

# DEPRESSIVE DISORDERS STANDARD OPERATING PROTOCOL FOR OCCUPATIONAL THERAPISTS (OT)

Compiled by K. Christmas, P. de Witt, I. Grobler, M. Lopes and K. Theunissen

for the Occupational Therapy Association of South Africa, January 2024

Note: This protocol should be read in conjunction with OTASA's Occupational Therapy Standards of Practice document to comply with professional standards and facility-specific protocols.

## **Introduction**

In recent years, mental health disorders have become more prevalent worldwide. According to the Global Burden of Disease survey, mental illnesses account for around 15% of years lost to disability globally, with depressive disorders rated second in global prevalence making them one of the leading causes of impairment (GBD 2019 Mental Disorders Collaborators, 2022). More than 400 million Disability Adjusted Life Years (DALYs) occur annually worldwide due to mental diseases, accounting for 16% of all DALYs. Mental health problems account for 13.8% of the illness burden in South Africa, higher than musculoskeletal diseases (10.4%) and HIV (11.8%) and are a primary cause of disability-adjusted life years (DALYs) (Department of Health, 2023).

## **Purpose of this Standard Operating Procedure**

The purpose of this Standard Operating Procedure (SOP) is to provide an evidence-informed practice guideline for the standard occupational therapy management of clients diagnosed with clinical depressive disorders across phases of the illness cycle(s) considering the short- and long-term course of the illness. This SOP speaks to our scope of profession, addresses services across the different service delivery platforms at all levels of care, and service delivery costs (Health Professions Council of South Africa, 1974).

This SOP aims to achieve efficiency, quality, uniformity, and cost effectiveness in services irrespective of service delivery site. Thus, this document provides a standard against which all occupational therapy services for clients with depressive disorders can be measured, managed, and reimbursed in the occupational therapy sector, regardless of the site of service delivery and source of funding.

This SOP assumes that all occupational therapy services are socio-culturally sensitive to our diverse clients' needs, cultural and socio-economic contexts, and that the desired outcome is to achieve health, quality of life, and participation in life through engagement in occupation (American Occupational Therapy Association, 2020).

# Literature review

## Definitions

Clinical depression is a mood disorder that causes a persistent feeling of sadness and loss of interest (World Health Organisation, 2021). It affects how one feels, thinks, and behaves and can lead to a range of emotional and physical problems as well as activity limitations and participation restrictions in the occupational therapy domains (activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, social participation, and leisure) (World Health Organization., 2001). Depression can occur across the life course. It can occur independently or can be associated with other co-morbid conditions such as HIV, anxiety, CVAs, and spinal cord injuries.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) describes eight depressive disorders, namely (American Psychiatric Association, 2022):

- Major depression (MDD)
- Dysthymia (dysthymic disorder)
- Bipolar disorder
  - Bipolar 1
  - Bipolar 2
- Mood disorder due to a general medical condition
- Substance-induced mood disorder
- Persistent Depressive Disorder
- Adjustment Disorder with Depressed Mood

The DSM-5TR describes the following symptoms (American Psychiatric Association, 2022, p 183-184):

- Feeling sad or having a depressed mood most of the day, or nearly every day
- Loss of interest or pleasure in previously enjoyed activities
- Changes in appetite resulting in weight loss (unrelated to dieting), or weight gain
- Trouble sleeping (either difficulty in falling asleep, staying asleep or early morning waking, or sleeping too much)
- Loss of energy or increased fatigue
- Increase in purposeless physical activity (e.g. inability to sit still, pacing, handwringing) or slowed movements or speech (these actions must be severe enough to be observable by others)
- Feeling worthless, unconfident, self-critical or guilty
- Difficulty thinking, concentrating, remembering, or making decisions
- Recurring thoughts of death or suicide

Five (or more) of these symptoms must have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure (American Psychiatric Association, 2022, p 183-184)

Depressive disorder symptoms cause significant distress and functional impairments, which lead to the inability to cope with or manage roles and responsibilities associated with normal everyday activities within the home, work, and community settings.

The World Health Organization’s (WHO) Eleventh Revision of the International Classification of Diseases (ICD-11) describes the following depressive disorders (World Health Organization., 2001):

- 6A80 Symptomatic and course presentations for mood episodes in mood disorders,
- 6C4C.70 Substance-induced mood disorders,
- 6E62 Secondary mood syndrome due to another health condition,
- 6A8Y Other specified mood disorders,
- 6A8Z Mood disorders, unspecified.

Depression can be described as both a symptom and a disorder. Many health conditions have an associated symptom of depression where the individual experiences sadness of a low mood associated with that condition, but this symptom may develop into a depressive disorder if the sadness or low mood is accompanied by many of the additional symptoms described above.

The severity of depression can be viewed as a continuum ranging from mild to severe, based on three things: symptoms (which may vary on frequency and intensity), duration and functional impact (Malhi *et al.*, 2015, 2021; National Institute for Health and Care Excellence, 2022). The use of validated scales can be used as a guideline for indicator of severity.

