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Research Article

An Occupational Therapy Programme for a Psychiatric Day Hospital: Voice of Occupational Therapy Practitioners and Patients

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Occupational therapy (OT) practitioners play a critical role in supporting recovery from disruptions in occupational performance caused by mental illness, particularly within psychiatric day hospital settings. Despite this, there remains a notable absence of published evidence-based guidelines to inform the development and implementation of OT programmes in private psychiatric day hospitals in South Africa. This study aimed to evaluate an existing OT programme in such a setting, with the goal of informing the development of context-specific, evidence-based practice guidelines. A qualitative research design was employed to explore the perspectives of both OT practitioners and patients who participated in the programme. Data were collected through in-depth interviews and analysed using reflexive thematic analysis. Four key themes emerged: (1) the competent facilitator with expertise in group dynamics; (2) the therapeutic group as a cohesive and healing entity; (3) the patient as a unique individual within the recovery process; and (4) the integration of evaluation, intervention and outcomes within a coherent therapeutic process. Findings demonstrated the therapeutic potential of group-based OT led by skilled facilitators, underscoring the importance of integrating clinical reasoning, patient-centred care and group dynamics expertise into programme delivery. The study contributes to the body of knowledge advocating for structured, evidence-based OT programmes in psychiatric day hospitals, tailored to both the therapeutic goals of practitioners and the recovery needs of patients. This research provides a foundation for the formulation of evidence-based guidelines that can strengthen OT practice in private psychiatric day hospital contexts, thereby promoting mental health recovery through structured and purposeful occupation.

Keywords: group cohesion; group therapy; interactive group model; mental health; occupational therapy programme and reflective facilitation

1. Introduction

Mental health is increasingly recognised as an integral component of overall well-being and a fundamental human right [1, 2]. The World Health Organization [2] emphasises that health is inextricably linked to mental health, a sentiment echoed in the 2022 World Mental Health Report, which advocated for transforming mental health through motivating for and guiding improvements in mental health globally.

Mental illness negatively impacts functioning and quality of life and leads to occupational dysfunction, including difficulties with optimal engagement in occupations and

the ability to develop and maintain relationships, which could lead to occupational imbalance and occupational marginalisation [3–5]. Encouragingly, progress is being made in shifting the focus to the prevention of mental illness and the promotion of mental health through raising awareness, reducing stigma and expanding access to mental health care, fostering hope for a future where mental health is prioritised universally [3].

However, despite the gains, mental disorders remain among the Top 10 leading contributors to the global disease burden, underscoring the need for sustained investment in mental health care and support systems [6]. As occupational therapists, we have a critical role to play in advancing mental health initiatives, addressing occupational dysfunction and creating opportunities for enabling individuals to lead meaningful and fulfilling lives [7] through occupational engagement and participation.

One way of providing mental health services is through in-patient and out-patient facilities and clinics, and the outpatient facilities can be in the form of day facilities [8]. Traditionally, acute mental health services were rendered at overnight hospitals through inpatient treatment. However, there has been a growing need for day hospitals, and the existence of these has been reported on in various countries, including South Africa, Sweden, Switzerland and Germany [9–11].

In comparison to inpatient treatment, a psychiatric day hospital is characterised by immediate intervention, with less waiting time for admission into an inpatient facility, which is considered a benefit [12]. Treatment at psychiatric day hospitals in the Swiss and German Healthcare Systems was found to be cheaper compared to traditional inpatient hospitalisation despite similar therapeutic outcomes [12, 13]. Although several studies showed no significant differences in the outcomes of patients treated with inpatient hospitalisation versus psychiatric day hospital care [12–14], these same studies also highlighted the advantages of day hospitals that make them an attractive option for many people with mental health and well-being challenges.

One significant advantage includes the reduction of the potential risk of institutionalisation by enabling daily opportunities for iteration between skills acquisition and the application thereof in real-time and real environments. In psychiatric day hospitals, individuals remain in their natural, familiar home and social environments while receiving intervention [12, 15]. This ensures comfort, access to and use of familiar resources in the same social environments [14] and facilitates the integration of day-to-day problems into the treatment process, thereby ensuring skills acquisition, practice and implementation in real time. Additionally, among the economic advantages, fewer resources are required to operate a day hospital setting such as no overnight staying facilities, no need for night staff, and there is access to a variety of therapies during the day programme [16].

In countries such as Sweden, psychiatric day centres are called 'community day centres', which have programmes that are run by occupational therapy practitioners, with specific therapeutic content and components that cater for patients' needs. Research by Eklund [17] who reported on programmes in Sweden found that attendees' motivation and satisfaction were enhanced by opportunities to socialise, engage in enjoyable activities and experience structured daily routines provided by occupational therapy practitioners. Heekeren et al.'s [12] study in Sweden is one of the few contemporary investigations in this area, highlighting a significant gap in the current literature. This paucity of research was noted in 2013 by Kallert et al., underscoring the need for more comprehensive studies to better understand the comparative and qualitative benefits of these treatment settings and to inform evidence-based practices in mental health care.

The public and private healthcare systems in South Africa have been largely operated through overnight hospitalisation facilities. However, there has been a rising trend of day clinics and/or day hospitals, more especially in the private healthcare sector. To this end, day hospitals are regarded as a good and effective alternative to the expensive inpatient care concerning costs, time and clinical outcomes. The concept of a psychiatric day hospital in South Africa dates back to the 1950s [9]. Gillis [9] documented the country's first psychiatric day hospital programme in a public health facility, which remains the only recorded and published account of such a facility. As the first facility of its kind, their intervention provided a structured therapeutic programme led by a multidisciplinary team, including psychiatrists, clinical psychologists and occupational therapy practitioners [9]. Occupational therapy practitioners primarily facilitated group therapy sessions, which patients were required to attend throughout their admission [9]. Although historical evidence on these early day hospitals is limited, the use of day hospitals in mental health services is well established.

In South Africa, the first private psychiatric day hospital, called Evexia Psychiatric Day Hospital (Evexia), was licenced in 2016. Evexia became the research setting and context for the study. At Evexia, patients are admitted daily, from Monday to Friday, for a weekly programme, and the minimum hospital stay is 2 weeks. This programme is similar to that of an inpatient facility. However, patients do not sleep over at the facilities. The programme runs from 07:30 to 15:30 on weekdays, with other multidisciplinary team members being part of the weekly programme. Occupational therapy services are one of the main focuses of this psychiatric day hospital. Occupational therapists in psychiatric day hospitals support individuals in addressing the effects of mental illness by promoting re-engagement in meaningful roles, routines and occupations and addressing occupational imbalance and marginalisation. In these settings, where group therapy is central, the group itself becomes a powerful therapeutic tool through shared experiences, interpersonal learning and mutual support [18, 19].

