by an interpretation of the data.

Table 4.1 Demographics of participants (n=10)

Participant	Age	Years of experience working in mental health
P1	27	5
P2	32	9
P3	29	6
P4	28	6
P5	32	9
P6	32	9
P7	32	9
P8	49	28
P9	30	5
P10	44	8

The study included ten occupational therapists currently working in private psychiatric settings across South Africa. All participants identified as women, not due to intentional sampling, but reflective of the profession's gender distribution, which is predominantly female (Ned et al., 2020).

Participants ranged in age from 27 to 49 years**,** with most falling in their late 20s to early 30s, suggesting a relatively young cohort. Despite their age, many had substantial experience in mental health practice, ranging from 5 to 9 years, which points to early-career professionals with established clinical exposure**.**

One participant (P8), aged 49, had 28 years of experience**,** making her the most seasoned practitioner in the sample. This indicates the presence of both emerging and

highly experienced voices in the data, contributing to a diverse range of professional perspectives within the group.

4.3 Results and discussion of the emerging themes

The inductive analysis conducted yielded four themes, namely 1) Perceived difficulties of implementing ROM into clinical practice, 2) Perceived value of implementing ROM in occupational therapy, 3) Current trends of measurement in clinical practice, and 4) Ways of improving ROM implementation in clinical practice. The themes have been arranged in a logical sequence to effectively present the participants' experiences and perspectives, ensuring a clear and engaging flow of information throughout. The results in this section will be presented and discussed under these themes. The codes, sub-themes, and overarching themes identified during the study are summarised in Table 4.2.

Table 4.2 Codes, sub-themes, and themes that emerged from the study

CODES	SUBTHEMES	THEMES
i. Limited time available for ROM implementation ii. Time intensive nature of implementing ROM iii. Limited time affects ROM accuracy iv. Prioritisation of other responsibilities due to limited time	**Time-consuming nature of ROM**	*Perceived difficulties of implementing routine outcome measurement (ROM) into clinical practice*
i. High expenses associated with acquiring ROM training and infrastructure ii. Negative effects of limited medical insurance coverage for occupational therapy iii. Clients may resist paying for assessments iv. Selectively implement ROM	**Cost implications of ROM implementation**	
i. Limited collaborative treatment ii. Communication barriers iii. Inconsistent therapy and length of stay iv. Resource constraints in inpatient settings	**Health system factors affecting the implementation of ROM**	
i. Limited awareness and availability of appropriate outcome measures ii. Contextual misalignment of outcome iii. Difficulty in assessing outcomes at a group scale	**Limited accessibility to appropriate outcome measures**	
i. Fluctuations in Mental Health Conditions ii. Subjectivity in psychiatric assessment iii. Lack of standardization	**Diverse perspectives on routine outcome measurement**	

i. Proves value of occupational therapy interventions to the MDT ii. Proves effectiveness of occupational therapy to medical insurances iii. Demonstrate intervention effectiveness	**Value of generating evidence**	*Perceived value of implementing ROM within occupational therapy*
i. Guides therapy by identifying intervention limitations and required adaptation ii. Clearly define the role of occupational therapy in mental health. iii. Appropriate placement of clients in therapy iv. Improves client's experience	**Making a valuable contribution**	
i. Clinical observations ii. Client feedback iii. Clinical records iv. Feedback forms v. Customised measuring tool	**Implementing non-standardised methods to monitor outcomes in clinical practice**	*Current trends of measurement in clinical practice in clinical practice.*
vi. Activity Participation Outcome Measure (APOM) vii. Alcohol, Smoking, Substance Involvement Screening (ASSIST) viii. Beck Depression Inventory ix. Behavioural Assessment of Dysexecutive Syndrome (BADS) x. Cognitive Assessment of Minnesota (CAM) xi. Depression Anxiety and Stress Scale 21 (DASS – 21) xii. DriveAble Cognitive Assessment (DCAT) xiii. Goal Attainment Scale (GAS) xiv. Hospital Anxiety and Depression Scale (HADS) xv. Montreal Cognitive Assessment (MoCA) xvi. Progressive Goal Attainment Program (PGAP) xvii. Repeatable Battery for Assessment of Neuropsychological Status (RBANS) xviii. Risk Appraisal Measure (RAM) xix. Thurstone Test of Mental Alertness (TMA) xx. World Health Disability Assessment Schedule (WHODAS 2.0)	**Implementing standardised methods to monitor outcomes in clinical practice**	

i. User-friendly and efficient outcome measurement ii. Alignment with Occupational Therapy Theory iii. Demonstrates functional change iv. Applicability to Group Therapy:	**Need for effective routine outcome measures in psychiatric settings**	*Ways of improving the implementation of routine outcome measurement (ROM) in clinical practice*
i. Provide and allocate time for ROM implementation ii. Make ROM implementation mandatory iii. Provide continuous training and management support	**Putting systems into place to improve the uptake of routine outcome measurement in clinical practice**	

4.3.1 Theme 1: Perceived difficulties of implementing routine outcome measurement in clinical practice

The first theme highlights the perceived challenges expressed by occupational therapists regarding the implementation of ROM in their daily practice. These perceived challenges were described in the following sub-themes. These included the time-consuming nature of ROM, cost implications of ROM implementation, health system factors affecting ROM implementation, limited accessibility of appropriate outcome measures, and diverse perspectives on ROM. This theme is discussed in the following subsection.

4.3.1.1 Time-consuming nature of routine outcome measurement

The time-consuming nature of ROM was a prominent challenge expressed by the participants in this study. In this subtheme, participants shared the time demands they faced in implementing ROM in their practice. Some of the challenges emphasised by the participants included the limited time available for ROM implementation, the lengthy process involved in implementing outcome measures, the impact of time constraints on ROM accuracy, as well as the need to prioritise other responsibilities due to an increased workload in their clinical practice. Some of the participants expressed difficulty in balancing the workload with the demands of ROM. Subsequently, the lack of time compromised a thorough assessment of a client before starting therapy. Participant 6 said the following:

> *So, for example, this week, um, in my 'Puzzle group,' I had a patient where, because we don't have enough time, um, in the first session, I didn't get a clear picture of where she was at on the first day, and it carried on all the way to day three. Um, this patient seemingly got lost, and thankfully, um, she was receptive to programming on day three. [P6]*

Additionally, Participant 5 expressed the following regarding ROM implementation and the related time demands:

It is so... it's difficult to implement it (ROM) because, I think, mainly because we don't have time. In most practices where I've worked, I've had to work 6 or 7 hours with clients and have maybe one hour to record outcome measures. We should try to do that, but I don't think we're getting there because we are all overworked and don't have enough time. [P5]

Other participants expressed that the lengthy nature of routine outcome measures contributed to the time constraints affecting the implementation of ROM. This was described by Participant 9, who said the following:

Um, it is a great tool (APOM), but I mean, it takes really a lot of time if you're not experienced with it, and if you are doing it with ten people, again, like I said, it's quite time-consuming [P9].

The time-consuming nature of ROM expressed by the participants in this study is unsurprising, as it is a widely recognised and well-documented obstacle in the literature. In their studies (Duncan & Murray, 2012; Boswell et al., 2015; Lewis et al., 2019; Davenport & Underhill, 2023), which corroborate these findings, mental health professionals often struggle to incorporate ROM into their daily practices due to the perceived time burden, despite acknowledging its importance.

The time-demanding nature of ROM implementation extends beyond the actual assessment process. According to Duncan and Murray (2012), substantial time investments are required for conducting measurements, documenting the findings, and integrating them into existing workflows, especially for those managing high caseloads and limited resources. Davenport and Underhill (2023) further highlighted that lengthy assessments made ROM more difficult to use among occupational therapists in the United Kingdom, which mirrors similar challenges faced by occupational therapists in South Africa, as established in this study.

The implementation of ROM offers numerous benefits, including enhanced tracking of client progress, more effective treatment planning, and the ability to deliver evidence-based care. By systematically measuring outcomes, ROM enables occupational

therapists to make data-driven adjustments, thereby enhancing the quality of care and ensuring that treatments are tailored to each individual's specific needs (de Jong et al., 2021).

However, despite these clear advantages, the adoption of ROM in clinical settings remains limited. Lewis et al. (2019) highlight that the time-consuming nature of ROM, coupled with the pressures of limited time for tasks beyond direct client care, means fewer than 20% of mental health practitioners regularly use ROM, with only 5% incorporating it into every treatment session. This low adoption rate emphasises the urgent need for ROM systems that are not only effective in theory but also practical and feasible in the day-to-day realities of clinical practice. The challenge of consistent ROM implementation is not confined to a single region. Still, it is a common issue across mental health practices in the United Kingdom, United States, and Australia, where occupational therapists face similar barriers in integrating ROM into their workflows.

The impact of time constraints is profound, significantly affecting the quality of care throughout the treatment process. Time pressures often lead to inadequate initial assessments, resulting in incomplete or inaccurate ROM. Consequently, this can lead to misaligned treatment plans, delayed identification of client deterioration, and missed opportunities for timely intervention adjustments (de Jong, 2021). As Participant 6 emphasized, these challenges not only compromise individual client outcomes but also hinder the profession's ability to establish a robust evidence base for its interventions.

Lambert and Harmon (2018) assert that limitations in implementing effective outcome measurement can erode the credibility and effectiveness of a profession. This is particularly pertinent for occupational therapy in psychiatric settings, where demonstrating the value and effectiveness of interventions is essential for securing professional recognition and resource allocation. In these settings, the subtle nature of client progress requires outcome measurement to validate the impact of occupational therapy, thereby supporting its role within the broader healthcare context.

In conclusion, the time-consuming nature of ROM implementation was a prominent challenge for participants, consistent with existing literature. High workloads and limited resources hinder effective use of ROM, leading to compromised assessments and suboptimal care. While ROM offers benefits such as improved treatment planning, its practical application remains challenging for many occupational therapists. Inadequate time for evaluations can lead to inaccurate data, which in turn affects treatment outcomes. To improve ROM adoption, more efficient systems are needed to fit the demands of clinical practice, ensuring ROM integration without compromising care quality. Addressing these time constraints is essential for better treatment and evidence-based interventions.

4.3.1.2 Cost implications of implementing routine outcome measurement

The participants in this study highlighted cost implications as an ongoing struggle influencing their ability to implement ROM in their current practice. In this subtheme, participants reported the financial demands of implementing ROM in clinical practice, which were mainly attributed to the high costs of acquiring ROM training, resources, and materials. Participant 7 expressed the following regarding the expenses of ROM training.

> *So, I mean, there is training available for that, but I mean, it's expensive. [P7]*

Other participants indicated that limited medical insurance coverage for occupational therapy services, particularly within mental health, along with the client's reluctance to pay out of pocket for assessments, was another factor obstructing the implementation of ROM. This was captured in the following:

> *Um, and then also the problem is that you need to be conscious of medical aid as well. So, it's not necessarily going to be the case that you're going to be able to bill for this, um, for whatever assessment, or you will be able to bill. However, for the amount of time and the energy you spend, you're not going to necessarily get the monetary value for the time spent. [P3]*

In line with previous studies, the participants in this study identified ROM as costly, thereby limiting its implementation in practice (Duncan & Murray, 2012; Boswell et al., 2015; Lambert & Harmon, 2018; Gelkopf et al., 2021). As alluded to by Gelkopf et al. (2021), the cost implications of ROM have several consequences for the occupational therapy profession. This includes the reluctance to adopt ROM practices, potential inconsistencies in their full implementation, and reduced quality of outcome measurements, as well as restricted opportunities for skill enhancement among occupational therapists (Ikiugu, 2017).

As highlighted by the participants, the expense of ROM may not be fully covered by medical insurance, making it more challenging to justify the costs in terms of the benefits they provide. This can lead to the selective implementation of ROM, as occupational therapists may prioritise activities with more straightforward or more immediate returns. This selective approach may result in limited or inconsistent data, thereby reducing the effectiveness of ROM in providing a reliable assessment of progress. As a result, it weakens its ability to track the client's progress over time. Subsequently, the limited adoption of ROM limits the ability to generate evidence supporting occupational therapy interventions in mental health, thus compromising the discipline’s ability to demonstrate its effectiveness (Silaule & Casteleijn, 2021). Alegría et al. (2023) further discussed numerous ethical considerations arising from the tension between the need for ROM in occupational therapy and the challenges associated with its implementation, particularly in psychiatric settings. These considerations include ensuring informed consent, safeguarding confidentiality and privacy, addressing potential stigma and discrimination, and striking a balance between clinical benefits and the welfare of the client.