Mild depression	Moderate depression	Severe depression
Mild depression is when a person has a slight to low presence of symptoms (5-24%) that have a limited effect on their daily life (Malhi et al., 2015).  The NICE guidelines describe mild depression as five symptoms or less (enough for a diagnosis), with minimal functional impairment (National Institute for Health and Care Excellence, 2022).	Moderate depression is when there is a medium to fair presence of symptoms (9-45%) that a person experiences, that makes their daily life much more difficult than usual (Malhi et al., 2015).  The NICE guidelines describe moderate depression as functional impairment being between mild and severe, regardless of number of symptoms (National Institute for Health and Care Excellence, 2022).	Severe depression is when a person has many symptoms (50-95%) that can make their daily life extremely difficult. This can occur with or without psychotic symptoms (Malhi et al., 2015).  The NICE guidelines describe severe depression as most DSM-5TR symptoms present that have a profound impact on functioning. This may or may not include psychotic symptoms (National Institute for Health and Care Excellence, 2022).

Depression can occur across the life course (Colman and Ataullahjan, 2010). It can be associated with a developmental stage (e.g. childhood, adolescence, or aging), or associated with biological instability (e.g. pregnancy or menopause). Life stressors, adjustments and changes such as motherhood, relocations, health issues, progression to and from school, employment, retirement, job loss and catastrophic environmental incidences (floods, fires, wars, or earthquakes) can also lead to a person developing depressive symptoms and /or disorder.

## Risk factors

Craig et al (2022) identified the following risk factors for depressive disorders:

- Low socioeconomic status and poverty
- Little or no education
- Retirement – feelings of uselessness predisposing older adults to high mental health risk
- Intergenerational transmission of depression in South Africa has been reported due to the historical social exclusion of people of colour from access to quality education during Apartheid era – many South African adults have been adversely affected by their parents’ level of education
- Crime levels and exposure to trauma associated with crime
- Unemployment
- Being widowed, divorced, separated (presumably linked to financial, personal, and psychosocial stress related to marital disruption)

Similarly, the risk for relapse includes (Malhi *et al.*, 2015):

- Concurrent factors
  - Gender (female)
  - Life events/social stress
  - Comorbid medical illness
  - Poor compliance
  - Persistent insomnia
  - Personality
  - Substance use
  - Poor supports
  - Unemployment
  
- Features of depression that need consideration and may influence outcome:
  - Severity of depression
  - Duration of episode
  - Presence of psychosis
  - Residual symptoms
  - Treatment resistance

## Prevalence

A recent white paper by the Wits/Medical Research Council, Developmental Pathways for Health Research Unit (DPHRU) revealed that 25.7% of South Africans are most likely depressed, with more than a quarter of these reporting moderate to severe symptoms of depression (Craig *et al.*, 2022).

The South African prevalence of major depression has been reported to be 9.7% for lifetime and 4.9% for the 12 months, with high reports of global role impairment (Department of Health, 2023). There is no evidence of differences between the socially defined racial groups or cultural groups in the prevalence of mental disorders (Department of Health, 2023).

Using a large nationally representative weighted survey, Craig *et al.* (2022) assessed the prevalence of probable depression, anxiety and adverse childhood experiences in South Africa (Craig *et al.*, 2022). Using the PHQ-9 screening test, the majority of the adult South Africans reported a minimal risk for depression (48.2%) (Craig *et al.*, 2022). The remaining scores were as follows: mild (26.1%), moderate (16.9%), moderately severe (7.0%) and severe depression (1.8%). This led to a 25.7% prevalence of probable depression in South Africa (Craig *et al.*, 2022). When looking at the prevalence rates throughout the nine provinces, the Northern Cape recorded the greatest prevalence of probable depression (38.8%) whereas the lowest rate was seen in the Free State province (14.7%).

## Pathophysiology of depression

### Genetic Predisposition and Environmental Influences

There is a reported genetic predisposition in major depression that runs in families. However, due to the large variance in symptoms, developmental and environmental factors must also be evaluated in the factors contributing to major depression. One view of mood disorders includes the connection between susceptible genes and environmental influence. Another is the combination of life stressors and a potentially dysfunctional serotonin (5-HT) system where the serotonin transporter serves in the reuptake of serotonin at the synapse and may moderate the serotonergic response to stress (McCance and Huether, 2014).

## Neurochemical dysregulation

The monoamine hypothesis of depression proposes a deficit in the concentration of the brain norepinephrine, dopamine, and/or serotonin resulting in depression. Antidepressant therapies focus on increasing the monoamine neurotransmitter levels within the synapses (McCance and Huether, 2014).

## Neuroendocrine dysregulation

There are two theories in the pathophysiology of depression that involve dysregulation of the neuroendocrine system.

The first focuses on stress and the Hypothalamic-Pituitary-Adrenal system (HPA) which plays an essential role in an individual's ability to cope with stress. Chronic activation of the HPA system and chronic glucocorticoid secretion have been found in 30-70% of individuals with major depression suggesting the correlation between the dysfunctional system and depression.

The second neuroendocrine dysregulation theory is linked to the Hypothalamic-Pituitary-Thyroid system. While this dysfunction is not completely understood, 20-30% cases of major depression have shown to have an altered Hypothalamic-Pituitary-Thyroid (HPT) system. There is an increase in Thyrotropin Releasing Hormone (TRH), blunted Thyroid Stimulating Hormone in response to TRH challenge and decreased nocturnal rise in TSH level that normally occur. This increases risk for relapse (McCance and Huether, 2014).