Widely used models such as the Canadian model of occupational performance and engagement (CMOP-E) [20] and the model of human occupation (MOHO) [21] provide valuable theoretical foundations for guiding intervention. Together, these models guide the understanding of individual therapeutic processes within group settings.

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However, while these models acknowledge social and environmental influences, they offer limited guidance on collective dynamics and the therapeutic mechanisms unique to group-based intervention. This theoretical gap is addressed by Adams and Casteleijn's work on collective participation, which provides a framework for understanding how people engage, grow and heal together through shared occupation [22, 23]. To translate these theoretical insights into practice, the occupational therapy integrative group model (OTIGM) [24] offers a structured and practical approach to planning and implementing group therapy. Widely used in South Africa, the OTIGM aligns well with collective participation theory and supports therapists in designing purposeful, recovery-oriented group interventions that are both evidence-based and culturally responsive.

While occupational therapy practitioners are implementing sound theoretical foundations and models, they and other health care practitioners are under enormous pressure to provide the best service that is well researched and evidence-based. It is on this ground that the Board of Healthcare Funders of South Africa emphasises the importance of research and translation of evidence into practice. As a result, it is strongly recommended that healthcare practitioners, including occupational therapy practitioners, utilise evidence to inform their practice, guide their decision-making and shape their treatment modalities, models and approaches in patient care.

In the South African context, there were no published evidence-based guidelines for developing an occupational therapy programme in private psychiatric day hospitals. Additionally, there is a significant lack of documented evidence to guide the development of such a programme. As a result, occupational therapy practitioners in these newly established private psychiatric day hospitals often rely on professional clinical reasoning, historical guidelines and past experiences to develop and implement services for their patients. While clinical reasoning and past experiences can be valuable, it is essential to balance these with evidence-based practice and critical thinking. Providing guiding principles for an occupational therapy programme in a psychiatric day hospital could ensure that practices are effective, evidence-based and cost-effective.

Evidence-Based Practice relies on the thoughtful integration of three essential components: the best available scientific evidence, individual clinical expertise and patient values and expectations [25]. As part of the process of developing evidence, both therapists and service recipients must reflect on intervention programmes to identify important ingredients and specific modalities that can form part of and contribute to the development of evidence-based practices. What this study reported on in this article forms part of a PhD study that sought to develop evidence-based occupational therapy guidelines for a programme that can be applied at a private psychiatric day hospital in the South African context.

The research question for the PhD was: What should evidence-based occupational therapy guidelines for a programme applied at a private psychiatric day hospital in South Africa include? This paper is part of Phase 1 of the larger PhD aimed at developing evidence-based occupational therapy guidelines for a programme applied to a private Psychiatric Day Hospital in South Africa. Phase 1 is aimed at evaluating an occupational therapy programme that was already in place at a psychiatric day hospital in South Africa, in order to inform the development of evidence-based guidelines for such a programme, and reports on the perceptions of occupational therapy practitioners who facilitated the occupational therapy programme and patients who were the recipients of the programme at a psychiatric day hospital. These reflections will be used and contribute to setting up the guidelines for the occupational therapy programme in day hospitals.

2. Methodology

This study employed an exploratory qualitative research approach as phase one of a multimethods PhD project, conducted within the principles of action learning and action research (ALAR) design, drawing from the two stages, namely, observation and reflection, to obtain comprehensive insights into the occupational therapy programme at Evexia Psychiatric Day Hospital. Given the scarce available knowledge on evidence-based occupational therapy guidelines for a psychiatric day hospital, an open-ended inquiry was conducted to enable the researcher to explore participants' experiences, perceptions and interpretations in a naturalistic context.

2.1. Research Population. Both occupational therapists and former patients were invited to participate in this study. In terms of the former, eligibility criteria included that participants must be mental health occupational therapy practitioners with a minimum of 12 months of experience, or those who have worked at Evexia Psychiatric Day Hospital for more than 6 months. Former patient participants included individuals who have previously been admitted to Evexia Psychiatric Day Hospital for a minimum of 5 days and have participated in the occupational therapy programme at the day hospital; they were also considered eligible for inclusion in this study.

2.2. Research Sampling and Recruitment. Fifteen occupational therapy practitioners were invited to participate in the study. A total of eight agreed to participate, while seven declined due to demanding schedules. Similarly, 15 former patients (functioning on passive participation level of creative ability) were recruited, and seven agreed to participate, with eight not responding to the invitation. Although the final sample size comprised eight practitioners and seven former patients, the data were aggregated and examined as a single dataset to capture a range of experiences. The sample size was guided by the principle of information power, which suggests that smaller samples can be adequate when the aim is specific, the dialogue is strong, and participants are highly relevant to the study question [26]. Furthermore, saturation logic was considered in the iterative analysis process, where no new themes emerged after several interviews, indicating conceptual sufficiency [26]. This approach

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supports the adequacy of the sample size in achieving the study's exploratory aims.

2.3. Ethical Considerations. All participants were asked not to disclose any personal information such as their names, age, or diagnosis during the interviews. Written consent was given to the researcher for audiotaping the interviews. Participants were provided with information about the research, and they voluntarily participated. Ethical clearance was obtained from the Human Research Ethics Committee (Medical) of the University of the Witwatersrand under Ethical Clearance Number: M220209. Furthermore, patients were interviewed after they had been discharged from the hospital; thus, they were free to be honest in their feedback.

2.4. Data Collection. Data were collected by the first author through semistructured interviews. Interviewing was selected as it provides rich contextual data and ensures that the voices and perspectives of participants are heard and represented authentically [27]. It was further used to explore and identify central themes of how participants experienced the occupational therapy programme from the provider side (occupational therapy practitioners) and the receiving end (patients). The interviews were conducted at Evexia Psychiatric Day Hospital in a private therapy room where privacy could be assured and was convenient for the participants. Six occupational therapy practitioners were interviewed in person, and the other two were interviewed online using a virtual Microsoft platform called Teams due to logistical challenges. Five patients were interviewed upon discharge from the programme, and two were interviewed online using virtual Microsoft Teams as they had been discharged and left the hospital already.