Interestingly, while participants highlighted the high costs associated with ROM, they did not consider its potential for cost savings. Delgadillo et al. (2017) demonstrated that psychotherapy with ROM feedback yielded similar outcomes, albeit with shorter treatment durations, suggesting potential cost-effectiveness. This study, conducted in the United Kingdom, focused on psychotherapy, but its findings suggest that ROM could offer financial benefits in other therapeutic contexts. However, there is limited research on the cost-effectiveness of ROM, particularly within the field of occupational

therapy. Most existing studies tend to focus on specific settings or populations, which may limit their broader applicability. Currently, there is a lack of conclusive evidence supporting the cost-effectiveness of ROM in mental health occupational therapy settings. To fill this gap, future research should focus on broader, more diverse studies that examine the financial implications and potential cost-effectiveness of ROM in various occupational therapy settings, including those related to mental health.

In conclusion, participants highlighted the substantial cost implications of ROM implementation, exceptionally high expenses, and limited medical insurance coverage for occupational therapy in mental health. Clients' reluctance to pay out of pocket further hindered the adoption of ROM. These findings align with previous research on financial barriers faced by allied health professionals. While not widely discussed, the potential cost-saving benefits of ROM warrant further investigation, as more research is needed to assess its cost-effectiveness in occupational therapy settings.

4.3.1.3 Health system factors affecting the implementation of routine outcome measurement

The participants identified numerous health system factors that hinder their ability to implement ROM in their practice and highlighted them as considerable challenges. They discussed the systemic issues that occupational therapists face when trying to implement ROM in private psychiatric settings. These challenges include poor communication and limited collaboration within the multidisciplinary team, resource constraints, inconsistent client participation in the occupational therapy program, and varying lengths of stay. Some participants reported struggling to collaborate with their multidisciplinary team (MDT) due to poor communication. Participant 3 specifically emphasised the lack of collaborative treatment planning and decision-making, stating:

> *Additionally, due to poor communication, I'm finding that patients are sometimes discharged without our knowledge, which means we don't have the opportunity to reassess them at the end of the therapeutic journey or provide recommendations or a home program, as needed* [P3].

Systemic factors, such as staff shortages, made it difficult for participants to manage their workload. These challenges were exacerbated by issues within the multidisciplinary team, making it even harder to implement ROM. Participant 3 expressed the following:

> *We are two therapists that need to run a 50-patient hospital. So, it's, um, it's quite hard to do what we need to do (work responsibilities). And because, um, we are struggling with our multidisciplinary team as well. So, we have to do a lot of legwork in other areas just to do the basic things. So, um, there's a lot of issues [P3].*

Additionally, the unpredictable nature of private psychiatric settings, including fluctuating lengths of stay and varying client participation in occupational therapy groups, was recognised as a challenge to ROM implementation. Participant 1 shared this perspective, highlighting the following:

> *So, some patients only stay for a few days, some of them stay for 21 days, and some of them don't attend all of the groups, so then that makes it difficult. So, then the discharge APOM isn't always necessarily a true reflection of the patient because they haven't maximally attended therapy. [P1]*

Poor communication and limited collaboration within the multidisciplinary team were perceived as ongoing barriers that hindered the participants' ability to implement ROM effectively. Timmins et al. (2022) highlighted the importance of tailored interventions and effective communication in the context of ROM. According to Taberna et al. (2020), the implementation of ROM is vital for providing valuable feedback that supports individualised treatment plans. Conversely, the limited communication among the multidisciplinary teams deters the effectiveness of ROM, thereby affecting the continuity and delivery of quality care. The lack of clear communication about the results of ROM or treatment adjustments can lead to difficulties in fully integrating ROM into practice. This negatively impacts the ability to consistently track client progress and make informed, individualised recommendations, ultimately weakening the potential benefits of ROM in occupational therapy within mental health. Therefore,

ensuring strong communication and collaborative approaches is necessary to overcome these obstacles and improve the implementation of ROM.

Woodcock et al. (2019) emphasise that poor communication and inconsistent client attendance disrupt continuity of care, posing a prominent challenge to the implementation of ROM in psychiatric settings. The unpredictable nature of private psychiatric care complicates ROM usage, as factors like fluctuating client attendance and varying lengths of stay can negatively impact the accuracy of outcome assessments.

In South Africa, these issues are worsened by limitations imposed by medical insurance schemes, particularly in private psychiatric care. For instance, many medical insurance plans limit inpatient treatment to just 21 days per beneficiary per financial year (Craig et al., 2022). These restrictions can be particularly detrimental for clients with severe mental health conditions, who often require extended care for proper stabilisation and recovery. A study conducted in South Africa by Mlay et al. (2025) demonstrated that while prolonged psychiatric hospital stays can involve risks, such as institutionalisation and higher costs, they offer crucial therapeutic interventions and notably lower the risk of relapse. On the other hand, shorter stays often dictated by limitations set by medical insurance schemes can result in premature discharge, which may impede long-term recovery and the comprehensive treatment necessary for sustained mental health stability.

Beyond inpatient care, access to occupational therapy services in psychiatric settings remains limited. This is partly due to a lack of evidence demonstrating the effectiveness of occupational therapy in psychiatric treatment (Silaule & Casteleijn, 2021). Consequently, many medical insurance companies enforce restrictions on occupational therapy coverage, limiting the number of mental health therapy sessions or restricting access to specialised professionals, such as occupational therapists (KeyHealth Medical, 2024). These limitations diminish the potential benefits of occupational therapy, particularly in enhancing functional skills and facilitating reintegration into daily life for psychiatric clients.

Medical insurance must consider extending treatment durations for clients who require intensive care to ensure comprehensive stabilisation and prevent relapse. The field of occupational therapy must strengthen its evidence base to advocate for broader coverage by medical insurance schemes. By demonstrating the discipline's effectiveness in psychiatric care, occupational therapists can help secure the necessary funding to ensure that clients receive the holistic support they need for long-term recovery. A more integrated approach, one that prioritises extended treatment duration, structured assessments, and enhanced occupational therapy access, will ultimately improve clinical outcomes and lead to better long-term mental health care.

The challenge of resource constraints, particularly labour shortages, is highly relevant to this study. Robinson (2023) highlights that hospital staff shortages can lead to safety issues and hinder the delivery of comprehensive care, a sentiment echoed by the participants in this study. Participant 3 highlighted the difficulties of managing a caseload of 50 clients simultaneously, with only two occupational therapists, thereby placing substantial strain on them. With this imbalance in the client-therapist ratios, therapists are less likely to find time to implement ROM.

Resource constraints pose a prominent challenge to the implementation of ROM in occupational therapy. The requirement for consistent tracking of client progress necessitates substantial time and attention, which can be challenging to allocate given heavy workloads and limited staffing (Boswell et al., 2015; Waldron et al., 2018; Bear et al., 2021). This scarcity of resources can lead to inconsistent implementation of outcome measurement and incomplete assessments, ultimately diminishing the effectiveness of ROM in enhancing treatment planning and client outcomes. To overcome these challenges, improving staffing levels and streamlining ROM processes are crucial to ensure a successful integration without compromising the quality of care provided.

In conclusion, the participants identified several systemic factors that significantly hinder the successful implementation of ROM in psychiatric settings. Challenges such as poor communication, limited collaboration within the multidisciplinary team, staff shortages, inconsistent client participation, and the unpredictable nature of private

psychiatric settings were all emphasised as prominent barriers. These factors not only disrupt the continuity of care but also make it challenging to assess and track client progress accurately. The experiences shared by participants align with existing literature, which indicates that effective communication, consistent participation, and adequate resources play a vital role in facilitating ROM implementation, essential for ensuring the success of occupational therapy interventions. Addressing these systemic challenges is critical to improving the implementation of ROM and the overall quality of care provided by occupational therapists in private psychiatric settings

4.3.1.4 Limited accessibility to appropriate outcome measures

The participants identified limited access to appropriate outcome measures as a difficulty that impacted their ability to implement ROM. The limited awareness of outcome measures, especially those suitable for psychiatric settings, the shortage of culturally sensitive tools, and the restricted access to outcome measures for evaluating clients at a group level were identified as prominent challenges. Participants expressed limited knowledge of occupational therapy outcome measures suitable for psychiatric settings. While they identified outcome measures, such as the APOM, as an option, they highlighted time constraints as a notable difficulty, preventing their practical use in their practice. This was captured by Participant 4, who expressed the following:

> *I think for myself, it's probably because I don't know really what's out there. You know, I don't know a lot about what the options are of a structured outcome measure, that's been set up specifically for mental health. I mean, the APOM is there, but the challenge with that specifically is time, you know, not being able to fit it in. [P4]*

Another factor that negatively impacted the implementation of ROM was the relevance of the available outcome measures to the participants' current practice context. Participants raised concerns about the appropriateness of these measures, pointing out that they were not well-suited to the cultural context and the specific needs of the individuals they worked with. This was expressed by Participant 9, who said:

If you look at South Africa and the culture, and so say you have something that's actually not so time consuming, like it needs to really like apply to our culture because a lot of the stuff does not. So, we kind of wing it a bit as therapists, I think. Um, and we try and observe and compensate with like our observation skills with regards, because it's not, it doesn't fit with our culture and our, the people we see. [P9]

Some participants reported challenges in assessing clients at a group level. They indicated therapeutic groups as frequently used interventions and emphasised the difficulty of finding effective methods to determine clients collectively rather than individually. Participant 7 voiced this concern, stating,

"But yeah. Um, like I said earlier, majority of our patients are in groups. And so, yeah, um, still maybe a challenge would be how do we actually assess them on a group, like on a larger scale, like a group scale, because we are working with groups." [P7]

The challenges related to the accessibility of appropriate outcome measures in occupational therapy settings within psychiatric care have been well-documented (Silaule & Casteleijn, 2021). While participants in this study were familiar with the Activity Participation Outcome Measure (APOM), a notable knowledge gap persisted regarding other available outcome measures. This gap highlights a broader issue in which occupational therapists often rely on generic tools that fail to capture the specific impact of interventions in psychiatric settings effectively. As Silaule and Casteleijn (2021) argue, this reliance on generalised measures compromises the accurate assessment of intervention effectiveness, as these tools do not address the unique and complex needs of mental health clients. Subsequently, the inability to assess outcomes in a meaningful way not only limits occupational therapy's ability to demonstrate its effectiveness but also impedes the development of targeted interventions tailored to the distinct needs of individuals in psychiatric care (Castelejin, 2010).

The availability of precise and contextually relevant outcome measures is essential, particularly in private psychiatric settings, The continued use of generic tools restricts occupational therapists' ability to effectively demonstrate the true impact of their interventions, which can affect clinical decision-making, hamper client progress tracking, and potentially limit the allocation of resources, including funding and policy support for occupational therapy services. Addressing this gap requires increased awareness, comprehensive training, and improved access to a broader range of validated outcome measures specifically designed for psychiatric settings. Without such measures, the effectiveness of occupational therapy in mental health care will likely remain undervalued, ultimately influencing both service provision and client outcomes.

The lack of awareness and access to appropriate outcome measures is not just an issue of missing tools but also affects occupational therapists' ability to provide culturally competent care. Silaule and Casteleijn (2021) emphasise the need for context-specific and culturally appropriate outcome measures. In the absence of these tools, occupational therapists are forced to rely on their observational skills to bridge cultural gaps. While this reliance can be beneficial in the short term, it introduces significant limitations, including the potential for inaccurate assessments and treatment planning. Without culturally sensitive tools, occupational therapists cannot fully address the diverse needs of their clients, which could lead to ineffective or misinformed interventions (Casteleijn, 2010).

An evident gap identified by participants is the lack of outcome measures specifically designed for group therapy, a primary treatment modality in occupational therapy psychiatric settings. Meyer et al. (2024) support this point, noting that group therapy is frequently used for conditions like major depressive disorder. However, despite its widespread use, there is a lack of strong evidence supporting its effectiveness. This gap in evidence may stem from the absence of specialised outcome measures to assess the specific impact of group therapy.

The inability to accurately measure the effectiveness of group therapy may hamper its credibility, integration into mental health care frameworks, and continued use

(Marmarosh et al., 2022). Without appropriate assessment tools, occupational therapists may struggle to justify and refine group interventions based on measurable outcomes. This emphasises the importance of research and innovation in outcome measurement to ensure that the benefits of group therapy are accurately captured, ultimately enhancing clinical decision-making, service provision, and advocacy for occupational therapy in mental health care.

In conclusion, the challenges surrounding the accessibility of appropriate outcome measures in psychiatric occupational therapy settings are multifaceted, including limited awareness of suitable measures, a lack of culturally sensitive tools, and difficulties in assessing clients in group settings. These issues impede the ability to effectively capture the impact of interventions, mainly when relying on generalised tools that fail to address the unique needs of mental health clients. Furthermore, the absence of specialised outcome measures for group therapy, a common intervention in psychiatric care, limits the evidence supporting its effectiveness. To improve service delivery, there is a need for more context-specific, culturally appropriate, and validated outcome measures. This would enable occupational therapists to assess better and demonstrate the effectiveness of their interventions, ultimately improving clinical decision-making, client outcomes, and the credibility of occupational therapy within mental health.