## Neuroanatomic and function abnormalities

Depressed individuals' post-mortem brains have shown widespread decrease in serotonin 5-HT<sub>1a</sub> receptor subtype binding in the frontal, temporal, and limbic cortexes as well as serotonin transporter binding in the cerebral cortex and hippocampus, reflecting a dysfunction in the Raphe-serotonin system. Norepinephrine receptor alterations are found in the frontal cortex of some suicide victims with depression. Alterations in Norepinephrine systems may be linked to attention or concentration difficulties as well as sleep and arousal disturbances in depression.

Depressed individuals have also been found to have abnormalities in cerebral blood flow and glucose metabolism. Dorsolateral prefrontal abnormalities which accompany depression may be responsible for the retardation in cognitive processing and speech deficits similar to those found in schizophrenia. Dorsomedial frontal dysfunction may be associated with mnemonic and attentional impairments that accompany mood disorders. (McCance & Huether, 2014).

## Co-morbidities

In South Africa, mental health conditions such as depression, have high levels of co-morbidity with infectious diseases, such as HIV/AIDS and tuberculosis, as well as with the growing burden of noncommunicable diseases, such as cardiovascular disease, cancer, and diabetes mellitus. High levels of violence and injury, alongside the social injustices reported, also contribute to the high levels of depression experienced. (Department of Health, 2023).

- In a national survey, 58.1% of respondents with probable depression also reported probable anxiety which highlights the comorbidity of these two mental health conditions (Craig *et al.*, 2022).
- The relationship between HIV/AIDS and mental illness is particularly pertinent. Approximately 28 to 62% of people living with HIV suffer from mental illnesses. This population has a prevalence of depression ranging from 14% to 78% (Department of Health, 2023).
- Maternal mental health must also be considered, as antenatal depression rates for South African women have reported to be 22-47%, whereas postnatal depression rates were reported as 11-34% (Honikman *et al.*, 2020).
- There is evidence that emerging global communicable diseases pose a great threat to mental health. COVID-19 is a classic example of how rapidly spreading infections can affect mental health. Anxiety, depression, and other severe mental illnesses, as well as feelings of isolation and loneliness, increased significantly during the pandemic compared to pre-pandemic times, with the global prevalence of depression and anxiety increasing by 25% (Department of Health, 2023).

- Late onset depression in adults has been linked to several physical conditions such as diabetes, Alzheimer's disease, myocardial infarctions, and strokes (Craig *et al.*, 2022).
- Co-morbid personality disorders have an impact on depressive disorders as they tend to pose increased challenges for rehabilitation efforts and daily functioning. In South Africa, the South African Stress and Health (SASH) study in 2009 found that 6.8% of South Africans suffer from personality disorders and the conditional prevalence of a personality disorder was similar to those with any mood disorder (18.5% (Suliman *et al.*, 2008; Herman *et al.*, 2009)
- Co-occurrence of substance use disorder and affective disorders is common and has an impact on prognosis and treatment (Quello, Kathleen Brady and Sonne, 2005). This is especially relevant in the South African context, where the prevalence of substance use disorders is twice the global average (Kaswa and De Villiers, 2020).
- South Africa has the third-highest suicide rate out of all African countries (World Health Organisation, 2019) with many factors contributing to depression and feelings of suicidality (Edeh and Eseadi, 2023). The median-point prevalence of depression in adolescents in sub-Saharan Africa is 26.9% (Department of Health, 2023). In the 15–19-year-old age groups, suicide counts as the fourth leading cause of death (Tomlinson, Kleintjes and Lake, 2021).
- In the absence of reliable South African data, Gauteng Department of Education spokesperson, Steve Mabona, reported 40 suicides in Gauteng schools in the first half of 2023.

## Impact on functionality and occupation

Functional impairment in clinical depression is associated with considerable social and economic burden. Occupational performance domains, such as the ability to perform activities of daily living, the ability to form and maintain interpersonal relationships, and work capacity/productivity and constructive use of free time are typically affected. Moreover, symptomatic improvement does not necessarily equate to improved functioning, which is of clinical significance as it increases the risk of relapse and recurrence of depression.

According to an international study undertaken to better understand the course of a depressive episode and its impact on functioning over a 2-year period, greatest improvement in depressive symptoms and functioning was seen during the acute phase of treatment (i.e., within 2 months of antidepressant initiation or switch), followed by more gradual improvement during the maintenance phase (2–6 months), and stabilisation over the long-term phase (6–24 months). It also highlighted the need for cognitive intervention as residual cognitive impairment often persists despite symptom remission (Hammer-Helmich *et al.*, 2018).

It has been documented that clinical depression has a significant impact on socialisation. Restriction of social functioning remain persistent even after three years of recovery from depressive symptoms and are correlated with unemployment, disability, and decreased work performance. Interpersonal difficulties might be a result of reduced motivation, altered empathic responding in social interactions and a reduced capacity to come up with effective solutions for interpersonal problems (Kupferberg, Bicks and Hasler, 2016).