Qualitative interview questions were carefully formulated to be accessible for occupational therapy practitioners and former patients. The primary question to the participants was: 'What do you think of the occupational therapy programme at Evexia Psychiatric Day Hospital?' Probing questions included the following: 'Is the practice of OT programme grounded in evidence? In what way is the OT practice evidence-based? Why? Tell me more? Which elements of the OT programme are supported by evidence? How was your experience of the programme; if there is anything to change, what can you change or improve? Please elaborate on what you have just said … namely? Please tell me more … such as?'

The interviews lasted between 15 and 50 min for the former patients, while those for occupational therapy practitioners extended up to 90 min. Participants agreed to the recording of the interview sessions, and data were captured using a Siemens voice recorder, with an iPhone mobile serving as a backup. Raw data was transcribed by a transcriber. Data saturation was achieved between the seventh and ninth interviews, as information began to repeat and common themes surfaced within the raw dataset. Data from the interviews were analysed using Atlas.ti 23.2.1 version, to produce codes, categories and themes. The study sample yielded adequate data to facilitate essential interpretations and conclusions.

2.5. Data Analysis. Data were imported into Atlas.ti 23.2.1 software upon completion of transcription, which was used to analyse the data. A six-step reflexive thematic analysis of Campbell et al. [28] was used to capture and derive meaning from the data. The reflexive thematic analysis process began with the first author familiarising himself with the dataset by repeatedly listening to the recordings and carefully reading the transcribed data. Following this, the data were systematically coded on Atlas.ti 23.2.1 software, which generates a code book, whereby themes, categories and subcategories were deduced from the code book, representing the raw data. The code book from Atlas.ti 23.2.1 software was used to generate the table with themes, categories and subcategories, breaking them down into manageable units to identify patterns.

The coding of the first three transcripts was done collectively by the first author and university supervisors, enhancing credibility and accuracy. Once coded, the first author followed the subsequent six steps of reflexive thematic analysis to generate meaningful themes from the data, with careful attention given to organising and refining the codes to establish clear boundaries and interpretations. Common codes were merged and captured to highlight underlying patterns and meanings. Categories and subcategories were generated from a group of codes that supported one specific theme. Subsequently, specific themes were refined. The themes were defined and named through careful scrutiny and evaluation. Finally, the analysed data were interpreted, the emerging themes were member-checked with participants, and the findings were comprehensively discussed.

2.6. Trustworthiness and Rigour. To fulfil credibility criteria, the first author engaged extensively with the occupational therapy practitioners who agreed to participate in the study during the data collection phase. This engagement entailed extended interaction with participants, observing group sessions and collecting insights regarding their experiences. To ensure triangulation, the analysed data and findings were supported by existing literature from other countries, even though there were limited references regarding occupational therapy programmes in psychiatric day hospitals.

The process, methods and findings were rigorously evaluated by the two supervisors (second and last author) during the peer review process. Additionally, to bolster credibility via member checking, the research findings were shared with participants during the focus group in the third stage of a multistudy PhD. This step guaranteed that the results faithfully represented the perspectives of the participants.

An audit trail was established to document the research process, ensuring transparency and facilitating the verification of decisions made throughout data collection and analysis. Furthermore, the first author engaged in reflexivity by consistently self-examining potential biases and their impact on data interpretation.

3. Findings

The characteristics of the study sample are elucidated in Table 1.

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TABLE 1: Occupational therapy (OT) and patient participants (PP).

Participants	Occupational therapy practitioners (OT) ($n = 8$)	Years of experience	Gender
Participant 1	OT 1	5–9	Female
Participant 2	OT 2	5–9	Female
Participant 3	OT 3	5–9	Female
Participant 4	OT 4	10–14	Female
Participant 5	OT 5	0–4	Female
Participant 6	OT 6	10–14	Female
Participant 7	OT 7	5–9	Female
Participant 8	OT 8	10–14	Female
Participants	**(Former) patient participants (PP) ($n = 7$)**	**Length of programme participation**	**Gender**
Participant 9	PP 1	10 days	Female
Participant 10	PP 2	10 days	Male
Participant 11	PP 3	5 days	Female
Participant 12	PP 4	10 days	Male
Participant 13	PP 5	15 days	Male
Participant 14	PP 6	10 days	Female
Participant 15	PP 7	10 days	Female

The study comprised eight occupational therapy practitioners and seven patients who agreed to participate in the research. The years of experience of the occupational therapy practitioners ranged from 5 to 14 years of practice in mental health, and the duration of patients' hospitalisation at the psychiatric day hospital and attended occupational therapy programme ranged from 5 to 15 days.

Four themes with their associated categories and subcategories (Table 2) emerged from the data in answer to the research question for this phase of the overall study. The themes were as follows: (1) skilled and competent facilitator with a good understanding of groups; (2) the group as a being (an entity); (3) the patient as an individual; and (4) ongoing interaction among evaluation, intervention and outcomes. The first theme emphasised the need for an occupational therapy practitioner, as the facilitator, to possess the necessary skills and knowledge to effectively navigate the group environment. The second theme focused on the group as a distinct being (an entity) formed by individual patients who united for therapeutic purposes and were shaped by interactive and experiential techniques. The third theme was the patient as an individual. Through working collectively as a group, the patients were identified as stakeholders who have personal journeys and could contribute to future recommendations for programme guidelines. The fourth theme was an ongoing interaction among evaluation, intervention and outcomes and was found to be the guiding framework for the therapy process and programme. The following tables give an outline of each of the themes and their concomitant categories and subcategories.

3.1. Theme 1: Skilled and Competent Facilitator With a Good Understanding of Groups. The findings of this study showed that the current occupational therapy programme at the predominantly group-based psychiatric day hospital is facilitated by skilled and competent occupational therapy practitioners as facilitators who have a good understanding of groups. Three associated categories emerged from the subcategories and codes, namely, reflective facilitation, skill and competence and group understanding.

Findings show that there must be 'reflective facilitation' (first category), which is ensured through "*facilitation of flow and dynamic*" (OT5) and "*facilitation of questions for discussion*" (OT5,7), during groups:

> *…to understand the dynamics and processes, and also how to facilitate, how to lead from the back. (OT2)*

The therapist becomes a facilitator in group therapy, and he/she must have adequate 'skill and competence' (second category) to "*use self therapeutically*" (OT11) and "*be person-centred*" (OT8):

> *…its leadership skills as well as part of the curative factors. So, that for me also falls into the use of self-therapy as a facilitator, but the power of the group lies in the group and its dynamic, and so you as the facilitator. (OT2)*

The facilitator must keep in step with the group, by staying in the process with the group (code 2, of the second category) and be fully immersed throughout the different stages of group development. This allows the "*facilitator to be more person-centred and responsive to the needs of the patients and group members*" (code 10, third subcategory of second category). The facilitator *"creates opportunities for group members to express themselves"* (P11) and *"express their needs"* (P11) by "*leading the group from the back through guidance.*" (P2)

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TABLE 2: Four themes with their associated categories and subcategories.