4.3.1.5 Diverse perspectives on routine outcome measurement

The participants identified three key perceptions that hinder the effective implementation of ROM in psychiatric settings: the variability of mental health conditions, the difficulty of quantifying abstract concepts, and the need for greater standardisation in measurement tools and documentation practices.

The fluctuation in clients' mental health states was recognised as a barrier to objective assessments. Participants noted that specific stress measures were less reliable because they depended on clients' emotional states on any given day. Participant 9 shared their perspective, stating:

Um, and I use, um, scales basically determining, like, where's your stress out of 10, or 10 is good. No, ten is ten is good. And one is bad. Um, and then I kind of like, yeah, I use that. And then if I do see the patient again, and it's kind of a journey, then I look at those again. Um, but what I found with that is, like, did I have a good day? So, then my stress is better, like, I cope with my stress better than if I'm at a bad place. So, I think that's, that is not helpful. [P9]

Other participants expressed difficulty in measuring abstract concepts such as spiritual growth and emotional well-being that are central to their therapeutic interventions. This was highlighted by Participant 9, who raised the following question:

But if I think of group therapy and some of the really abstract concepts of spirituality and forgiveness, how do I measure that? Like, how do I measure your change with regards to, like, really, really abstract concepts? Like that people can't even, like, how do I, I don't know, like, how do you? [P9]

Inconsistencies in measurement tools, systems, and documentation practices were identified as prominent obstacles to implementing ROM in psychiatric settings. Some participants emphasised that variations in practices across different settings make it difficult to compare clients and share insights, limiting opportunities for mutual learning. One participant expressed this concern, stating:

Um, time and that we probably all use different measuring scales or systems or note-keeping formats, um, which means I can't compare my patients with yours. There's like a million practices, but we're all doing things differently. So, if we all did it the same way, we could learn something from that or share cases or, um, compare. [P5]

The lack of standardisation in administering outcome measures by different occupational therapists was seen as contributing to discrepancies in client assessments. One participant recalled:

I also remember while 'locuming', many OTs see the same person over these days, and our scoring is different. So, even if we did have a score system, we didn't all agree on it. So how accurate is it anyway? [P5]

Concerns were also raised about the impact of inconsistent documentation on measurement accuracy. Participants noted that differing interpretations of a client's behaviour could lead to skewed results. As Participant 5 explained:

So, I often read notes of two people, two therapists of the same patient on one day, and one will say passive and one will say passive-aggressive, or passive-aggressive and aggressive often gets, um, confused. I'm just using that as an example, but it's because we don't have a proper understanding of what it looks like. So, if the team all have different opinions, the measurements aren't going to be accurate, really. [P5]

The results of this study are in agreement with previous research conducted by Kilbourne et al. (2018), Woodcock et al. (2019), and Maciejewski et al. (2022). Developing quantitative measures for abstract mental health concepts presents a recognized assessment challenge (Maciejewski et al., 2022). This difficulty extends beyond just assessing mental health outcomes; it also involves articulating how to measure these complex concepts effectively. This raises concerns about the validity and reliability of existing outcome measures, as they may not adequately capture the dynamic nature of mental health conditions. Such limitations complicate the implementation of routine outcome measures in psychiatric settings.

The struggle to translate complex psychological concepts into measurable data points is a fundamental issue in mental health research and practice. This challenge is not only crucial for evaluating the effectiveness of interventions but also for informing treatment decisions and enhancing client outcomes. The need for more effective measurement tools that capture the complex and dynamic nature of mental health remains a central concern in occupational therapy (Meyer et al., 2024). In private psychiatric settings, these challenges can lead to inconsistent treatment plans, making

it difficult to monitor progress accurately and justify the allocation of resources effectively.

The research findings accentuate the variability in how occupational therapists interpret client behaviours, which leads to inconsistent documentation practices. This lack of standardisation in outcome measures presents numerous challenges in mental health settings. Kilbourne et al. (2018) highlighted that differences in practices and measurement systems across various settings complicate data comparison and hinder the sharing of insights. Even when identical measures are applied, discrepancies in scoring can compromise both the accuracy and reliability of assessments.

Woodcock et al. (2019) further observed that the absence of standardisation impedes effective communication and collaboration among healthcare professionals. This challenge is compounded by perspectives such as that of Participant 9, who noted the inherent difficulty of measuring abstract concepts in mental health. Without standardised tools, interpretations of these abstract concepts can differ, further contributing to inconsistencies in documentation and diminishing the overall reliability of assessments.

Prost et al. (2022) emphasised the need for standardised outcome measures in psychiatric settings to facilitate comparisons across services, improve service quality, and enhance consistency in assessment and documentation. Standardised tools are required to ensure consistent outcome assessments across diverse settings, as well as for evaluating and continuously improving mental health services. The need for such tools is even more pressing when considering how different occupational therapists approach and document client behaviours. In the absence of standardisation, these inconsistencies undermine the overall quality and utility of assessments in mental health care (Prost et al., 2022).

The challenge of accurately measuring progress in psychiatric settings is compounded by daily fluctuations in a client's condition. As revealed in this study, a client's reported response may vary depending on their emotional state or events occurring on any

given day, making it challenging to capture a consistent picture of their mental health status. Boswell et al. (2015) similarly highlighted the difficulties in measuring psychotherapy outcomes, stressing the importance of using measures that are sensitive to change, clinically meaningful, and capable of capturing the inherent fluctuations in mental health conditions. Given these daily variations, there is a pressing need for outcome measures that not only assess progress over time but also adapt to the dynamic nature of mental health conditions. Current tools often fail to capture the full spectrum of a client's experiences, underscoring the necessity for more accurate instruments that can track these fluctuations effectively.

Focus must be placed on developing more standardised outcome measures that can accurately capture abstract mental health concepts to address these challenges. This includes creating guidelines for the consistent implementation and interpretation of these measures across psychiatric settings, as well as designing tools that can effectively track and analyse day-to-day fluctuations in mental health, offering a more comprehensive view of a client's progress over time. Addressing these issues in mental health practice will pave the way for more reliable, valid, and clinically helpful outcome measures, ultimately improving the quality of care provided to individuals with mental health conditions.

In conclusion, the challenges identified in this subtheme highlight key barriers to the effective implementation of ROM in psychiatric settings. These include the variability of mental health conditions, difficulty quantifying abstract concepts, and a lack of standardisation in measurement tools and documentation practices. In private psychiatric settings, these issues can lead to fragmented treatment plans, making it difficult to monitor progress and justify resource allocation. Addressing these challenges requires the development of standardised, dynamic tools that can capture fluctuating mental health conditions and assess abstract concepts more accurately. By establishing consistent guidelines and reliable tools, mental health care can be enhanced, resulting in more accurate assessments and improved client outcomes.

The implementation of ROM in clinical occupational therapy practice faces numerous challenges, as highlighted in this study. Key barriers include the time-consuming

nature of ROM, financial constraints, systemic healthcare factors, limited access to appropriate outcome measures, and diverse perspectives on its application. The findings emphasise that while ROM provides valuable insights for treatment planning and improving the quality of occupational therapy interventions, its practical adoption remains hindered by resource limitations, inconsistent methodologies, and the complexities of mental health assessment.

Addressing these challenges requires a multi-faceted approach, including streamlining ROM processes, improving staff training, advocating for financial support, fostering collaboration within multidisciplinary teams, and developing culturally relevant and standardised assessment tools. By making ROM more practical and accessible, occupational therapists can enhance evidence-based practice and ultimately improve client outcomes in psychiatric settings. The second theme shifts focus to the importance of ROM for occupational therapists in psychiatric settings, emphasising its contributions to clinical practice.

4.3.2 Theme 2: Perceived value of routine outcome measurement for occupational therapists in mental health

The second theme of the study focuses on the benefits of implementing ROM for occupational therapists in private psychiatric settings. The perceived value of ROM was expressed in the following subthemes, which include value in generating evidence and making a valuable contribution. This theme is discussed in the following subsection.

4.3.2.1 Value in generating evidence

The participants highlighted the value of ROM in generating evidence. In this subtheme, the participants discussed the importance of using objective data to validate and support occupational therapy interventions in psychiatric settings. They identified key benefits, including the ability to demonstrate the effectiveness of occupational therapy interventions by generating evidence of functional improvements or regressions in clients, highlighting the contributions of occupational therapy within the multidisciplinary team, and demonstrating its impact on medical insurances.

Some participants noted the value of using ROM to monitor change during occupational therapy interventions. They explained that this data enables them to track progress over time and adjust or optimise therapy to support client outcomes better. As Participant 6 highlighted:

> *If you are treating a therapist, you need to be able to track change, and you need to track whether there is improvement or if therapy isn't working to be able to sort of pivot from that, upgrade or downgrade. [P6]*

The study reveals that client data is leveraged to demonstrate the effectiveness of occupational therapy interventions in psychiatric settings. The necessity to present evidence of occupational therapy contributions was further highlighted to ensure the discipline's efforts are recognised. Participant 6 expressed the following:

> *So, I think it's a very needed skill or something that we need to do to actually see whether our therapy made any difference or any changes, so to see where the patient is. Our profession is easily diminished or just, um, ignored because we are not proving that we are making a difference. So overall, yes, we should be implementing ROM so that we can show the effectiveness of our therapy. [P5]*

In addition to emphasising the need for objective data to assess the impact of occupational therapy on client outcomes, several participants stressed the importance of generating evidence that demonstrates their unique contributions within multidisciplinary teams. As Participant 2 stated:

> *All right, so I think I've already mentioned it's a way for us to create an evidence base, as I think as a profession to create evidence for occupational therapy in mental health and psychiatry. But I think also maybe in specifically our practice to create an evidence base that makes our role clearer within the MDT and make it easier to communicate our role to our colleagues. [P2]*

Similarly, participants emphasised the need to provide evidence to medical insurance

companies to secure ongoing funding for occupational therapy services in private psychiatric settings. By demonstrating measurable improvements and cost-effectiveness, occupational therapists can build a compelling case for allocating resources. Participant 4 expressed the following:

> *I know for, for example, with medical aids, if you are able to show that the service that you provide is actually effective or makes a difference, does make a change in a patient's mental health or quality of life, then they're more likely to fund it and, or more likely to continue funding it. [P4]*

The pivotal role of evidence in validating and advancing occupational therapy practices has been widely acknowledged in recent studies from both the United States and South Africa (Lambert & Harmon, 2018; Pretorius & Franzsen, 2023; Meyer et al., 2024). The growing emphasis on evidence-based practice, particularly in healthcare systems undergoing significant transformation, underscores the need for occupational therapy to demonstrate its distinct contributions to mental health care.

Pretorius and Franzsen (2023) emphasised the importance of evidence to demonstrate the impact of occupational therapy in mental health settings. This aligns with broader trends in healthcare, particularly the shift toward outcome-driven care, as seen in South Africa's move toward adopting the National Health Insurance (NHI) (South African National Department of Health, 2023b). As healthcare increasingly focuses on measurable outcomes, occupational therapy must adapt by providing clear evidence of its effectiveness and its vital role within multidisciplinary teams. This not only strengthens occupational therapy's position within mental health care but also ensures that it remains an integral part of evolving healthcare frameworks such as the NHI.

A fundamental way to enhance the professional credibility of occupational therapy in mental health is through the implementation of ROM. Participants in this study recognised ROM as a valuable tool for showcasing the effectiveness of occupational therapy interventions. By providing quantifiable evidence of progress, ROM helps clarify the unique role of occupational therapy within multidisciplinary teams. This, in

turn, fosters improved communication and collaboration with other healthcare professionals, ultimately reinforcing the position of occupational therapy in healthcare systems (Meyer et al., 2024). However, as this study revealed, occupational therapy is often underappreciated or overlooked due to the lack of concrete evidence supporting its effectiveness. Demonstrating the tangible impact of occupational therapy interventions is essential for ensuring that occupational therapists are recognised as key stakeholders in mental health care.

Funding and sustainability were also prominent perceptions discussed by the participants. A connection was highlighted between the need for evidence and securing financial support for occupational therapy services, especially in private psychiatric settings. The study findings are consistent with those of Pretorius and Franzsen (2023), who emphasise the importance of using ROM to present clear, compelling evidence of intervention effectiveness. Such data is essential for persuading medical insurance companies to maintain or increase funding for occupational therapy services. This is particularly pertinent in the South African context, where mental health services—occupational therapy included—face limited funding despite the high prevalence of mental health conditions (Docrat et al., 2019). By presenting evidence of their impact, occupational therapists can advocate for expanded medical insurance coverage for mental health services, thereby improving access to care and contributing to the long-term sustainability of these services.

In summary, the participants' perceptions emphasise the prominent role of evidence in occupational therapy practice. Evidence not only promotes professional development and improves client care but also helps secure the discipline's position within the broader healthcare system. By adopting ROM and its benefits, occupational therapy can continue to evolve in an evidence-based healthcare environment. Ongoing funding for services is essential for this progress. ROM provides valuable data to demonstrate the effectiveness of occupational therapy, which is crucial for securing continued support and resources. By integrating evidence-based practices into clinical work, the profession can improve client outcomes and ensure sustained funding and growth for occupational therapy services.