Major depressive disorder (MDD) is associated with reduced work productivity and permanent disability. Occupational therapists are often called upon to make a return-to-work decision regarding employees with clinical depression to facilitate continued employment (Ramano, Buys and de Beer, 2016). Sustaining employment is in alignment with achieving the Millennium Development Goal 1: Eradicating extreme poverty. People suffering from mental health disorders are frequently denied employment opportunities leading to reduced financial resources and therefore possible poverty.

## Legislative framework for OT practice in Mental Health Contexts

Occupational therapy practice is governed by relevant legislature and the HPCSA Standards of Professional Practice guidelines 2022, and as such, occupational therapists must practice within their scope.

The following legislation is pertinent to all occupational therapy practitioners:

- Health Professions Act 56 Of 1974 and all its amendments and regulations
- Allied Health Professions Act 63 of 1982 and all its amendments and regulations
- The HPCSA Guidelines for Good Practice in the Healthcare Professions; revised 2021
- Protection of Personal Information Act 4 of 2013 and its regulations and amendments
- Framework and Strategy for Disability and Rehabilitation Services in South Africa 2015-2020

Mental health care in all settings is governed by:

- The National Health Act 61 of 2003
- The Mental Health Care Act 17 of 2002
- The Children's Act 38 of 2005
- The Labour Relations Act 66 of 1995
- The South African Strategic Plan for Health 2020/21-2025
- The South African Policy Framework and Strategic Plan for Mental Health 2023-2030
- Occupational Health and Safety Act 85 of 1993
- Prevention of and Treatment for Substance Abuse Act, No 70 of 2008

### **Core competencies**

All occupational therapists must complete a full time four-year (480 credit) bachelor level first professional degree registered with SAQA at a level 8 on the higher education qualifications framework. All eight occupational therapy programmes have to meet the HPCSA's Minimum Standard of Training for Occupational Therapists (HPCSA, 2019). Each programme is re-evaluated every 5 years to ensure compliance and quality of the training.

On completing of an accredited OT programme, graduates must complete a year's community service before registering as an independent practitioner with the HPCSA. Annual registration is subject to compliance with the HPCSA CPD regulations to ensure lifelong learning and on-going professional competence.

All occupational therapy programmes include courses, amongst others, in psychology level 2, psychiatry, health systems, cultural competence and socio-cultural issues that influence mental health and occupational performance, and assessment and occupational therapy management of clients with mental health issues and conditions across the life course on all levels of care at the novice level. This includes 1000 hours of supervised clinical experience in this field. All students learn basic counselling techniques and the use of psychological techniques that enhance the occupational therapy process. OTs should have basic knowledge of mental health pharmacological interventions and the medication side-effects that cause functional disturbances as well which substances can be misused. Training in basic life support is mandated at the undergraduate level as is working collaboratively with the traditional and extended multidisciplinary team, especially on the primary care platform, including traditional healers, mid-level health care workers and OT technicians. All occupational therapists are recognised as having the core competencies for providing services to those with mental health conditions (Academy of Science of South Africa (ASSAf), 2021).

Master's programmes in the mental health field of occupational therapy are offered to teach advanced professional skills within the occupational therapy scope as a coursework master's programme plus short research report.

Occupational therapists attend organised CPD activities and both informal and formal courses to develop advance specific skills, and occupational therapy methods and techniques in this field in to meet their annual CEU allocation for HPCSA registration compliance.

Work-based support to enhance learning and professional competence includes:

- Post qualification clinical supervision and mentoring ensures that the therapist is emotionally well and contained to manage clients with mental health concerns. This is an ongoing process and may include improving self-awareness.
- Employee Assistance Programmes may be offered to staff as extra supportive measures to manage work stressors, burnout, and other personal issues.
- Debriefing as a team or individually helps improve insight into case management. Focus should be on what was done well, what can be learnt from a case, and what improvements can be made when managing similar cases in the future.

## **Risk management**

This SOP recognises the reality that mental health occupational therapy services are rendered in many different settings, such as single practices, departments in public or private hospitals, community health centres and clinics, schools, NPOs, etc. The Office of Health Standards Compliance (OHSC) have requirements that all health service providers must meet to be registered to offer a health-related service. This is to ensure quality and safety in health across the health sector. Compliance is required and facilities and practices may be audited. Compliance standards may be found [HERE](#).

**General risk in terms of infection control and Occupational Health and Safety (OHS):** Evidence of application of the OHS regulations must be available. Prevention of communicable and non-communicable diseases must be managed with a protocol relevant to the setting. Not only hand hygiene and universal precautions, but safety and cleanliness of all therapy equipment and tools after each session must be maintained.

**Environmental factors that contribute to clinical risk:** It is important to identify and prevent circumstances that could expose either the client or the OT to the risk of an adverse event associated with a depressed person. Risk assessments must be used within inpatient or outpatient settings to determine the safety of the physical environment. The use of safety measures needs to be used in conjunction with supervision of high-risk clients (Joint Commission, 2019). A list of environmental risk assessments may be found [HERE](#).

**Client safety:** Suicide risk for acutely depressed clients is a high priority concern and requires careful assessment. Clients suffering from depression may have suicidal ideation, with or without a plan. Additionally, these clients may make use of self-injurious behaviours as a way to emotionally regulate. As such, client safety needs to be considered in every setting. Antidepressants are more effective initially to manage the physical symptoms of depression (decreased energy, slowed movements, fatigue, decreased motivation) whereas the effectiveness on cognitive symptoms (suicidal thoughts, hopelessness etc.) improves a few weeks later as the client's acute symptoms improve. Clinicians therefore need to be aware that clients may still have suicidal thoughts yet increased energy and motivation to act on their suicidality.