Theme	Category	Subcategory
Skilled and competent facilitator with a good understanding of groups	Reflective facilitation	Facilitator creates opportunities for group members to express self and needs
		Facilitation of flow and dynamic
		Facilitation of questions for discussion
	Skill and competence	The need for intentional facilitation
		Use of self therapeutically
		Competent multidisciplinary team member
		Person-centredness is at the core
	Group understanding	Group planning and handling skills
		Equipped with group techniques
		Group principles as foundation
The group as a being (an entity)	Group power	There is entrenched power in the coming together of patients
		Deeper connection and interdependency births group process and healing
		Emotional boundness to each other leading to mutual safety
	Group space—physical and emotional	Holding and sharing space with different people in group format
		Safe physical space of the group
	Group dynamic and strength	Group as microcosm
		Strength of the group
	Interaction leading to experience	Group progression through different stages
		Collective interaction among group members
		Should be experiential in nature
The patient as an individual	Self-motivated for change	Getting to know self
		Bring about change in behaviour
		Willing and able to do
Ongoing interaction among evaluation, intervention and outcomes	Continuous evaluation	Value and principles on assessment
		Useful tools for assessment
		Assessment of individual needs within group
	Continuous intervention—planning	Mutual group themes
		Enough time for themes
		Enabling function
		Structured programme
		Continuous engagement
	Continuous intervention—implementation	Use of activity as a catalyst
		Building group cohesion
		Focus on 'here and now'
		Ensure group dynamic
		Allow time for processing
		Facilitate emotional insight
		Facilitate learning
	Continuous intervention—review	Should encourage sharing of experiences
		Reflection and evaluation of progress
	Continuous outcome measuring	Fluidity and measurability of the programme

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> *…to understand the dynamics and processes, and also how to facilitate, how to lead from the back. (P2)*

> *…building cohesion and having those principles when structuring my group or leading my group or facilitating the group, through the week, is quite important especially in week one. (PP14)*

Data show that the therapist should demonstrate *group understanding* (third category), to be able to plan the group session and handle patients in sessions. The facilitator should '*afford patients time and space to practice skills in a trial & error approach*' (Code 26, first subcategory of third category) and facilitate the '*use of curative factors or Yalom's principles, such as cohesion, installation of hope, and universality.*' (Code 32, third subcategory of third category)

3.2. Theme 2: The Group as a Being (an Entity). The participants recognised the group as an entity, which emerged as the second theme in this study, as elucidated in Table 2. Four associated categories emerged from the subcategories and group codes, namely, group power, group space (physical and emotional), group dynamic and strength and interaction leading to experience:

> *…what's beautiful about the interactive group model or psycho-social group process is that, when you are through that process, enabling and facilitating the group to be able to do that for themselves because the power lies in the group members. (OT3)*

The group is fostered by the therapeutic rapport between the facilitator and patients within the group setting and facilitated through adhering to the occupational therapy processes interactively and experientially, which produces group power (first category). Referring to the group space (second category), participants reported that:

> *…what's beautiful about the interactive group model or psycho-social group process is that, when you are through that process, enabling and facilitating the group to be able to do that for themselves because the power lies in the group members. (OT3)*

The group is fostered by the therapeutic rapport between the facilitator and patients within the group setting and facilitated through adhering to the occupational therapy processes interactively and experientially, which produces group power (first category). Referring to the group space (second category), participants reported that:

> *…through the physical coming together of patients at a certain geographical location, and through group therapy, an unseen safe space (physical and emotional space) is created. (OT8)*

This allows for accountability through "*holding and sharing space with different people in the group format*" (Subcategory 1, second category). The space ensures '*simulation of real-life experiences in a safe physical space*' (OT8). This is supported through the heart of code 18 of the first subcategory that "*how you behave in group, is how you behave in everyday life*", which means that a group can be viewed '*as a microcosm*' (first subcategory):

> *…What happens outside happens on the inside - those are principles within psycho-social group model, where the group is a mini society. And so, in order to facilitate the change that people want to see when they are outside, we need to facilitate that change within the group. (OT2)*

It is through these principles that deeper g*roup dynamic & strength* (third category) are facilitated through "*group progression in the different stages*" (third subcategory of third category):

> *…So, forming is the first stage of the group development process. You've got forming, storming, norming and performing. And so, I think knowing that there are four (4) stages for groups development, and norming and performing is where we want the group to be within a two-week space. (OT7)*

Findings in our study show that there is a collective interaction among group members that is intentionally facilitated by the occupational therapy practitioner. To explain this phenomenon, one participant said, '*interactive model stirs questions, through activities*' (PP12). Therefore, the programme should have '*more interaction through activities than psychoeducational*' (OT7). It is by intentional interaction that realisations are facilitated through the experiential nature of the programme. It was noted by one participant that '*experiencing interaction and engagement, among patients can be beneficial*' (Code 2, second subcategory), and this can also be ensured through "*therapist-patient interaction*" (OT1) in the group process:

> *…the basis of the groups that we do at Evexia are that they are experiential processes to the patients, it is not psychoeducational. The patients have an actual experience and then grow through their experience, and therapy happens through the experience itself. (OT1)*

3.3. Theme 3: The Patient as an Individual. The patient as an individual emerged as the third theme of this study. The participants identified the patient as a key role player and entity that is central to the occupational therapy programme at the psychiatric day hospital. *Self-motivation for change* (category) emerged as the only category from the subcategories and group codes, respectively. Patient motivation has always been a cornerstone of successful occupational therapy

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intervention. By understanding and enhancing motivation, therapists can effectively support patients in achieving their goals, improving adherence to treatment plans, and ultimately enhancing their quality of life. The patient should be intrinsically *self-motivated for change* (category):

> *…as a therapist, I have never once felt that a patient cannot participate. If they are motivated, willing and able, they can participate – and I think that is incredible for patients that are mental health care users, for a lot of their lives, have felt the need that people don't understand them, or they can't participate, or they are excluded or something like that. (OT5)*