4.3.2.2 Making a valuable contribution

This subtheme examines the role of ROM in occupational therapy practice, specifically its application in utilising occupational therapy models and outcome measures to assess, categorize, and tailor group interventions based on clients' levels of functioning. The study highlighted how ROM enhances the overall therapeutic experience for clients.

A valuable contribution of ROM identified in this study is its role in tailoring group interventions to match the individual capabilities of clients. Some participants reported using the Creative Ability Model to guide this process by assessing and categorising clients based on their levels of creative ability. This approach ensures that group interventions are appropriately structured to meet the specific needs of clients. As Participant 1 explained:

> *So, within our setting in the hospital, we grade our groups according to the different levels of creative ability. The group is then structured for self-presentation or passive, and so on.* [P1]

Other participants emphasised the importance of conducting outcome measures, particularly the APOM, to tailor groups according to clients' capacity for self-reflection and introspective processes. This was further illustrated by Participant 1:

> *Also, clients fall within a certain level; they may struggle with experiential or projection or introspection in reflection groups. So, using the APOM helps with creating our groups according to it.* [P1]

Other participants shared about the emotional and psychological benefits of involving clients in ROM. They highlighted how ROM fosters hope, enhances self-worth, and reinforces a sense of progress. One participant explained that ROM data provides tangible evidence that validates clients' experiences and strengthens their sense of agency. This sentiment was conveyed by Participant 4:

I think it can improve patient experience, and maybe if the patient is also involved in doing the outcome measure, completing it themselves or in conjunction, that can also show them that they're being taken seriously and give them a sense of hope if there is a change that that is shown, um, yeah, reflecting back and looking at where they're at currently. It can give a sense of hope, I'm sure. Yeah, and a sense of feeling proud and not having wasted time, you know. [P4]

The findings of this study underscore the pivotal role of ROM in tailoring group interventions to meet the unique capabilities of clients, with a particular focus on the Creative Ability Model (CAM) and the Activity Participation Outcome Measure (APOM). As participants highlighted, tools like the APOM and CAM are for assessing and categorising clients based on their functional levels. This allows occupational therapists to structure group interventions effectively, addressing clients' unique needs, whether related to their creative potential or ability to engage in self-reflection.

These results are consistent with broader research that emphasises the significance of ROM in psychiatric settings, where client progress can often be complex and non-linear (Lambert & Harmon, 2018). As demonstrated in this study, tools like the APOM and CAM provide objective data that not only inform clinical decisions but also ensure interventions are tailored to meet individual needs. This aligns with studies showing that standardised tools improve service delivery, track outcomes, and support professional development (Van der Reyden et al., 2019).

However, challenges persist in effectively implementing these tools, particularly in private psychiatric settings. The complexity of tools like the APOM, especially in terms of scoring and interpretation, can create obstacles for some therapists (Silaule & Casteleijn, 2021). Furthermore, financial limitations and the need for professional recognition underscore the importance of demonstrating the impact of occupational therapy. Overcoming these challenges through additional training and better contextualisation of data is crucial to fully leverage the benefits of ROM, especially in private settings, where it plays a key role in both clinical practice and securing support from insurance providers (Pretorius & Franzsen, 2023).

In psychiatric occupational therapy, the emotional and psychological benefits of involving clients in ROM are profound. Routine outcome measurement, when combined with outcome measures and theoretical frameworks, not only helps structure therapy but also fosters hope, enhances self-worth, and reinforces clients' sense of agency. As highlighted by Participant 4, showing evidence of progress makes clients feel validated and taken seriously, aligning with Lambert and Harmon (2018), who argue that such validation helps counteract the disempowerment often experienced in mental health settings.

Additionally, involving clients in the ROM process strengthens their sense of hope and optimism. When clients observe measurable improvements in areas such as self-esteem and emotional regulation, they are more likely to believe in their ability to recover (Oster et al., 2023). This belief, in turn, boosts motivation and engagement in therapy, which are essential for progress (Unsworth, 2011). Additionally, ROM also promotes client- centred care by involving clients in tracking their progress, which improves therapeutic relationships and respects their autonomy (Van der Reyden et al., 2019).

The implications of involving clients in ROM are far-reaching. It not only aids recovery but also increases motivation and engagement, which are vital for successful therapy. The validation clients experience mitigates feelings of disempowerment, contributing to a more favourable therapeutic journey (Lambert & Harmon, 2018). Moreover, active participation in their progress strengthens the client-centred approach, leading to more personalised and empowering interventions.

In conclusion, this study underscores the crucial role of ROM in psychiatric occupational therapy, particularly in tailoring interventions to meet the unique needs of individual clients. By utilising tools such as the CAM and APOM, occupational therapists can structure group interventions more effectively, addressing diverse functional levels and enhancing therapeutic outcomes. The emotional and psychological benefits of ROM, including fostering hope, improving self-worth, and validating clients' experiences, further strengthen its importance. Despite challenges in implementation, especially in private psychiatric settings, overcoming these

obstacles through training and data contextualisation can maximize the benefits of ROM, ultimately supporting recovery, motivation, and client-centred care. This approach leads to more personalised, empowering interventions, contributing to a positive and practical therapeutic experience for clients.

Theme two of the study underscores the value of ROM in psychiatric occupational therapy, highlighting its role in generating evidence, tracking progress, and validating the impact of occupational therapy. Routine outcome measurement supports decision-making, secures funding, and tailors interventions to clients' needs, thereby enhancing therapeutic outcomes. It also fosters emotional benefits, such as hope and self-worth. While challenges exist in implementation, proper training and contextualisation can overcome these, ensuring ROM promotes personalised, client-centred care and improves therapy effectiveness and client engagement.

4.3.3 Theme 3: Current trends of measurement in clinical practice

The third theme of the study focuses on the current trends of measurement in clinical practice. In this theme, participants shared their perceptions of the various methods used to measure outcomes in clinical practice. The subthemes for this theme included implementing non-standardised methods to monitor outcomes in clinical practice and implementing standardised methods in clinical practice. The following subsection discusses this theme.

4.3.3.1 Implementing non-standardised methods to monitor outcomes in clinical practice

The participants reported utilising a variety of non-standardised methods to monitor outcomes in their clinical practice. These methods included clinical observations, client feedback, goal setting and evaluation, reviewing clinical records, use of client feedback forms, and assessment tools tailored to their specific mental health contexts.

Some participants reported relying primarily on clinical observations and their clinical judgements to monitor the outcomes in their clinical practice. They emphasised the

importance of using a non-standardised framework to monitor changes. Participant 1 described this by saying:

> *We don't, well, I don't use any formal, um, standardised assessment, but I mean, I use my, like, clinical, yeah, clinical judgments, I think, and, like, just having a more non-standardised structure of what to observe for, um, and then you can see the difference [P1].*

Along with clinical observations, the participants reported using the evaluation of goals as a method to assess whether interventions offered enabled clients to meet their treatment objectives. This involved setting goals at the beginning of the treatment session and evaluating if these were reached at the end. This was expressed in the following:

> *Yeah, primarily clinical observations and then, like reaching certain goals, I guess. So, you know, evaluating goals that were set maybe at the start of the session, or what the patient brought to the session, you know, as what they would like to focus on. Yeah. So, looking at reaching those goals. [P4]*

Other participants mentioned that they depended on direct feedback from clients to understand the clients' experiences and the improvements resulting from their interventions. This was expressed by participant 3:

> *Um, so mostly for me personally, it's basically the feedback that I get from clients. It's seeing how clients improve and seeing how they actually experience therapy. [P3]*

Additionally, a few participants reported adapting existing tools to make them more relevant and applicable to the specific type of therapy provided by the occupational therapist. This was expressed by Participant 3, who stated:

> *So, um, breaking it up was our solution because also, um, it's very difficult to see some of these things in a process group, um, from the creative ability level. And so, taking those things away and rather using the things that are relevant, like the interpersonal, um, aspects and things like that. So, yeah, that's how we've been trying to just implement it, um, more effectively. [P3]*

This sentiment was further supported by some participants who noted that adapted assessment tools were used to better communicate the assessment findings to the multidisciplinary team. Participant 2 expressed this in the following statement:

> *So, we have developed a different little tool of our own so that it is more translatable to psychiatrists and psychologists who don't necessarily want to see functioning from an occupational therapy perspective but in language that they understand, which I feel the APOM doesn't necessarily do. [P2]*

Non-standardised outcome measures provide occupational therapists with the flexibility to tailor assessments to individual client needs, which is particularly valuable in mental health settings. Kearns et al. (2021a) argue that although standardised measures have their place, non-standardised approaches are crucial for capturing the personalised, recovery-focused aspects of mental health care. Standardised tools often fall short in addressing the full complexity of a client's experience, while non-standardised methods—such as clinical observations, client feedback, and goal setting—enable therapists to assess progress more comprehensively. These methods provide a clearer understanding of key aspects of recovery, including emotional well-being, coping strategies, and functional participation (Kearns et al., 2021b; Grey et al., 2020).

A key advantage of non-standardised outcome measures is their adaptability to different therapeutic contexts. Participants in this study emphasised modifying existing tools to improve their relevance and tailoring assessments to the needs of various healthcare providers. Tse et al. (2023) argue that for outcome measures to be effective, they must be locally acceptable and feasible, highlighting the importance of adapting tools to specific clinical settings and provider perspectives. Customising tools in this way fosters interdisciplinary collaboration, supports informed clinical decision-making, and ensures assessments align with diverse professional frameworks (Tse et al., 2023). Furthermore, tools like the Activity Participation Outcome Measure (APOM) may not always align with the perspectives of professionals from different disciplines. This provides evidence for the need to develop adaptable tools that facilitate effective communication across multidisciplinary teams (Cahill et al., 2022).

Non-standardised approaches also prioritise client-centred care. By emphasising client feedback and goal setting, occupational therapists actively engage clients in

their treatment, which helps foster empowerment and motivation. Bowman et al. (2015) demonstrate that structured goal setting can enhance motivation, foster collaboration, and provide a clear framework for tracking progress. Additionally, client feedback plays a crucial role in strengthening the therapeutic relationship, ensuring that treatment remains adaptable to the client's changing needs and ultimately improves the overall effectiveness of therapy (Boswell et al., 2015).

However, non-standardised outcome measures come with their own set of challenges. One limitation documented is the subjectivity inherent in informal observations and clinical judgments. Although participants valued their clinical expertise, such methods can introduce biases and inconsistencies (Jensen-Doss & Hawley, 2019). Similarly, client feedback is susceptible to influences like recall bias or emotional state, which can distort the accuracy of reported progress (Boswell et al., 2015). These subjectivities can undermine the reliability of non-standardised assessments.

Additionally, the use of customised tools raises concerns about standardisation and comparability. Oster et al. (2023) highlight that, without standardised benchmarks, comparing outcomes across different practitioners, settings, and populations becomes challenging. This lack of consistency can impede the development of a robust evidence base in occupational therapy, affecting both the generalisability of findings and the credibility of interventions (Oster et al., 2023).

To address these challenges, a more balanced approach is needed. Combining both standardised and non-standardised outcome measures can bring together the strengths of both methods. Standardised measures can enhance objectivity, comparability, and consistency, while non-standardised tools maintain the flexibility required for personalised, client-centred care. Future research should explore ways to integrate standardized tools without sacrificing the individualised nature of mental health occupational therapy. By refining assessment practices, occupational therapists can continue to deliver high-quality, evidence-based care that meets the diverse needs of clients.

In conclusion, non-standardised outcome measures offer key benefits, including flexibility, customisation, and a more holistic view of client progress in mental health settings. These measures also encourage interdisciplinary collaboration and

strengthen the therapeutic relationship by involving clients directly in the treatment process. However, challenges such as subjectivity, bias, and limited comparability persist in customised tools. A balanced approach, integrating both standardized and non-standardised measures, could improve the reliability and flexibility of outcome assessments in occupational therapy. Future research should focus on strategies to maintain this balance, ensuring effective, client-centred care in mental health practice.

4.3.3.2 Implementing standardised methods to monitor outcomes in clinical practice

The participants emphasised the implementation of standardised assessments, which enabled them to evaluate various domains of client functioning. These measures support the assessment of cognitive abilities, functional participation, and the screening and evaluation of mental health and substance use.