Risk is not limited to suicidality and self-injurious behaviours and includes risk related to falling, risk of accidental harm to self, risk of harm to and by others (aggression), risk of abscondment, and even risk of exploitation due to the client's vulnerability. Risk management is an ongoing process which requires assessment and reassessment, collaboration with other healthcare professionals, health and safety officers, and/or caregivers, and may require action that can breach confidentiality (HPCSA, 2021). Risk management may impact the client-clinician relationship, and ethical consideration, along with sound clinical reasoning, will need to be used to ensure that the best path of action and care is taken.

## **Resources**

This SOP intends to provide a comprehensive resource for use in any setting and can be used to plan for the development or the expansion of services and practices to ensure quality occupational therapy services and provide value for money. All equipment, spaces and consumables need to be appropriate for the population being treated and context of service delivery.

### **Therapeutic spaces**

Though there are no checklists for required resources, the following aspects (though not exhaustive) can be considered to promote adequate therapeutic spaces for clients:

- **Office spaces**

Adequate office space with appropriate furniture (a desk and chairs) and equipment, will need to be used by the clinician for report writing, and safe storage of files, along with a means of communication (for booking of appointments/telehealth opportunities).

- **Therapy spaces**

- All therapy spaces should have access to medical assistance should this be required, such as panic buttons placed in easily accessible areas to call for assistance.
- In hospitals
  - Building infrastructure needs to be secure, up to code, and adhere to IUSS standards (such as electrical outlets, secured windows, etc.)
  - Supervision of the client's commute between the OT department and wards, depending on distance and presence of acute/florid symptoms
  - Individual therapy room(s) which can also be used for consultations or assessments.
  - Multipurpose therapy room for group interventions which are large enough to accommodate 10-15 people and allow space for movement, cleaning up, furniture and equipment.
  - Facilities to provide intervention for activities of daily living (such as cooking) and work task simulations
  - Parallel treatment areas (such as craft rooms) which can accommodate work areas for up to 30 people and allow space for movement, furniture, cleaning up, safe storage and equipment
  - Sports or leisure areas which allow space for movement and equipment.
- In community health centres and clinics
  - Therapy spaces must be appropriate to the client profile and services being delivered, and may be used for more than one function. There should be a quiet and private space to conduct a therapy group, and outside spaces should also be available for use.

Several treatment areas would be ideal for a mental health setting, but limited resources and space is a reality within our context. As such, spaces may be used for more than one function. For example, an office may be used for individual consultations or assessments. All furniture needs to be appropriate for the function, in good working order and safe, and be appropriate for the client population (e.g. children's furniture for children).

There are many added value spaces with correlating activities which could be beneficial to practices. These include gardening, mindful (empty) multipurpose spaces, debrief and distress spaces, private spaces for staff, welcoming creative spaces, and youth (18 to 35 years old) friendly spaces at a primary health care level.

All furniture needs to be appropriate for the function, in good working order and safe, and be appropriate for the client population (e.g. children's furniture for children).

## Tools and equipment

Occupational therapists working with high-risk depressed clients may need to consider using alternate materials and monitor tools and equipment to reduce risk. Appropriate safety precautions and regular stock taking is essential. Tools and equipment may include (but are not limited to):

- The use of Perspex or plastic instead of glass
- Ensuring anchor points are minimised
- Protocols regarding the safe usage and storage of tools and materials (e.g. group using scissors, needles, blades, tools, etc.). Sufficient lock up storage for potentially hazardous or dangerous items, such as scissors, sharpeners, mosaic cutting pliers, paints, glues etc.
- Minimum use of non-hazardous glues and paints
- Safes and lockable cupboards with regards to the protection of personal information and client files
- Sanitisers
- Standardised and non-standardised assessment tools
- Computer equipment such as laptops, tablets, monitors and screens (in compliance with POPIA)
- Printers and scanners
- Whiteboards
- Laminators
- Radio with a speaker
- Exercise and sport equipment such as yoga mats, different ball games, etc.
- Board and table games such as Rummykub, Phase 10, connect-4, Pictionary, 30-Seconds and Jenga
- Garden tools such as hoes, spades, gloves, and watering cans
- Craft and art tools such as scissors, paintbrushes, Stanley knives, and rulers
- Tools for activities of daily living and instrumental activities of daily living, such as kitchen appliances, bowls, plates, knives, forks and spoons
- Work simulation equipment such as files, computers and equipment relevant to the client population
- Consumables such as tissues, paper towels, paint, glue, calico, white and colour paper, ingredients for cooking and baking, coffee, and tea
- Low cost or recycled materials which may benefit practices due to their low costs but can also be easily collected and effectively used in projects.
- Technology such as apps for assessment and treatment, Mood calendar apps, connectivity/WIFI/GBN for access to national database and online resources

## Telehealth services

Telehealth is the administration of health services (assessment, consultation, and treatment) via electronic communications, information technology and applications. The use of telehealth services ensures access to quality and cost-effective health services, for the client to access service providers in a different geographical location, to create access to under-served areas, and to improve, facilitate and enhance health care services overall. Telehealth services are particularly valuable for clients in remote and rural areas, vulnerable groups, aging populations and to connect with younger generations (HPCSA, 2021).