The findings showed that *getting to know self* (first subcategory) is central and part of what the occupational therapy programme is about, which will *bring about change in behaviour* (second subcategory). These were supported by some participants who noted that "*cohesion building in the group leads to self-awareness"* (OT1) and that "*patients get to know self, through the group"* (OT8). One participant noted that the programme assists them to "*facilitate the translation of change learnt in group, into the real world"* (P8), due to the reality that "*change is facilitated within the group itself*" (OT7), in the "*here and now"* (OT7,PP13). Lastly, it was noted that the individual must be *"willing and able to do the work*" (OT1,PP14,PP15):

> *…I appreciate the work that is done in the group, and within the group process and the stages of group development and dynamics. And I mean, I've found also that because it's slightly different from what you get from other hospitals, that I've experienced the OT program within Evexia speaks a lot to the needs of the patients in a "here and now" perspective. It's very aligned to the "here and now", and what needs to happen moving forward in terms of your occupational status. I think that's something that I found also quite nice. (OT8)*

3.4. Theme 4: Ongoing Interaction Among Evaluation, Intervention and Outcomes. The *continuous interplay among evaluation, intervention and outcomes* emerged as the fourth theme in this study. Participants recognised the occupational therapy process as a fundamental framework that unifies the programme and guides the progression of group therapy. Subcategories underscored specific elements and techniques integral to this process, serving as the foundation of the programme.

The findings of this study show that there is value in commencing the programme with assessment and through following certain *principles for assessment* (first subcategory of first category). Among other things, participants noted that there should be an "*initial assessment on Monday*" (P12), to ascertain and "*identify the needs of the group"* (PP2).

> *…within the group we do, on a Monday, something called the wellness recovery action plan which also doubles as self-awareness treatment. So, it is an assessment that the facilitators can use to identify what are the group needs, but it can also be used as a means to reflection for the patient for self-awareness. (PP1)*

Secondly, it was noted that there are certain useful tools for assessment that are utilised in the occupational therapy practice such as the Wellness Recovery Action Plan (WRAP) (P9,10), "*interview with patients, and the use of creative ability and activity participation outcome measure (APOM)"* (PP2). Although these assessments can be done at the beginning of the week, the actual '*evaluation and reevaluation process is continuous*' (first category) as the facilitator must '*consider individual needs within the group*' (PP2,3), recognising the group developmental stages and process:

> *…so forming is the first stage of group development process. You've got forming, storming, norming, performing. I think that knowing that there are four stages of group development and norming and performing is where we want the group to be within two weeks space, we need to somehow facilitate that process. (PP7).*

Our findings revealed that there is a need for *continuous intervention planning* (second category) once the assessment of the individual patients and group has been done. This is where the *mutual group themes* (first subcategory of second category) can be derived and prioritised for the week's intervention. It is noted that the facilitator follows the lead and needs of the group and identifies the "*emerging group themes and responsive nature of the programme"* (PP15) and introduces the themes and subsequent sessions:

> *…Group themes are captured upon the assessment of the group, in the beginning of the week. However, the group progression determines the direction and needs of the group and dictates the next theme to be addressed, in next session. (OT3)*

The programme must ensure that there is *enough time for themes* (second subcategory of second category) to be discussed, which ultimately *enables function* (third subcategory of second category), by "*addressing occupational performance areas (social interaction; occupational balance; work; leisure; self-care; sleep hygiene)"* (PP11) and other *"life skills such as communication; boundary setting; time management and stress management"* (PP9,14).

The findings show that the occupational therapy group programme is structured (fourth subcategory of second category), as noted by one of the participants that "*the occupational therapy groups synergistically align with the rest of the Evexia daily program"* (PP14), therefore "*there should be occupational therapy sessions on a daily basis"* OT5):

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> *…So, what I really value in working here is also the structure of the program. So, the manner that it is setup is; OTs come generally in the morning, and then process group is in the afternoon. (OT1)*

As part of planning the intervention, the facilitator should keep in mind the need for continuous engagement through "*human interaction and human connection*" (OT1) in the group space. This can be ensured and facilitated by using activity as a catalyst, as noted by one of the participants that "*activities facilitate reflection and interaction*" (OT2), and can be used "*as a vehicle*" (OT2,7):

> *…In terms of the actual OT program, I like the use of activities, and be more occupation based. (OT6)*

> *…whereas the rest of the activities, there is a lot more interaction and a lot more cohesion and feedback that is happening during the activity. For me, I feel like I need to already be achieving my outcome during the activity. So, when it comes to reflection and discussion, we are really just touching on things that were highlighted already. (OT1)*

This is in synchrony with the flow and sense of engagement that is experienced through meaningful and purposeful occupation. Therefore, it is important for the occupational therapy facilitator to carefully plan, analyse and select the right activities for the group members on the programme. Lastly, the data reveal that the "*interactive model stirs questions through activity*" (OT6, PP12):

> *…The interactive group model comes with an activity that stirs questions in the group. And then the OT facilitates these conversations and facilitates the questions and the conversations between the patients so that they can grow in terms of how to make it practical for themselves. (PP12)*

Continuous intervention implementation emerged as the third category of Theme 4. When considering the implementation of the programme, the participants indicated that group cohesion is fundamental, and it must be '*built from the first session and/or early in the week*' (OT8). '*Solidifying cohesion; creating safe space and delving deeper*' is what was reported by one of the participants (OT8), which allows the group facilitator to work from and focus on the '*here and now*' (OT8):

> *…Now that the group cohesion is solidified and there is a good group dynamic, we can move on to what it is that they need. Now that the safe space has been created. I think that at this point it is the right time to delve deeper into what they are dealing with. (PP9)*

Alongside the building of group cohesion, the findings show that there is a group dynamic that is ensured in the process. Herein lies the power of healing.