The participants reported using a variety of standardised outcome measures in their clinical practice. They selected these tools based on factors such as the client's diagnosis, treatment goals, and the specific aspects of function or progress being assessed. Various outcome measures were identified by participant 7 in the following statement:

> *Okay, and so, um, the CAM, the RBANS, HADS, um, the Beck Depression Inventory. Um, APOM. Um, I've done the BADS. Um, like, a few years ago, I've done that, um, but I think that's all that I've used, yeah. [P7]*

Similarly, some participants reported using the APOM for both initial and post-intervention evaluations, indicating its role in assessing changes in client participation over time. However, similar to Participant 7's statement, its use seems to be infrequent. This was further emphasised by Participant 5, who remarked:

> *So, I have used the APOM, you know, that I've used more as an initial and then after the treatment, you know, but that was, that's very seldom to be honest, very, very seldom. [P5]*

The infrequent use of standardised measures was reiterated by some participants, suggesting that they typically implement ROM and report on the findings upon request. This was expressed by participant 2:

> *Um, so not often, um, normally it (APOM) happens upon request. We don't necessarily do it for all patients and we don't necessarily do it for all, all admissions. So normally it would be upon request if a doctor or if a psychiatrist or a psychologist asks for feedback as to the patient's functioning, it could be to assist a doctor with writing motivations for work or whatever it is that they need the information for. [P2]*

Another outcome measure recognised as particularly valuable in substance abuse rehabilitation is the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST). This tool is effective for long-term monitoring and continuous evaluation. However, within an acute inpatient setting, it may be less suitable for assessing changes in substance use over a short period. This perspective was highlighted by Participant 5, who stated:

> *So, but, but again, that's more of, um, it's been used more often like an initial to see how bad the addiction was, I guess, but it can be used as an outcome to see if, if the patient gets readmitted or it's, it's more, it's a more beneficial, I guess, from an outpatient perspective. [P5]*

Some participants discussed incorporating cognitive outcome measures into their clinical practice. While these standardised outcome measures were identified as valuable assessment tools, the availability of sufficient time and resources was noted as essential for their routine implementation. This was evident in participant 6's statement, who reported:

> *For me, I love the MoCA because it gives me a great picture of their state and the Intellectual functioning as well. So, yeah, if obviously, if I have the time and I have the resources, I use MoCA as a sort of standardised measurement [P6].*

The use of standardised assessments in occupational therapy is a fundamental element of evidence-based practice, enabling healthcare professionals to systematically evaluate client functioning and ensure informed decision-making (AOTA, 2022). The participants in this study demonstrated familiarity with a range of standardised outcome measures, such as the Montreal Cognitive Assessment (MoCA), the Behavioural Assessment of Dysexecutive Syndrome (BADS), and the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), all of which are essential tools for cognitive evaluations. Additionally, measures like the Activity Participation Outcome Measure (APOM) and the Goal Attainment Scale (GAS) are used to assess functional participation and goal attainment. At the same time, tools such as the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Depression, Anxiety, and Stress Scale (DASS-21) are employed for substance use and mental health screenings.

The diverse array of standardised outcome measures reported by participants is selected based on their ability to address the unique needs of each client effectively. This diversity arises from the variety of interventions and the distinct requirements of different populations (Smith et al., 2023). While this flexibility in choosing from a broad range of standardised assessments allows occupational therapists to offer personalised and context-specific care, it also presents challenges. According to Jones and Brown (2022), the variability in the selection and implementation of outcome measures across settings can complicate efforts to standardise practices and establish a cohesive framework for care delivery.

While participants highlighted the benefits of standardised outcome measures, they are not routinely implemented in clinical practice. As conveyed by Participant 2, the use of routine outcome measures is often situational, primarily driven by external requests, particularly from doctors, psychiatrists, or psychologists seeking specific feedback on a client's functioning, rather than being systematically integrated into everyday practice.

This lack of consistency is further compounded by participants' reports of inconsistent implementation, primarily due to practical barriers such as limited time and resources,

which was highlighted by participant 6. This finding aligns with Johnson et al. (2020), who highlighted that these factors often result in the underutilisation or even abandonment of standardised assessments. This can be particularly challenging in settings with high client turnover, such as acute psychiatry. However, Johnson et al. (2020) further emphasised that the inconsistent use of outcome measures was influenced by occupational therapists' preference for specific tools, driven by familiarity and ease of use, which may contribute to more consistent implementation of outcome measures.

The effectiveness of these outcome measures also depends on the specific therapeutic context in which they are applied (Williams, 2022). Participant 5's experience with the ASSIST screening tool illustrates the varying utility of this tool across different settings. While ASSIST is valuable for tracking outpatient progress through repeated administrations, its relevance decreases in inpatient settings where the risk of relapse between admissions may reduce its ability to track long-term progress (Jones & Brown, 2022).

Standardised outcome measures offer a structured and objective framework for evaluating client progress. However, the reported wide variety of outcome measures used, the infrequent implementation of ROM, and the reduced applicability of certain measures in specific contexts contribute to their inconsistent use. This inconsistency may hinder the development of a unified evidence base, potentially affecting the integration of best practices and impeding progress in evidence-based occupational therapy. This highlights the need for greater methodological consistency to improve comparability across settings (Leavy et al., 2019)

One essential step is to establish a consensus across the occupational therapy profession on core outcome measures, which would enhance data harmonisation across various mental health settings (Leavy et al., 2019). Alongside this, developing clear guidelines on when and how to use these assessments can promote consistency among practitioners. This study suggests that targeted professional development programs are also needed to empower therapists to select and administer these tools effectively (Robinson, 2023). Lastly, creating frameworks that integrate standardised assessments into practice while maintaining a focus on client-centred care is vital for

balancing the standardisation of procedures with the need for individualised therapy (Martin, 2024).

In conclusion, this study underscores the essential role standardised outcome measures play in occupational therapy, aiding in the assessment of cognitive abilities, functional participation, and mental health. However, inconsistent use and limited implementation, often due to time and resource constraints, pose prominent challenges to their routine application. While the flexibility in tool selection helps tailor interventions, it complicates standardisation and the creation of a cohesive evidence base. To address this, establishing a consensus on core outcome measures, clear guidelines, and targeted professional development is essential for enhancing consistency and effectiveness. Ultimately, integrating standardised assessments into practice requires balancing structured evaluations with client-centered care. Addressing these challenges will advance evidence-based practices, improving client outcomes and the credibility of the profession.

Theme three highlights the importance of both standardised and non-standardised methods in outcome measurement within occupational therapy, particularly in mental health. Non-standardised approaches, such as clinical observations and client feedback, offer flexibility but may be affected by subjectivity and biases. Standardised measures provide consistency but are often inconsistently implemented due to time and resource constraints. A balanced approach that combines both methods is recommended to improve assessment reliability. Establishing consensus on core measures, clear guidelines, and professional development will enhance consistency and ensure high-quality, client-centred care, ultimately improving client outcomes in mental health occupational therapy.

4.3.4 Theme 4: Ways of improving the implementation of routine outcome measurement in clinical practice.

The participants in this study shared a range of perspectives on different strategies for enhancing the implementation of ROM in private psychiatric settings. The theme includes two subthemes, namely the need for effective routine outcome measures in

psychiatric settings and putting systems into place to improve the uptake of ROM in clinical practice. This theme is explored in the following subsection.

4.3.3.3 The need for effective routine outcome measures in psychiatric settings

The participants shared their perceptions on the essential characteristics of outcome measures that could support and improve the implementation of ROM in private psychiatric settings. In this subtheme, they emphasised the need for outcome measures that are user-friendly and time-efficient, ensuring they align with occupational therapy theory. Additionally, the participants emphasised the importance of outcome measures applicable to group therapy settings. Finally, they stressed the need for clear and accessible language in outcome measures to facilitate effective communication among multidisciplinary teams.

Some participants emphasised the importance of outcome measures that can be adapted to various clinical contexts, suggesting that they should be comprehensive when necessary but also provide shorter, more time-efficient versions for situations where brevity is crucial. This was expressed by participant 2:

> *If there are ways to adapt it or change it so that you can still have your lengthy one for when it's appropriate, but have something that's more useful and quicker. [P2]*

Another perception that emerged was the preference for outcome measures rooted in occupational therapy theory. Some participants emphasised the importance of aligning assessment tools with the core principles and foundational theories of occupational therapy, ensuring that assessments remain relevant to the discipline's unique perspective and role in clinical practice. Participant 2 further advocated for adaptations that would reduce the time required to conduct an APOM assessment. Participant 2 expressed this sentiment as follows:

> *I think all of us psych OTs are familiar with the foundational theoretical roots that the APOM is rooted in. So, I think all of those things are good. What would*

make it more useful or user-friendly is if we can make it more time effective. [P2]

The study reported the predominant use of group therapy interventions in psychiatric settings. Other participants noted that existing outcome measures often focus on individual assessments and emphasised the need for outcome measures that can track changes in participation within groups. This was expressed by participant 2:

In our settings, I don't often do individual therapy; I am only a group therapist, so an outcome measure to measure the outcomes of groups would also be very helpful and important. [P2]

Along with a group-scale outcome measure, some participants reported the need for outcome measures that could facilitate articulating occupational therapy outcomes to the multidisciplinary team.

More outcome measures that help us, or that provide us with language we can use as it is, but also that maybe structure information in a way that makes it easier to communicate so that OT can also speak the same language as our colleagues. Our language is sometimes so different; it makes it hard for our colleagues to understand what we are saying and to value our inputs. [P2]

The participants' perceptions of outcome measures in private psychiatric settings accentuate the need for adequate ROM. A key concern was the necessity for adaptable tools that balance comprehensiveness with time efficiency. This aligns with Davenport and Underhill (2023), who emphasise the practical challenges of high caseloads and the demand for meaningful tools in occupational therapy settings. Developing outcome measures that provide in-depth insights when needed while remaining quick and easy to administer in busy clinical environments could enhance their usability and adoption in practice.

The preference for outcome measures grounded in occupational therapy theory aligns with the development of tools such as the APOM, which is based on Vona du Toit's Model of Creative Ability. This theoretical foundation ensures that assessments are

closely tied to occupational therapy's unique perspective (Casteleijn, 2014). While the APOM is rooted in solid theoretical frameworks and was designed for user-friendliness, participants noted the prominent time demands involved in its implementation. As a result, it does not fully meet the participants' expressed need for more time-efficient measures.

The study findings highlight the need for tools that capture group dynamics and outcomes. This is particularly important in psychiatric settings, where group therapy plays a central role, and individual assessments may not fully capture the collective impact of interventions. In group therapy, the dynamics of collective intervention are fundamental to achieving therapeutic goals, making it essential to have tools that assess group progress and effectiveness. As noted by Tse et al (2023), group-scale outcome measures would provide occupational therapists with more relevant data to evaluate the effectiveness of group interventions.

Precise language is vital for effective communication across disciplines, as demonstrated by the use of ROM to provide structured, standardised information that aids communication (Jenkinson et al., 2013). However, as highlighted by Davenport and Underhill (2023), occupational therapy often employs specialised terminology that may be difficult for professionals from other multidisciplinary backgrounds to understand fully. This challenge is especially prominent in mental health care, where the unique language of occupational therapy can hinder clear communication of therapeutic outcomes. To overcome this barrier, developing outcome measures that present structured, universally understandable information could bridge the communication gap, similar to how ROM improves clarity across different healthcare settings. This aligns with Meyer et al. (2024), who emphasise the importance of standardised outcome measures in promoting better interdisciplinary collaboration and enabling occupational therapists to communicate their distinct contributions to client care effectively.

In conclusion, outcome measures in private psychiatric settings must be adaptable, theory-based, and efficient for group therapy while supporting multidisciplinary communication. There is a critical gap in group-focused assessments, underscoring

the need for tools that strike a balance between comprehensiveness and usability. Standardised language is essential for collaboration, ensuring occupational therapists' contributions are recognized. Future development should prioritise practical, theory-aligned tools that enhance group therapy evaluation and interdisciplinary teamwork.

4.3.3.4 Putting systems into place to improve the uptake of routine outcome measurement in clinical practice

The participants shared their perceptions of establishing systems to enhance the implementation of ROM in clinical practice. In this subtheme, participants highlighted the need for dedicated time to facilitate effective implementation of ROM, the importance of making ROM mandatory, and the necessity of ongoing support and education to enhance its integration into clinical practice. These factors were identified as fundamental to improving the uptake and consistent use of ROM in occupational therapy within private psychiatric settings.