Services can replicate physical consultations but should not be used as a substitute nor should services be exclusively rendered via telehealth platforms. A prior professional relationship is preferable, yet it is no longer a compulsory requirement for rendering telehealth services. All HPCSA practice and ethical guidelines, and the Protection of Personal Information Act (POPIA) requirements as well as service site regulations need to be adhered to.

## Occupational therapy process

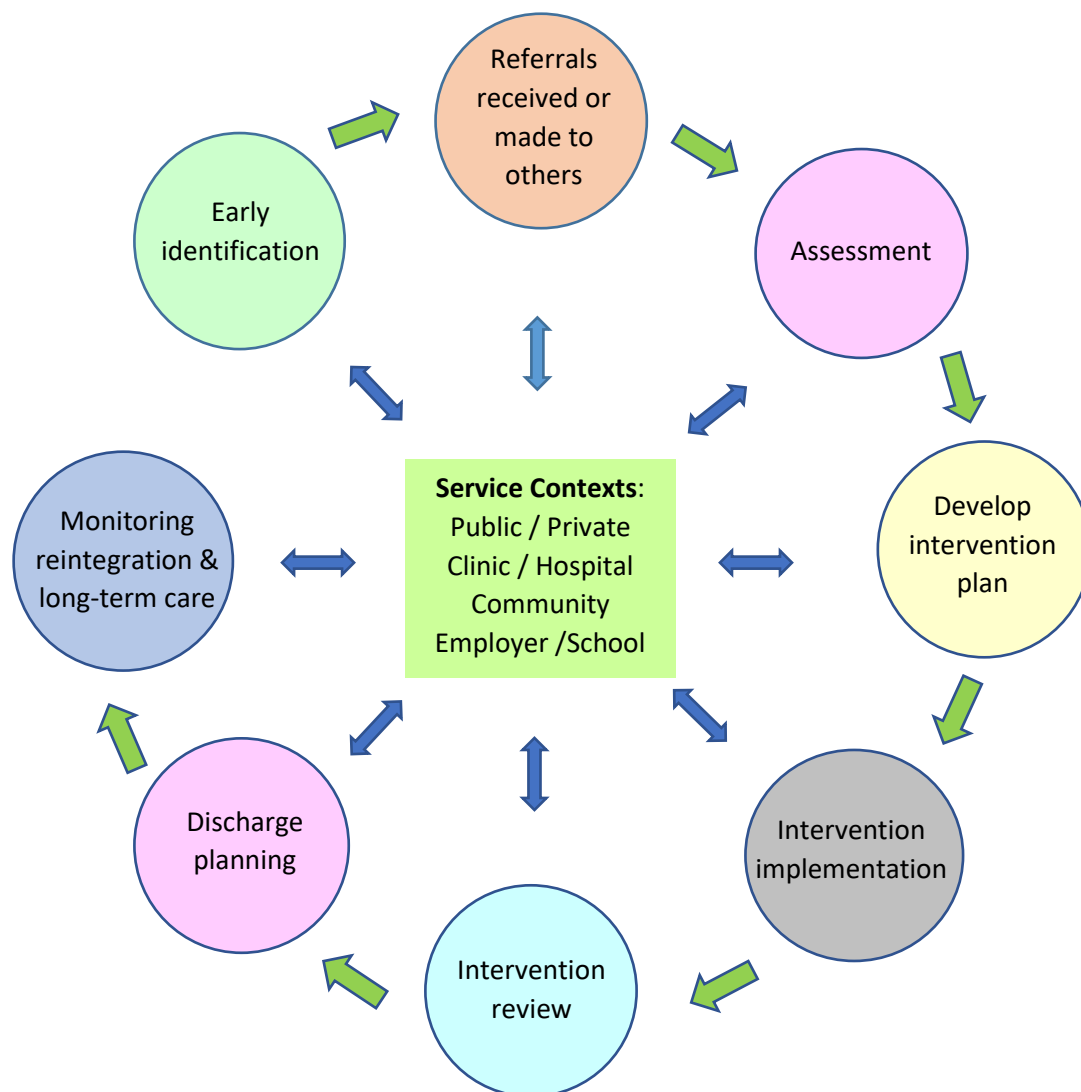


Figure 1 The occupational therapy referral process, adapted from the Occupational Therapy Practice Framework, 4th Edition (American Occupational Therapy Association, 2020)

### Consent

Informed consent must be attained from the client and/or caregivers for any evaluation or intervention and documented in the client's record. Written consent must also be obtained from the client in order to obtain collateral information from others (e.g. employers). To obtain informed consent, the OT should follow the guidelines set out in the HPCSA booklet 4, namely "Seeking Patients' Informed Consent: The Ethical Considerations". Should consent be granted, the OT must document each interaction made and the details discussed.