This study shows that there is a *continuous review* (fourth category) of the intervention as part of the implementation, which emerged as the fourth category under Theme 4. Review of intervention takes place throughout the programme and it is done by the group facilitator while journeying with the group members in the group process. However, the patients also undergo a review of their own during the programme, which is linked to *getting to know self* (first subcategory of Theme 3). '*Reflection & evaluation of progress*' (subcategory of fourth category) is ensured through the intervention phases. One participant noted that '*the programme allows for reflection*' (OT1,2,4,7) and others noted that '*the occupational therapy group helps them connect the*' (OT3,PP10) as they come to make important realisations:

> *…the conflict management session, became a session because the facilitator could sense tension, Right. So she used that opportunity to have just everybody reflect and, and speak. (PP13)*

> *…A very big thing for me was at the end of the day in the OT groups, it's like to connect the dots, so that when the process groups happen, you learn so much about yourself in OT that without the OT part, the process group won't be so well, or you won't be so insightful about yourself. (OT3)*

Following continuous review is *continuous measurement of outcomes* (fifth category) throughout the programme, and at the end of the week before the patients can be discharged. This is when the shifts and progress that have been made are harvested and reflected upon. The *fluidity & measurability of the programme* (subcategory of fifth category) allow for these factors to take place. The "*use of the STAR recovery tool*" (OT1,6) and other tools such as *"APOM"* (OT1,5), can ensure the measurement of patients' outcomes at the psychiatric day hospital programme:

> *…And then at the end of the week we use something called 'The Star'. The Star is based on the recovery model, and is basically a self-rating skill for the patient on certain areas of development that they have grown through in the week, and they will then give it a score on a scale of 1-10 – and we found this to be really empowering for the patients to measure their own progress on both Fridays of admission (week one and week two), because they can also personally reflect on their growth, and because we use the interactive model, the rest of the group can give them feedback as well on their score should they be too hard on themselves or should they possibly still have a development to do in a certain area. (OT1)*

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4. Discussion

This study uncovers core elements, inherent healing dynamics and therapeutic forces that form the foundation of the occupational therapy programme at a psychiatric day hospital in South Africa. This affirms and solidifies the significance of occupational therapy and its various therapeutic approaches, including the utilisation of therapeutic groups in this context, which require astute and complex facilitation skills.

The study included eight experienced female occupational therapy practitioners with diverse clinical perspectives. The seven former patient participants had the ability to give objective feedback, and their experiences contributed to the significance of occupational therapy in day hospitals. Collectively, the demographic profile reflects typical patterns within these settings, where practitioner expertise and structured patient involvement shape the delivery and experience of group-based occupational therapy. A skilled and competent facilitator is essential to the success of the occupational therapy programme in various settings, including the psychiatric day hospital. The facilitators must have knowledge of groups as an intervention modality and comprehend group dynamics. As healthcare practitioners, occupational therapy practitioners' levels of skill and competence are among the important qualities in ensuring effective service delivery, including in day hospital settings [29, 30]. Effectively navigating and facilitating groups demands strong clinical reasoning, particularly in the realm of mental healthcare, where such reasoning is essential and crucial [31].

Skill and competence contribute to using self therapeutically as part of the art of group facilitation. Punwar and Peloquin [32] define therapeutic use of self as: '*A practitioner's planned use of his or her personality, insights, perceptions and judgements, as part of the therapeutic process*' (p.285), while Evatt and Scanlan [33] mentioned that the therapeutic relationship has led occupational therapy practitioners rich understanding of the therapeutic use of self. This is crucial in group therapy as it attempts to encapsulate the role that an occupational therapy practitioner plays in the therapeutic relationship with the patients [34, 35] and undergirds core skills and competence of an occupational therapy practitioner as the facilitator of groups.

The occupational therapy practitioner becomes a 'group facilitator' in group therapy. [19, 36]. Group facilitation requires an occupational therapy facilitator to have a good understanding of group principles [19, 36]. The facilitator must possess certain foundational group principles integral to the group therapy process, such as specific and intentional questioning, addressing dysfunctional occupational performance areas and having a clear goal that can be achieved through active participation in an activity within the group context [37].

A group functions as a microcosm, complicating patients' ability to hide within the therapeutic setting, making group therapy particularly suitable for psychiatric day hospital occupational therapy programme. Home programmes are given to patients to practise the skills that they learned during the day, to ensure continuity. Consequently, the identities and experiences of patients within the broader society are represented and elicited in the here and now, particularly within group sessions, as part of group dynamics. The established group dynamics and foundational principles necessitate a specific degree of expertise and proficiency, along with meticulous facilitation of the healing elements or Yalom and Leszcz's [18] therapeutic principles, which serve as the core drivers. They identified 11 therapeutic factors, and cohesion is one of them [18], which was highlighted in this study and reported to be the force that builds trust among and within group members. Trust in group therapy develops through the creation and deepening of group cohesion [35, 38]. Therefore, the study findings are consistent with literature that group cohesion is central to group formation and development and ensures group identity, which is fundamental to the healing process of each patient in the group.

The limited body of research on the role of occupational therapy practitioners within day hospital settings reveals a notable absence of discussion regarding their professional competencies in facilitating socioemotional group interventions. In particular, no studies have reported on the application of therapeutic frameworks such as Yalom's curative factors in group therapy contexts. Eklund et al. [17] described the role of occupational therapy practitioners as providing meaningful and purposeful engagement in activities at a day centre but did not reference group therapy focused on Yalom's curative factors. These factors, including interpersonal learning, altruism, universality and instillation of hope, were not addressed in the context of navigating group dynamics for therapeutic purposes. From our findings, these factors are integral in the group interventions at a psychiatric day hospital.

As the group is formed, there is a distinct identity that is also created within the group. [39], p. 175) define identity as "a composite of roles, values and beliefs that are acquired and maintained through social interaction". Identity is important in a group therapy space. Individuals, such as patients in the group space, tend to project their identities to others through meaningful interaction. Our data revealed that the group possesses an intrinsic vitality, it is an entity that is evident in the profound collective influence observed among patients, which contains healing potential that is inherent in group feedback. This underscores the undeniable presence of a potent, self-sustaining force within the group environment, fostered by profound connections and interdependence, nurturing both the group process and healing. Cohesion fosters a deeper emotional bond among group members, cultivating mutual safety, all facilitated by the group process [18]. Moreover, closed groups have better outcomes than open groups [40].

Close groups play a vital role in occupational therapy programmes at mental health settings, including psychiatric day hospitals, due to the strength of their dynamic. The study revealed that the group dynamic in a closed group can be stirred by the different characteristics of the group members or patients, supported by Howe and Schwartzberg [41], who argued that the group dynamic has the power to self-direct and lead each group member to meet their

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individual needs. Group composition of the group is essential for the occupational therapy programme at a psychiatric day hospital, as this study indicates that group dynamics and efficacy are inherent in the group process when individuals from diverse backgrounds, ages, races, experiences and diagnoses come together. Corey [42] refers to this phenomenon as the heterogeneity of the group, which carries inherent power to increase creativity, provide triggers and propel change in individual members of the group [18, 42, 43].