Some participants highlighted the opportunity to enhance time allocation, recommending that more dedicated time be allocated within clinical practice to support both therapy and outcome measurement. Participant 10 emphasised this need, stating:

> *We need more allocated time; in my setting, there is not enough time provided to do therapy and outcome measurement [P10].*

Additionally, participants suggested that making ROM mandatory in psychiatric settings could be beneficial for its integration into clinical practice. Unlike physical therapy, where progress is often visibly noticeable, changes in psychiatric clients can be more subtle and more complex to assess, further underscoring the value of implementing outcome measurement. This was described by Participant 8:

> *Um, so I think it should be mandatory, especially in psychiatry, because in physical therapy, you can see changes quite easily. However, in psychiatry, it's not so clear [P8].*

A few participants emphasised the need for increased awareness, education, and training on outcome measures in psychiatric settings. They noted limited familiarity with options beyond the APOM and highlighted the value of education in expanding their knowledge. Participant 3 expressed this sentiment, saying,

> *I don't know where I haven't really come across any outcome measures specifically for mental health besides the APOM, so I think that would help a lot—just education on outcome measures and options available [P3].*

Other participants emphasised the need for more exposure to a variety of assessments, noting that these can differ across settings. They suggested that additional training could enhance both understanding and implementation. Participant 7 echoed this, stating,

> *Um, I suppose maybe more training on it. It depends on the settings you work in; the kind of assessments you're exposed to might differ [P7].*

Routine outcome measurement (ROM) has emerged as an essential tool for occupational therapists working in psychiatric settings, where subtle changes in client conditions can be challenging to assess. Participants emphasised the importance of making ROM mandatory to improve its integration into clinical practice, a recommendation supported by Barkham et al. (2023). Their research suggests that the compulsory use of ROM results in better client outcomes, as it encourages clinicians to actively utilise feedback in treatment planning.

Making the routine implementation of ROM mandatory aligns with the broader call for standardized implementation of outcome measures across healthcare settings, especially in mental health. In South Africa, integrating ROM into the National Health Insurance (NHI) framework can ensure the consistent application of outcome measures across both the public and private sectors, fostering a culture that prioritises outcome measurement (South African National Department of Health, 2023b). Mandatory policies can drive systematic changes in clinical decision-making,

enhancing treatment effectiveness and aligning with the NHI's goals of improving healthcare quality and equity

The NHI's emphasis on universal health coverage and improved healthcare quality highlights the importance of standardised outcome measures (Pretorius & Franzsen, 2023). By making ROM mandatory, occupational therapists can more effectively assess the effectiveness of interventions, particularly in psychiatric settings where subtle changes may be more difficult to detect. This supports clinical decision-making and contributes to the broader objectives of the NHI, including reducing healthcare disparities and enhancing health outcomes for all South Africans.

Participants highlighted several key factors necessary for the effective implementation of ROM. Firstly, there is a need for allocated time to implement ROM. Wray et al. (2018) corroborate the participants' need, highlighting that without sufficient time allocated for both therapy and outcome measurement, clinicians struggle to fully integrate ROM into their practice. This lack of time can lead to inconsistent use of outcome measures, ultimately impacting the quality and effectiveness of client care. Therefore, structured time for ROM activities is required to ensure that occupational therapists can effectively implement outcome data to inform treatment planning and decision-making.

Secondly, participants stressed the importance of ongoing training and support. They noted limited familiarity with outcome measures beyond the APOM and emphasised the need for education to expand their knowledge and improve implementation. This aligns with Al-Omary et al. (2024), who highlighted the importance of continuous professional development for successful ROM implementation, particularly in complex psychiatric settings. Ongoing education can foster a culture of competence and confidence among occupational therapists, enabling them to utilise ROM effectively.

Another key point raised by participants was the need for greater exposure to diverse assessments, as these vary across settings. They suggested that additional training could enhance both the understanding and implementation of ROM, highlighting the importance of context-specific training to account for the variability in assessments

used across different psychiatric settings. Edbrooke-Childs et al. (2016) supported these findings, emphasising that further training can improve both the understanding and application of ROM, stressing the importance of training tailored to the specific needs of different settings This highlights the need for occupational therapists to engage in targeted, ongoing professional development, enabling them to adapt their practices to the unique demands of each setting and fully utilise ROM for better client outcomes.

In conclusion, this study identifies key factors for enhancing ROM uptake in psychiatric occupational therapy, including dedicated time, mandatory implementation, and ongoing education. These elements ensure effective ROM use, improving client outcomes. Support for mandatory ROM aligns with research showing its positive impact on treatment outcomes. Adequate time and continuous professional development are vital for successful integration. Overall, the study emphasises the need for systemic changes, including mandatory ROM policies and professional development, to enhance occupational therapy practices and improve healthcare quality, particularly within South Africa's NHI framework.

Theme four highlights key strategies for improving the implementation of routine outcome measurement (ROM) in private psychiatric settings. Participants emphasised the need for user-friendly, time-efficient outcome measures that align with occupational therapy theory and are adaptable to both individual and group therapy settings. To enhance the uptake of ROM, it is crucial to allocate dedicated time for its implementation, make ROM mandatory, and provide ongoing education and support for clinicians. Additionally, exposing therapists to a broader range of assessments and providing context-specific training can further enhance the application of ROM. These changes are essential for ensuring consistent use of ROM, enhancing clinical decision-making, and ultimately improving client outcomes in psychiatric settings.

4.3.4 Conclusion

In conclusion, this study provided valuable insights into the implementation of routine outcome measurement (ROM) in clinical occupational therapy practice, especially within mental health settings. The findings were discussed across four key themes, each revealing critical factors that influenced the adoption and effectiveness of ROM in practice.

The first theme highlighted the prominent challenges encountered in implementing ROM in clinical practice. Participants discussed several barriers, including the time-consuming nature of ROM, financial constraints, and systemic issues within healthcare. Additionally, limited access to appropriate outcome measures and diverse perspectives on its application were identified as obstacles. While ROM was recognised for its potential to inform treatment planning and improve therapy quality, its practical adoption remained hindered by these resource limitations, inconsistent methodologies, and the complexities inherent in mental health assessment.

The second theme focused on the value of ROM in psychiatric occupational therapy. Participants emphasised that ROM played a crucial role in generating evidence, tracking client progress, and validating the impact of occupational therapy. Additionally, ROM supported clinical decision-making, secured funding, and helped tailor interventions to the specific needs of clients, ultimately enhancing therapeutic outcomes. Moreover, ROM provided emotional benefits, such as fostering hope and self-worth in clients. Despite the challenges in its implementation, the study suggested that proper training and contextualisation could overcome these barriers, ensuring ROM supported client- centred care and improved therapy effectiveness.

The third theme addressed the importance of both standardised and non-standardised methods in outcome measurement within mental health occupational therapy. Non-standardised methods, such as clinical observations and client feedback, offered flexibility and were adaptable to specific therapeutic contexts. However, they were often susceptible to subjectivity and biases, which may have impacted their reliability. Standardised measures, while offering objectivity and consistency, were not always implemented consistently due to time and resource constraints. The study advocated

for a balanced approach that combined both methods, recommending clear guidelines, consensus on core measures, and professional development to improve assessment reliability, enhance consistency, and ensure high-quality, client-centred care.

The fourth theme discussed strategies for improving the implementation of ROM in private psychiatric settings. Participants emphasised the importance of user-friendly and time-efficient outcome measures that align with occupational therapy theory and are adaptable for both individual and group therapy settings. To improve the uptake of ROM, it was essential to allocate dedicated time for its implementation, make ROM mandatory, and provide ongoing education and support for clinicians. Participants also suggested that exposing therapists to a broader range of assessments and providing context-specific training would enhance the application of ROM. By implementing these strategies, ROM could be more effectively integrated into practice, improving clinical decision-making and client outcomes in psychiatric settings.

Overall, the study emphasised that addressing these challenges and adopting a balanced, systematic approach to ROM implementation would have enhanced the effectiveness of occupational therapy in mental health settings, ultimately leading to better client outcomes and more consistent, evidence-based practice.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Summary of findings

The study aimed to explore the perceptions of the occupational therapists on the implementation of routine outcome measurement (ROM) in private psychiatric settings. Overall, the findings provided insightful information on the perceived difficulties of implementing ROM in clinical practice, the value of ROM for occupational therapists in mental health, current measurement trends in clinical practice, and various ways to consider improving the uptake of ROM in private psychiatric settings. This chapter presents the study's limitations, evaluation, recommendations, and conclusion.

5.2 Limitations of the study

The study aimed to explore the perceptions of occupational therapists working in private psychiatric settings. To gather insights, the researcher employed a descriptive qualitative design and used purposive sampling to recruit participants who were selected based on specific characteristics relevant to the research focus. This method allowed the researcher to target participants with direct experience in the setting being studied, ensuring rich and relevant data. However, this approach also introduced certain limitations, particularly regarding the generalisability of the findings. Since participants were deliberately selected rather than randomly chosen, the results may not fully represent the experiences of all occupational therapists working in private psychiatric environments.

Despite this, the researcher was aware of the potential for selection bias and took careful steps to minimise it. To ensure a diverse range of voices, participants were recruited through the Institute for Occupational Therapists in Private Practice (INSTOPP) platform. The goal was to avoid selecting participants who might be more articulate or knowledgeable than others, thereby ensuring that the sample represented a diverse range of perspectives. While the non-random selection process still posed some challenges, these efforts helped to mitigate the bias and provide a broad range of views were included in the study.

To further safeguard against bias, the researcher also addressed the issue of researcher bias. Knowing the potential impact of personal relationships, the researcher took the critical step of excluding current colleagues from the study. This decision was made to avoid any conflicts of interest or the subtle influence that personal relationships could have had on the responses. By maintaining a neutral and objective research process, the researcher sought to preserve the integrity of the findings and ensure that any existing biases or preconceptions did not influence the data.

Another concern was response bias, where participants might have been inclined to provide answers, they thought the researcher wanted to hear or answers that painted them in a favourable light. To address this, participants were assured of confidentiality and encouraged to speak openly and honestly about their experiences. This approach was designed to minimise the influence of social desirability, allowing participants to offer genuine insights without fear of judgment.

As the study relied on qualitative data gathered through interviews, interviewer bias could have been another factor that influenced the findings. The researcher, by nature of their involvement, could unintentionally guide the conversation or interpret answers in ways that skewed the results. To minimise this, a standardised interview guide was used. This ensured that each participant was asked the same set of questions consistently, reducing the risk of inadvertently influencing responses and helping to keep the data collection process as neutral as possible.

Finally, confirmation bias—the tendency to seek out data that supports preconceived notions—was something the researcher consciously worked to avoid. The researcher remained vigilant throughout the study, regularly revisiting the data and ensuring that new findings emerged without being influenced by prior expectations. This ongoing reflection helped ensure that the conclusions drawn were based on the data itself, rather than any assumptions the researcher may have had going into the study.

In summary, although the study was subject to some inherent limitations due to non-

random sampling and design choices, the researcher took various measures to address different types of bias. These steps were taken to enhance the reliability and validity of the study's findings, ensuring that the data collected was as accurate and representative as possible, despite the limitations of the chosen methodology.

5.3 Strengths of the study

This study makes a significant contribution by addressing a critical gap in the literature on ROM in occupational therapy within private psychiatric settings, with a particular focus on South Africa. This study is the first qualitative study to explore the implementation of ROM from the perspective of occupational therapists, offering valuable insights into the challenges and facilitators of its use in practice. Additionally, it is one of the few studies examining ROM in private psychiatric facilities, where research on outcome measurement remains limited. The findings provide a deeper understanding of how ROM can be integrated into private practice, highlighting its potential to enhance clinical decision-making, improve service delivery, and support evidence-based interventions.

Furthermore, as South Africa moves toward implementing the National Health Insurance (NHI), the study's findings offer essential insights into how ROM can support standardised, outcome-driven care within occupational therapy in mental health By demonstrating the value of ROM in tracking the effectiveness of interventions and ensuring accountability, this research can inform policy development and guide the integration of evidence-based practices within the evolving healthcare landscape. By exploring the perceptions of occupational therapists, this study contributes to both academic research and clinical practice, highlighting the practical implications of ROM in improving client care within private psychiatric settings and supporting the broader objectives of the NHI.

5.4 Critical evaluation

The qualitative design of the study offered a comprehensive exploration of occupational therapists' perspectives, providing insights into their experiences with

ROM implementation. By focusing specifically on occupational therapists in private mental health settings, the study examined the benefits, practical challenges, and strategies for overcoming barriers to the adoption of ROM. Furthermore, it explored the professional implications, such as the integration of ROM into clinical decision-making and service evaluation, alongside the personal impact on therapists, including workload, administrative burden, and professional development. This in-depth understanding adds a valuable layer to the study's findings, highlighting the complexities and subjective experiences of ROM implementation—elements that may be overlooked or underrepresented in quantitative studies.

However, the absence of quantitative data limits the ability to draw broad conclusions, and relying solely on interviews restricts the range of data that can be collected. Incorporating additional methods, such as surveys, could have addressed these limitations by providing a broader and more representative dataset and offering quantifiable insights to identify trends, patterns, and statistical relationships.

The small sample size of only ten participants, all of whom were female, aged 27 to 49, and had at least five years of experience in private psychiatric settings, may have impacted the study's external validity. This homogeneity limits the generalisability of the findings, as they may not reflect the perspectives of male occupational therapists, those with less experience, or those working in public healthcare settings. Furthermore, the private sector context of the study means the findings may not easily translate to public mental health services, which differ in terms of resources, policies, and workload pressures. Despite these limitations, the study offers valuable insights into the use of ROM in private psychiatric settings, providing practical, real-world value by highlighting specific barriers and enablers that can inform the development of tailored strategies for ROM implementation.