### Recording and reporting

Client records is a requirement from HPCSA and POPIA and therefore must comply with the set standards. Records must be completed immediately after each session and include the following:

- The client's name, and ID number or hospital number (depending on setting).
- Date and time of treatment
- Objectives of treatment and progress that must reflect the scope of our profession. The SOAP (Subjective, Objective, Assessment/Activity, Progress) format is often used to ensure appropriate file entries and to ensure all relevant information of the session is included.
- Name, signature, and designation of the OT and their HPCSA number

If any potential harm or at-risk behaviour (to self or others) is expressed by a depressed client or a collateral source, it is essential to document it comprehensively. Precautions are to be taken that are in accordance with best treatment guidelines and policies. Mandatory reporting must be adhered to, as is stipulated in the Children's Act No 38 of 2005 and the Mental Health Care Act 2002.

Reports need to be written for the setting and purpose it is intended for. Clients have the right to have access to information about themselves and, as such, to any report or clinical document, which may be used in a litigation process. Referral, assessment, progress and discharge reports form part of the clinical requirements. Therefore these must be written in universal language to make the implementation transferrable to any setting within the OT community.

Occupational therapy service delivery sites should consider the development of an electronic record for all clients as electronic health records are essential with the move towards establishing a National Health Insurance fund. Electronic health records form the basis for monitoring occupational therapy service outcomes, informs funding and all health-related purchasing decisions including human and other resources.

## Early identification

Occupational therapists work in a wide range of contexts with clients and their caregivers who are exposed to the risks of depression as described above (see risk factors and comorbidities). Occupational therapists, due to their holistic training, are competent to identify persons with signs of depression which may be present in clients who access OT services for other treatment options, such as the caregivers of children with disabilities and in families for stroke survivors (Scherer, Verhey and Kuper, 2019; Chun *et al.*, 2022). Early identification can ensure appropriate referrals can be made and specifically targeted intervention can be provided.

According to Colizzi *et al.* (2020) many mental disorders start to emerge by 14 years old and are usually preceded by non-specific psychosocial disturbances and disengagement from life roles and activities in the occupational domains which potentially evolve into a major mental disorder (Colizzi, Lasalvia and Ruggeri, 2020). Depression is prevalent in adolescence and evidence suggests that early detection and management by multidisciplinary and transdisciplinary teams that focus on early prevention and health promotion strategies may modify the trajectory of chronic clinical depression and the poor outcomes in the long term (Costello, 2016).

## Referrals

Occupational therapists are recognised as first line practitioners. This implies that clients can self-refer, and practitioners can make an independent occupational-related diagnosis and can treat a condition provided that it falls within the OT scope of practice and the practitioner's level of training (OTASA, 2022). However, funder rules may require a written referral from a medical practitioner/specialist doctor to an occupational therapist to access necessary benefit structures. Medical referrals are still a gazetted requirement for treatment of injury on duty patients if claiming through the Compensation Fund (OTASA, 2022).

Where a referral is needed, referral pathways and processes should be well-documented, and referral documents must be included in the client's record. Due to the scope of our profession, referrals can be intersectoral:

Within the healthcare sectors: The first contact with OT mental health services can be in any setting and subsequently clients may be referred to any level of care (district hospital, specialist hospital, clinic, or community) according to the referral pathway (Department of Health, 2020). It is important to have a seamless referral system to ensure continuity of care. Sources of referral can include, but are not limited to, doctors, registrars, psychiatrists, psychologists, teachers, social workers, nursing staff, community initiatives (such as NPOs), the client or their caregivers.

- Services linked to employment: Referral can be requested by employers, including their employee assistance programmes and wellness initiatives, return to work programmes, occupational health and safety risk assessments, as well as disability insurers and case managers.
- Services linked to the community: providing holistic integrated service users might be referred to other significant role-players such as community organisations and other government departments.

## Assessment

### Indications

The indications for occupational therapy assessments for persons with depression:

- Determining functional impairments and activity performance
- Determining treatment needs linked to related functional impairments and activity performance
- Reviewing progress following treatment for monitoring purposes
- Recommending assistance, school or work accommodations, assistive devices, and support.

### Method of assessments

An assessment of functioning requires multiple methods and complex clinical reasoning about the results to understand the implications of the assessment for the client and occupational therapy practice.

- Using a client centred approach and following the defined occupational therapy process, occupational therapists use several assessment methods and assessment tools to collect health, activity, and participation related data to determine the barriers and challenges the client experiences in their occupational performance (functioning) that have been compromised by the depressive disorder (American Occupational Therapy Association, 2020; Bryant, Fieldhouse and Plastow, 2022). Some evaluations are done individually while other may be done in small, controlled groups.
- Self-reported information regarding the difficulties with capacity and habits linked to their activity performance. This information can be further triangulated with rating scales, behavioural checklists, as well as collateral reports from family members, treating practitioners and employers, provided consent has been obtained (Innes and Straker, 2002).
- Impairment assessments can include both standardised and non-standardised assessments which should be clinically substantiated in terms of expected areas of impairment and be valid and reliable for the client cohort and context.
- Performance-based assessments include direct observations of task performance, simulations and situational assessments. Often this extends to assessments at home, in the workplace, or social settings. These assessments are the distinguishing feature of OT assessments, which enhances the ecological validity of assessment results. Specific to the South African context, it also provides results which are culturally appropriate and addresses concerns regarding suitability of tests.