This study confirms that the execution of an occupational therapy programme employing group therapy in a psychiatric day hospital allows patients to candidly discuss their authentic concerns, current situations and immediate triggers, promoting an atmosphere favourable to reflection, transformation and personal growth. Similarly, just as human beings live and connect in their natural societies, Goldberg and Hoyt [44] argue that a group in the therapy space can also be viewed as a microcosm and minisociety. The patterns and uniformity of patients' behaviour and pathology are clearly observable throughout the programme at the day hospital. Thus, in a supportive and nurturing environment, the individual is encouraged and allowed to simply be, rather than conform to expected behaviours, allowing their authentic self to surface. These principles unify the group, fostering and enhancing its collective identity. The combined capabilities of the group empower its members to navigate towards solutions, promoting development within the collective, as indicated by our findings.

The interactive and experiential nature of the programme was identified as a crucial component of the group and programme in this study. Interaction in groups is comprised of direct communication among group members, reciprocal actions and deeper exchanges that lead to interconnectedness [45]. Our data indicate that activity plays a crucial role in facilitating interaction and shaping experiences within groups. The results further assert the use of group activities to enhance interaction, which guarantees the experiential element as a key ingredient of the OT group session on the programme. This is consistent with the position paper on group-work in occupational therapy, where the Occupational Therapy Association of South Africa [37], assert that the group should be guided by a clear goal for the group session, and once this has been established, a suitable activity should be carefully selected, that will facilitate the achievement of the set goals, through active participation [37]. These activities offer group members the opportunity to practice specific skills, such as problem-solving and social skills, in a real-time, 'here-and-now' setting [37]. Therefore, it is through these interactions that members effortlessly unearth and manifest their innermost and unconscious feelings in the 'here and now' experience [46], which propels change.

Change involves actions that must be taken. Actions require inner drive and motivation; therefore, every individual patient on the psychiatric day hospital programme needs to be self-motivated for change, which can be achieved by presenting the group sessions at the patient' appropriate levels of function or creative ability level. This is consistent with the Vona Du Toit Model of Creative Ability (VdTMoCA) [47], which strongly upholds the principle that motivation governs action, and action is an expression of motivation. It is therefore imperative that occupational therapy practitioners implement strategies that enhance patient motivation, such as individualised interventions, collaborative goal setting and the use of positive reinforcement. Equally important is the facilitation of experiences of success through the careful calibration of tasks to achieve the 'just right challenge', thereby promoting a sense of competence and supporting sustained behavioural change.

It is through this inner drive and intrinsic motivation that patients are self-motivated to bring about change in behaviour [48]. This type of change should be facilitated and experientially encountered in the here and now and in real time. These principles are consistent with the work of Zedel and Chen [19] who argued that the element of the here and now is necessary for participants to experience the benefits of occupational therapy groups. Therefore, each patient engaging with other patients in a group format, therapeutically facilitated by a competent occupational therapy practitioner, yields positive findings and propels healing and change [49]. This can be ensured using occupational therapy theoretical and scientific processes.

Occupational therapy practitioners in all fields of practice, including mental health, undertake certain scientific processes and frameworks when rendering their service to patients, as described in the occupational therapy practice framework [34]. In the third edition of the occupational therapy practice framework, domain and process, 'the three-part process is noted which includes: (1) evaluation and (2) intervention to achieve (3) targeted outcomes, and it occurs within the purview of the occupational therapy domain' ([34], p. 41). This study revealed a systematic process that an occupational therapist may follow to guide a programme at a psychiatric day hospital programme and inform the unfolding of the group therapy process. The evaluation of each patient, individually and the collective evaluation of the group is important to identify problem areas and needs of the patients, which enables the facilitator to set clear goals for the group.

Occupational therapy group interventions in psychiatric day hospitals are anchored in key occupational therapy theory, which includes both individual and collective dynamics to achieve meaningful, recovery-oriented outcomes. The CMOP-E [20, 50], the MOHO [21] and the VdTMoCA [47] provide valuable theoretical frameworks that enable occupational therapy practitioners to evaluate, understand and respond to each group member's unique needs, values and contexts. The CMOP-E emphasises the dynamic interaction between the person, their occupations and the environment, supporting a client-centred approach that respects the individual's occupational identity and promotes meaningful engagement within group contexts [20]. The MOHO offers a system-oriented view, focusing on volition, habituation, performance capacity and the influence of the environment, which helps occupational therapy practitioners understand how individuals function within social groups and how occupational performance is shaped by both personal and contextual factors [51]. Within a group setting, these models assist in viewing individuals not merely as isolated clients but as active agents whose participation

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and transformation are both personal and relational, which ultimately contribute to and are shaped by the group as a therapeutic social system.

In psychiatric day hospital settings, VdTMoCA offers a nuanced framework for tailoring group interventions that foster creative participation, enhance group cohesion and promote progression through levels of occupational functioning. In the context of psychiatric day hospital programmes, collective participation offers a powerful mechanism for unveiling and addressing the complex sociocultural realities of South African communities. The therapeutic group serves as a microcosm of broader society, a space where shared vulnerabilities, mutual accountability and cocreated meaning can be harnessed to promote mental health and social cohesion. Drawing on Adams and Casteleijn's [23] framework on the assessment of participation in collective occupations and based on the VdTMoCA, the five domains of collective participation: motivation, action, product, collective relations and emotive-cognitive functioning, can be used to assess and facilitate therapeutic group processes that go beyond the individual to support collective growth and empowerment [23]. Integrating individual-centred models like VdTMoCA, CMOP-E and MOHO with these collective participation domains bridges the gap between personalised care and group-level transformation. This synthesis enables occupational therapy practitioners to design culturally relevant and therapeutically robust day hospital interventions that align with South Africa's collective ethos and the broader goals of recovery-oriented psychiatric care.

Once goals have been set, intervention can be planned and implemented accordingly, with careful consideration of activities to be used for each identified theme and within every group session. The use of activities facilitates interaction among patients in groups, which automatically triggers and facilitates follow-up questioning among group members, thus creating self-awareness and unearthing hidden traits and habits about self that one would not naturally confront or be aware of. Personal realisations and self-awareness deepen among the patients in the group, which can be identified during the review of patients' progress and outcomes within the programme. The APOM tool is one of the occupational therapy-based tools that is based on the VdTMoCA, which can be used to measure patients' outcomes at the end of the programme [40]. These principles are consistent with Rocamora-Montenegro et al.'s [49] scoping review on occupational therapy interventions for adults with severe mental illness.