The study also offers culturally and geographically relevant insights specific to South African private psychiatric settings. This contextual relevance is crucial, as healthcare systems, patient demographics, and institutional structures vary across regions. By focusing on South African contexts, the study offers practical guidance that is directly applicable to local practitioners and may inform policy decisions in similar

environments. The findings could inform policy development and resource allocation, driving improvements in care delivery, patient outcomes, and the overall quality of psychiatric practices in South Africa and similar countries.

Moreover, the study contributes to the understanding of ROM in occupational therapy by bridging the gap between theory and practice. It offers actionable insights into how ROM is integrated into real-world settings, making it more relevant and applicable to practitioners. The findings also pave the way for future research, identifying areas for further exploration, such as the long-term impact of ROM on patient outcomes and its applicability in other healthcare settings. By contributing to both practice and future research, the study strengthens the unique contribution of occupational therapy to evidence-based practice, ultimately enhancing the effectiveness of ROM in occupational therapy.

As an occupational therapist working in a private psychiatric setting, my positionality played a crucial role in shaping this study. My insider perspective allowed for a deeper understanding of the experiences occupational therapists encounter when implementing ROM. This influence extends to the research design, where a qualitative design was chosen to capture detailed insights into the real-world experiences of occupational therapists. My professional background informed the selection of participants and data collection, ensuring that the study reflects the practical challenges of ROM integration.

Throughout the research process, I maintained reflexivity to address potential researcher biases stemming from my own experiences, ensuring that the findings genuinely represent the perspectives of the participants. This self-awareness helped maintain transparency and trustworthiness in the data interpretation.

Additionally, my position in South Africa provides cultural and geographical relevance, offering insights directly applicable to local practitioners and policymakers in private psychiatric settings. Given the disparities in mental health service provision and the limited evidence base for occupational therapy in mental health, understanding these contextual factors is crucial for the effective implementation of ROM. By aligning ROM

practices with the specific challenges faced in South Africa's private mental health sector, including insurance limitations, disparities in access, and the need for evidence-based practice, my research contributes to enhancing service quality, demonstrating treatment efficacy, and securing broader institutional support for occupational therapy interventions.

5.5 Recommendations

Participants identified two prominent challenges to implementing routine outcome measurement (ROM): the time-consuming nature of ROM and limited access to appropriate outcome measures. To address these challenges, future research should focus on developing time-efficient and comprehensive outcome measures tailored for occupational therapists working in psychiatric settings. These measures should achieve a balance between practicality and quality assessment, while maintaining flexibility to accommodate the unique needs of clients. Mixed-methods research could be particularly valuable in developing or adapting culturally relevant measures. These measures should incorporate the cultural and environmental factors pertinent to South Africa, thus enhancing clinical validity and ensuring contextual relevance.

The development of modular assessment tools could provide additional flexibility in addressing the dynamic nature of inpatient care. A modular assessment tool for psychiatric settings could incorporate various modules to evaluate cognitive function, emotional health, and social behaviour, enabling occupational therapists to select the most relevant modules based on the specific context. This would result in a more efficient and adaptable assessment process.

Additionally, participants emphasised the need for outcome measures that assess functioning on a group scale. Future research should explore the development of tools that not only evaluate individual functioning but also provide insight into broader group-level outcomes, which could be crucial for assessing the overall effectiveness of ROM in diverse clinical settings.

Limited medical insurance coverage was reported as a notable challenge to the implementation of routine outcome measurement. To overcome this, medical

insurance coverage for occupational therapy services is necessary to support the consistent use of ROM. Occupational therapists must advocate for better reimbursement rates and collaborate with professional bodies and medical insurance schemes to drive these changes. It is recommended that future studies focus on the cost-effectiveness of ROM implementation. Demonstrating the economic benefits of ROM, such as improved client outcomes, shorter hospital stays, and reduced long-term healthcare costs, could provide compelling evidence to secure additional funding and support.

Leveraging research findings to justify investment in ROM implementation is vital for securing funding and driving policy changes. Participants emphasised the need for ROM to be made mandatory, as this would establish it as a standard practice, ensuring consistent use across private psychiatric settings. Making ROM mandatory could prompt policy changes by influencing healthcare organisations and insurers to prioritise ROM in their practices, allocate necessary resources, and integrate it into official treatment protocols.

Resource constraints, including limited staff and time, were identified as other difficulties in implementing ROM in clinical practice. To overcome this, future studies should explore innovative staffing models and technological solutions. For example, task-sharing within multidisciplinary teams could allow occupational therapists to delegate certain aspects of the ROM assessment to other team members, thus optimising resource use. Additionally, using digital tools and mobile applications for ROM assessments can streamline data collection, analysis, and documentation, thereby reducing the time burden on therapists and improving overall efficiency.

Lastly, organisational policies can play a significant role in successfully implementing evidence-based practices, such as ROM, in private psychiatric settings. It is recommended that healthcare organisations, in alignment with the goals of the National Health Insurance (NHI), develop policies that prioritise and allocate dedicated time for ROM assessments. These policies should recognise the importance of ROM as an essential aspect of evidence-based practice and quality improvement. Ensuring that occupational therapists have the time, resources, and support needed to carry out

these assessments effectively is crucial. By incorporating ROM into standard practice within NHI frameworks, healthcare providers can contribute to improved healthcare outcomes, more efficient resource utilization, and a more substantial commitment to quality care.

Educators and clinical supervisors are uniquely positioned to promote the integration of ROM into everyday practice. To facilitate this, it is recommended that ROM be incorporated comprehensively into both undergraduate and postgraduate curricula, ensuring that students gain a solid understanding of its theoretical foundations and practical applications within mental health settings. Providing students with hands-on experience using ROM tools during clinical placements—along with guidance on interpreting data and applying results to client-centered intervention planning—will enhance their competence and confidence. Emphasizing critical thinking and evidence-based reasoning throughout academic and clinical training will further reinforce ROM's role in professional accountability and service improvement.

Clinical supervisors should actively model the use of ROM in practice to foster positive attitudes and build students' confidence in applying these measures. By embedding ROM thoroughly into occupational therapy education and supervision, academic institutions can play a pivotal role in developing a workforce that is well-prepared to adopt and sustain evidence-based practices in mental health care. It fosters data-driven clinical reasoning, enhances reflective practice through measurable feedback, and prepares graduates to meet the growing demands for accountability in mental health services. By normalising outcome measurement from the outset, academic institutions help bridge the gap between research and practice, ultimately improving service quality and client outcomes

5.6 Conclusion

This study aimed to explore occupational therapists' perceptions of the implementation of routine outcome measurement (ROM) in private psychiatric settings. The findings provided insights into the challenges faced by occupational therapists in implementing

ROM into their clinical practice, the recognised value of ROM for improving mental health care, current practices in measurement, and potential strategies to enhance ROM adoption in these settings.

The study highlighted key obstacles in implementing ROM, including time constraints, resource limitations, and the need for more user-friendly and adaptable tools. Despite these challenges, the participants expressed strong support for the value of ROM in enhancing client outcomes, improving therapeutic decision-making, and justifying funding for services. The study also emphasised the need for a more systematic approach to ROM, including better training and more precise guidelines to promote its widespread use.

Ultimately, this research highlights the importance of involving occupational therapists more actively in the ROM implementation process. By addressing their concerns and supporting their engagement, the study highlights the potential for improving the quality of care in private psychiatric settings. These findings are crucial for advancing the use of evidence-based practices in mental health care and refining the implementation of ROM, ultimately enhancing client outcomes and the overall effectiveness of occupational therapy in private psychiatric settings across South Africa.

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APPENDICES

APPENDIX A: Approval from Institute for Occupational Therapists in Private Practice (INSTOPP)



Permission Letter for The Institute for Occupational Therapists in Private Practice (INSTOPP)

I, Haneke Jonas (INSTOPP chairperson) hereby give permission to Priscilla Myburgh, a student of the University of Witwatersrand (596162) studying an MSc in Occupational Therapy (psych) to use INSTOPP as a platform to advertise participation in the following research project:

OCCUPATIONAL THERAPISTS' PERCEPTIONS OF ROUTINE OUTCOME MEASUREMENT WITHIN PRIVATE PSYCHIATRIC SETTINGS IN SOUTH AFRICA

The advertisement will aim to encourage occupational therapists working within a private psychiatric setting within South Africa with at least 5 years of experience to partake in the study.

INSTOPP will only be responsible for distributing the advertisement to appropriate potential participants. If participants are interested and willing to partake, they will contact the researcher via email which ensures that the POPI Act legislation is adhered to.

Signature: HJonas

Date: 3 October 2022

APPENDIX B: Demographic questionnaire



Participant OT practice number: _____

Age of the participant: _____

Gender of the participant: _____

What year did you complete your undergraduate studies? _____

Where did you complete your undergraduate studies? _____

Do you have a post-graduate qualification? If yes, please specify the qualification_____

How long have you been practicing as an occupational therapist? _____

How long have you been practicing in mental health? _____

Where are you currently employed? _____

How long have you been employed at your current work setting? _____

APPENDIX C: Interview Guide

Tile: Occupational therapists' perceptions of routine outcome measurement within private psychiatric settings in South Africa

Aim of the study: To explore the perceptions of occupational therapists on the implementation of routine outcome measurement in private psychiatric settings within South Africa

Objective of the study: To describe occupational therapists' perceptions of routine outcome measurement in private psychiatric settings within South Africa.

Type of interview: Online semi-structured interview

Estimated Duration: Approximately 45 mins (to be reviewed once all interviews have been conducted)

Arrangements for interview: The researcher will contact the participant to set up a meeting at a time that is suitable for the participant, when the participant is available and has access to internet.

Introduction of the session: The researcher will welcome the participant and thank them for participating in the study. Following this, the researcher will explain that the purpose of the interview to have an open discussion about their perceptions of the implementation of ROM within private psychiatric settings.

Interview questions:

The interview will start with an open-ended question (This is to allow for the capture aspects of the occupational therapists' perceptions)

Q1: What are your perceptions of the implementation of routine outcome measurement (ROM) in mental health?

** Following the open-ended question, the questions in the table below will be asked**

Main question	Probing questions
What are your perceptions of the implementation of ROM within private psychiatric settings?	1. What are your thoughts on the use of ROM in private psychiatric settings 2. What factors influence your approach to ROM in your setting?
Have you implemented ROM within your private psychiatric setting?	**Yes:** What outcome measurements do you implement? **Yes:** How often do you conduct ROM? **Yes**: What criteria do you use to determine which clients require ROM in your setting? **No:** How do you assess the effectiveness of your treatment and track client progress?
How do you perceive the implementation of ROM within your practice?	• What has been your experience of implementing ROM? • What do you perceive as the benefits of implementing ROM within your setting? • What do you perceive to be the challenges of implementing ROM within your setting?
What do you think is required to increase the implementation of ROM in private psychiatric settings?	• What would help occupational therapists in implementing ROM? • What do you think this support should entail? • How would accessing this support assist in implementing ROM • What advice would you offer occupational therapists on implementing ROM within their settings?

APPENDIX D: Ethical Clearance Certificate from the Human Research Ethics Committee

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Miss Priscilla Myburgh

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M221159

NAME: (Principal Investigator)	Miss Priscilla Myburgh
DEPARTMENT:	Occupational Therapy School of Therapeutic Sciences
PROJECT TITLE:	Occupational therapists' perceptions of routine outcome measurement within private psychiatric settings in South Africa
DATE CONSIDERED:	25/11/2022
DECISION:	Approved unconditionally
CONDITIONS:	N/A
NOTE:	N/A
SUPERVISOR:	Miss Olindah Silaule
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	28/02/2023

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 Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. 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 resubmit the application to the Committee. **I agree to submit a yearly progress report.** The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **November** and will therefore be due in the month of **November** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX E: Informed consent



Title: Occupational therapists' perceptions of routine outcome measurement in private psychiatric settings in South Africa

1. I have been given a Participant Information Sheet, which explains the nature and processes involved in this study, and it is attached hereto.
2. I was given time to read it, or it was read to me in the language I best understand.
3. I was given time to ask any questions I wanted and found the answers provided to be reasonable and satisfactory.
4. I believe I have a thorough understanding of the study's purpose and the intended outcomes.
5. I understand that I will not receive any immediate benefit from participating, nor will I receive any payment; conversely, participation will not incur any costs beyond my time.
6. 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 study would immediately be destroyed, unless I give consent for it to be retained
7. 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 contact any of the individuals listed.

Contact details:

Priscilla Myburgh, Principal Investigator, telephone no. 072 770 3264, or by 596162@students.wits.ac.za

Professor CB 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:_____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

APPENDIX F: Consent for video recording



Title: Occupational therapists' perceptions of routine outcome measurement in private psychiatric settings in South Africa

I hereby consent to the video recording of the semi-structured interview. I understand that:

The video recording will be stored in a secure location, such as a locked cupboard or a password-protected computer, with restricted access granted only to the researcher and the research supervisor.