Severe mental illnesses are associated with neurobiological and psychosocial challenges, requiring occupational therapy group intervention. To strengthen the conceptual depth of occupational therapy group interventions in psychiatric day hospitals, it is essential to link psychosocial frameworks with emerging neurobiological models [52]. The glymphatic system, a recently identified waste clearance pathway in the brain, plays a critical role in maintaining neurophysiological homeostasis, particularly during sleep [52, 53]. Dysfunction in this system has been implicated in a range of psychiatric disorders, including schizophrenia, depression, anxiety and sleep disorders, which are commonly addressed in structured OT interventions [52–54]. Glymphatic impairment is associated with neuroinflammation, emotional dysregulation, cognitive deficits and disrupted circadian rhythms, all of which manifest in psychiatric populations and are targeted through group-based occupational engagement [52]. Group interventions that promote regular routines, embodied and purposeful activity and group cohesion may support restoration of glymphatic function by enhancing sleep quality, reducing neuroinflammation and reinforcing circadian stability [52, 53]. Therefore, the therapeutic use of rhythm, structure and coregulation in occupational therapy groups may contribute not only to psychosocial recovery but also to neurophysiological regulation, offering a compelling interface between occupational science and neuroscience.

Building on the importance of occupational therapy in flexible service delivery, recent comparative data from Italy underscore the strategic value of psychiatric day hospitals in times of crisis [52–54]. Barlattani, Salfi, et al. [54] analysed hospitalisation trends during two major events the 2009 L'Aquila earthquake and the COVID-19 pandemic, which revealed fluctuating yet long-lasting effects on psychiatric admissions. Notably, while acute admissions initially declined during these crises, a significant rebound occurred 18–24 months later, particularly for schizophrenia spectrum, bipolar and substance use disorders [52]. These findings support the notion that psychiatric day hospitals, especially those incorporating structured, group-based occupational therapy programmes, can function as adaptive buffers during and after emergencies [52, 53]. Their modular, nonresidential nature enables continuity of care amid disruptions, while structured occupational therapy interventions help stabilise routines, rebuild daily functioning and offer therapeutic containment for individuals navigating postcrisis instability, especially when conventional programmes are overfull [52]. Group occupational therapy activities that target routine formation, social reconnection and shared occupational engagement may play a critical role in preventing decompensation and reducing the need for inpatient care, particularly when traditional services are strained [52, 53]. Integrating these insights into occupational therapy psychiatric day hospital programmes reinforces their role in crisis-resilient mental health systems and strengthens the argument for sustained investment in structured occupational therapy service models. Therefore, although the study was conducted in South Africa, its relevance cuts across different countries, highlighting the universal potential of structured occupational therapy group interventions within psychiatric day hospitals to enhance crisis-resilient mental health care on an international scale.

5. Potential Limitations and Recommendations of the Study

Among the limitations of the study is the fact that it was conducted at a private psychiatric day hospital that has access to more resources, including human resources, than public mental health care facilities. It would be great to see what the results would be like if another study could be carried out in public mental health care facilities and compare

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the results. Although the core occupational therapy concepts and process remain the same and can be replicated, one may have some limitations with replicating the exact programme in the public sector and/or at overnight hospitals, due to different routines, setting arrangements and availability of resources. However, the study provides important ingredients that could be considered when developing evidence-based occupational therapy guidelines for a programme that can be applied to a psychiatric day hospital.

6. Implications for Practice

This study emphasises the significance of integrating evidence-based practice within occupational therapy, especially concerning mental health. The study was carried out in a psychiatric day hospital; however, the results can be applied to an overnight hospital environment, given that the fundamental principles and practices of occupational therapy are consistent across different settings. Nonetheless, it is essential to thoughtfully evaluate the quantity of treatment sessions, the tasks patients undertake at home and their attendance for the subsequent day's programme.

Group therapy has demonstrated significant efficacy as a treatment method for individuals facing mental health challenges. This indicates a possible necessity to adjust and reassess treatment approaches, weighing the importance of group and individual therapy according to the particular context and the needs of the patients. The results highlight the importance of continuous training for occupational therapy practitioners to guarantee they have the skills and competence required to effectively lead group therapy sessions.

7. Conclusion

The findings from the study highlighted important elements that should be incorporated into practice guidelines for occupational therapy practitioners working in a psychiatric day hospital. Given the scarcity of studies related to occupational therapy practice in day hospitals, these qualitative findings contribute significantly to the existing body of literature. This study highlighted that the connection between the occupational therapy practitioner acting as a facilitator and the patients, who are essential participants in the group, is crucial for the effectiveness of an occupational therapy programme in both scientific and therapeutic contexts. The study emphasises the distinctiveness and significance of the occupational therapy role in group therapy as a vital and alternative intervention method that can be applied not only in a psychiatric day hospital but across all psychiatric hospitals within the South African context and abroad.

8. Key Findings

- Occupational therapy practitioners must embrace their unique role in group settings, particularly in the realm of mental health. The function of adept facilitators is essential in occupational therapy group interventions, as they comprehend group dynamics and ensure experiential interaction and foster a supportive atmosphere. They adapt their approach to each group's unique needs, promoting engagement and meaningful connections.
- Group therapy is a collective process, with shared experiences and peer support contributing to the therapeutic process. A sense of belonging enhances patient motivation, reinforces positive behaviours and facilitates emotional healing.
- However, each patient within the group process is a distinct entity with specific needs and goals. Tailored interventions within the group setting ensure each participant's benefits while contributing to the collective experience.
- A continuous cycle of assessment, intervention and review is essential for effective occupational therapy practice. Regular reviews allow for adjustments to treatment plans, optimising both individual and group outcomes.

Data Availability Statement

The data underpinning the findings presented in this study are available from the corresponding author, July Masango. Interested parties may obtain access to these data by submitting a reasonable request, subject to considerations of ethical approval, data protection and the intended use of the information.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

Tania Rauch van der Merwe: involved in scoping review design in all drafts and finalisation of the scoping review research proposal, including as part of the conceptualisation of an overall PhD research proposal; critical review and input to the writing of drafts and text to completion. Fasloen Adams: involved in scoping review design in all drafts and finalisation of the scoping review research proposal, including as part of the conceptualisation of an overall PhD research proposal; critical review and input to the writing of drafts and text to completion. Daleen Casteleijn: assisted with writing up the study, methodology, results and discussion, review of final drafts.

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consented to share their experiences and insights, thereby contributing significantly to this study.

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