The video recording will be transcribed, and field notes will be taken; 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 need to obtain approval from the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg.

Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other research-related publications.

Name of Participant:

Date:_____
Place: _____
Signature: _____

Witnessed by:

Name of Witness: _____
Signature: _____
Date: _____

APPENDIX G: Information Sheet

Title: Occupational therapists' perceptions of routine outcome measurement in private psychiatric settings in South Africa

Dear Sir/Madam

Introduction: My name is Priscilla Myburgh, and I am currently registered for my master's degree at the University of the Witwatersrand, Johannesburg. I am conducting a research study on occupational therapists' perceptions of routine outcome measurement in private psychiatric settings in South Africa. In this study, I aim to gain a deeper understanding of your views on the implementation of ROM within your setting, to identify the barriers and facilitators that influence the routine implementation of outcome measurement. The study will contribute to determining and addressing factors that affect the implementation of ROM within mental health, to increase the uptake of ROM in clinical settings.

Invitation to Participate: I am requesting your permission to participate in the study by joining an online semi-structured interview of approximately 45 minutes, conducted via any online platform accessible to you.

What is involved in the study? Should you agree to participate in this study, I will contact you to arrange an appointment at a time that is convenient for you, taking into account your schedule and internet access. You will be required to complete and submit your demographic questionnaire before the interview. I will then conduct a semi-structured interview, following a set of open-ended questions, to gain an accurate representation of your perceptions on the implementation of routine outcome measurement within your setting.

Benefits of participating in the study: There are no direct benefits to the

participant in this study. The information obtained in this study can be used to understand occupational therapists' perceptions of implementing ROM in private psychiatric settings. Participants will be provided with pertinent information on the survey during the project and after the results are available.

Participation is voluntary. Refusal to participate will incur no penalty or loss of benefits, and participants may discontinue participation at any time without penalty or loss of benefits. There is no requirement to provide a reason for withdrawing, and any data collected on such a person will be destroyed by default unless the participant explicitly consents to its retention.

Confidentiality: Participants' identification numbers will be used to identify each participant in the study. Personal information will be treated with the strictest confidence. It will only be accessible to the Principal Investigator (PI) and their supervisor, if the PI is a postgraduate student. The only exceptions - and all of them are rare - would typically be:

1. Personal information may be disclosed if required by law
2. The Human Research Ethics Committees of the University may exceptionally require personal data to respond to a formal complaint, or for a compliance audit
3. The South African Health Products Regulatory Authority (SAHPRA), which is the successor body to the South African Medicines Control Council (SAMCC), might conceivably require access to personal data if investigating a drug trial
4. If results are published, this may, exceptionally, lead to cohort, or more rarely, individual identification. All data collected during the study will be securely retained for two years if a scientific publication arises from the study, and for six years if no publication is generated. Thereafter, it will be destroyed accordingly.

Contact details of researchers:

Priscilla Myburgh, Principal Investigator, telephone no. 072 770 3264, or by 596162@students.wits.ac.za

Olindah Silaule, Supervisor, on telephone no. 011 717 3701, or by e-mail at

Olindah.Silaule@wits.ac.za

Outputs

This study will be submitted as an academic research project, and the survey findings will be shared with all participants.

Contact details of HREC administrator and chair

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project, as well as the integrity of the research. If you have any concerns about the way the study is being conducted, please get in touch with the Chairperson of this Committee, Professor Clement Penny, at telephone number 011 717 2301 or by email at Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234, and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za.

APPENDIX H: Transcripts coding in NVivo application

PM Thanks so much for joining m[redacted]. Um, I just wanted to make sure that you're happy with being recorded before we start. Yep. All good. Thank you. Awesome. Thanks. So what I'm going to do is I'm just going to open up with my main research question and then we'll kind of see where it goes from there.

MC: Um, yeah. All right.

PM: Cool. So my question is, what are your perceptions of the implementation of routine outcome measurements in mental health within your setting?

MC: So I think, I think except for like interview questions, it's actually a very difficult thing to, to get to. And I think it might be really good for us to have. Measurements just to actually see where patients are at, like being hospitalized and then like further the plan as well and see how that develops. I do think it will really be a great. So I think in general, we sometimes a bit iffy and what we do. Um, so I think, uh, to have, like, an actual outcome that we can measure it. I don't think everything is like, measurable, um, inside, but I think it will be great if we develop more outcomes so that we actually can prove to others like this is what we do. And this is actually the improvement because I think in general, get slack for that at the moment because we, we don't have those like physical proof you can actually, if you can call it that.

PM: Um, what outcome measures do you currently use if any?

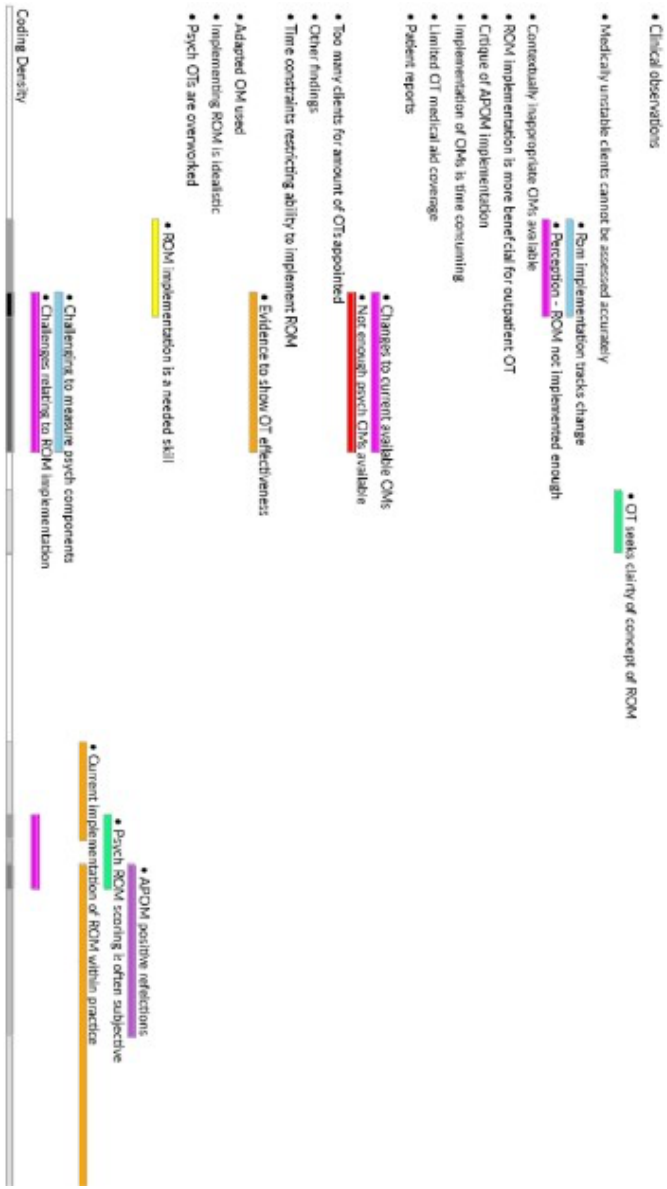
MC: So, I think, I think before I'm going to answer that, like, if you think of routine, like, measurements, I just want to double check, like, like, what exactly do you mean with it?

PM: Um, it's pretty much just a general term for having a baseline assessment, and then from there, Um, at the end of therapy, having some kind of a reassessment to, to determine whether there's been any change to actually rate the effectiveness of intervention. So it doesn't necessarily have to be all standardized, um, but any kind of means that you use, um, to, to track or measure change.

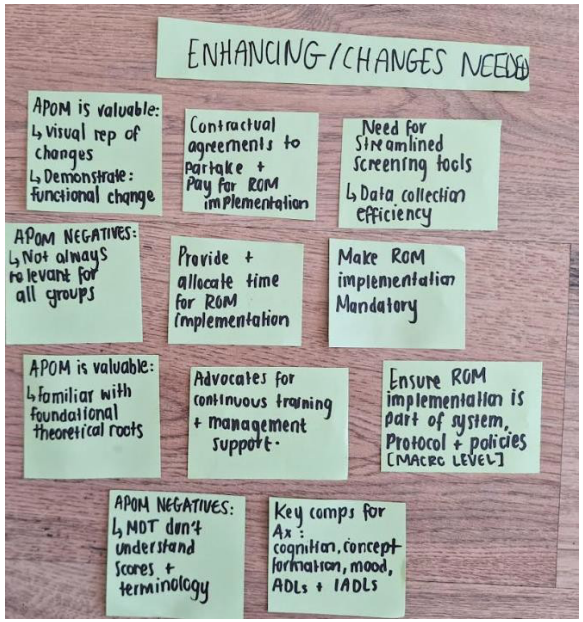
MC: Okay, change in general, like, uh, any change?

PM: Yes, change in, yes, whatever components you're looking at.

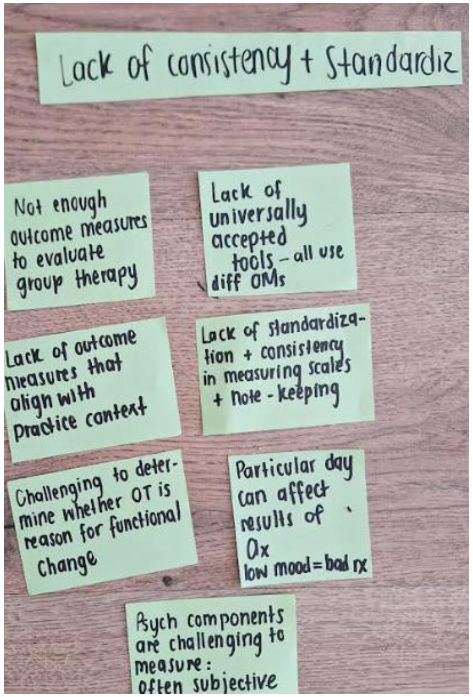
MC: Yeah, so I think for me, what I usually do is I, before I started seeing patients, I do like interviews generally. Um, and I use, um, scales basically determining like, where's your stress out of 10 or 10 is good. No, 10 is 10 is good. And one is bad. Um, and then I kind of like, Yeah, I use that. And then if I do see the patient again, and it's kind of a journey, then I look at those again. Um, but what I found with that is like, did I have a good day? So then my stress is better, like, I cope with my stress better than if I'm at a bad place. So I think that's, that is not helpful. Um, and I also make use of the APOM sometimes as well. Um, and that is obviously very effective. I'm sure you do know like the APOM , and especially in, in, um, hospital settings, that's something that the doctors really enjoy because of the visual thing of that. And that does give you some sort of a, the patient GA came in, maybe they discharge after like a few weeks and then reassessment as an outpatient. So that is quite effective if we look at specific outcomes with specific. Like social participation or whatever it is. Um, and sometimes what else do I use? I think if I just look at like self reporting questionnaires, I know like it's not like it's very frowned upon to always use it. But for me, like if I can do a DAS or a HATS like in hospital and then you look at those again a little bit later on, um, which is a good indication of where the patient is at. But I've also found with that like good day. Good results bad day really bad results. Um, I'm just thinking what else am I using? Um, sometimes I do cognition. Obviously you don't do the same cognition, um, taste, but sometimes I would do like a cam. And then I would do like another cognitive state a little bit later on, but I don't work with cognition and

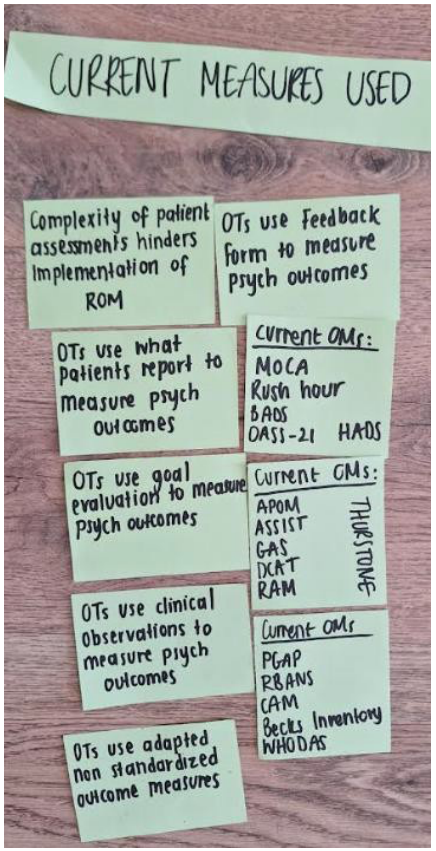


APPENDIX I: Example of groupings of codes into subthemes and themes









APPENDIX J: Information on Language Editor

Occupational therapists' perceptions of routine outcome measurement within private psychiatric settings in South Africa, by P Myburgh, was language edited by CJ Myburgh.

Editing by Carole

Bachelor of English studies (UKZN)



28/03/2025