### Considerations when selecting the appropriate assessment tools

- The occupational therapists analyse and synthesises the evaluation outcomes using clinical reasoning as well as consulting with the clients' priorities.
- All assessment tools used should be valid, reliable, sensitive to change, and time and cost efficient.
- Assessment tools should be selected that are appropriate to the clients' developmental phase, culture, education, language, daily activity, and participation needs, as well as the context and level of health care delivery.
- While it is preferable to use standardised evaluations and outcome measures, therapists must select appropriate measures and understand the psychometrics of each test and follow the administration and interpretation requirements robustly, as well as the licencing requirements.

## Content of assessments

Occupational Therapy’s unique role is to assess the impact of the diagnosis, trauma, or behaviour on functioning, and subsequent role competence. The findings are represented in the assessment report, and the following should be included (World Health Organization., 2001; American Occupational Therapy Association, 2020):

1. Occupational profile: personal information detailing history and current status regarding medical treatment, therapies, education, as well as occupational performance. Identify the client’s priorities and desired targeted outcomes related to occupational performance, prevention, health and wellness, quality of life, participation, role competence, and occupational justice.
2. Analysis of occupational performance involves:
  - Making observations regarding the client’s mental status.
  - Considering physical and medical problems and other co-morbidities and their impact on functioning
  - Assessment outcomes linked to impairment and performance of:

Occupations	Contexts	Performance patterns
<ul style="list-style-type: none"> <li>• Activities of daily living (d510 – d599),</li> <li>• Instrumental activities of daily living (d610 – 699),</li> <li>• Health management (d570),</li> <li>• Rest and sleep (b134),</li> <li>• Education (d810 – d839),</li> <li>• Work (d840 – d859),</li> <li>• Play,</li> <li>• Leisure (d920),</li> <li>• Social participation (d710 – d799)</li> </ul>	<ul style="list-style-type: none"> <li>• Environmental factors (e110 – e599).</li> <li>• Personal factors</li> </ul>	<ul style="list-style-type: none"> <li>• Habits</li> <li>• Routines,</li> <li>• Roles,</li> <li>• Rituals</li> </ul>
Performance skills		Client factors
<ul style="list-style-type: none"> <li>• Motor skills (should be screened and may be associated with comorbid conditions),</li> <li>• Process skills (how effectively a person organises objects, time and space, including sustaining performance, applying knowledge, organising timing, and adapting performance, therefore it links to specific mental functions, which is inclusive of attention, memory, psychomotor functions, emotional functions, perceptual functions, thought functions, higher level cognitive functions, calculation functions, and experience of self and time functions: b140 – b189 in the ICF),</li> <li>• Social interaction skills (d710 – d799)</li> </ul>		<ul style="list-style-type: none"> <li>• Values,</li> <li>• Beliefs,</li> <li>• Spirituality (d930),</li> <li>• Body functions (links to global mental functions inclusive of orientation, intellectual functioning, global psychosocial functions, temperament and personality, energy and drive: b110 – b139), and</li> <li>• Body structures</li> </ul>

3. Synthesis of evaluation process: through the use of one’s clinical reasoning to determine the client’s problem areas and goal setting for therapy, it is important to determine the client’s current level of functioning, identify supports and hindrances to occupational performance, and to use objective measures to do so.

It can be useful to categorise a client’s current level of functioning using a functional classification scale, such as the WHO Disability Assessment Schedule (WHODAS 2.0) , or Social and Occupational Functioning Assessment Scale (SOFAS) (Rybarczyk, 2011).

The use of scales and/or questionnaires are often indicated initially for diagnostic clarification, normative comparison, and level of impairment. It can also be used for monitoring to determine treatment progress. Functional or disability

scales are more in keeping with functional performance than symptom scales and can be used to determine and monitor treatment progress, as well as disability determination.

Symptom Scales	Functional / Disability Scales
Patient Health Questionnaires (Ford <i>et al.</i> , 2020) Depression Anxiety Stress Scale (Lovibond and Lovibond, 1995) Hospital Anxiety and Depression Scale (Stern, 2014) Zung Self-Rating Depression Scale (Zung, 1965)	WHO Disability Assessment Schedule (WHODAS 2.0) (Konecky <i>et al.</i> , 2014) Goal Attainment Scale (Turner-Stokes, 2008) The Range of Impaired Functioning Tool (LIFE RIFT) (Leon <i>et al.</i> , 1999) Functional Assessment Rating Scale (Ward and Dow, 2006)

## Examples of Standardised Tests

Standardised tests consist of a wide variety of available and emergent assessment tools, which may require additional training. Certain tests may be relevant to co-morbid neurological or psychogeriatric conditions. The list aims to provide explanatory examples and is not considered an exhaustive list:

Domain	Example of Test
Cognition	Montreal Cognitive Assessment (Nasreddine <i>et al.</i> , 2005) Test of Everyday Attention (Evans and Preston, 2011) Behavioural Assessment of the Dysexecutive Syndrome (Rozenblatt, 2011) Repeatable Battery for the Assessment of Neuropsychological Status (Randolph <i>et al.</i> , 1998) Rivermead Behavioural Memory Test (Wilson, Cockburn and Baddeley, 1991) Trail Making Test (Meyers, 2011) Hirebright Cognitive Ability Test (H-CAT) (Swanepoel, Grobler and De Klerk, 2020) Assessment of Motor and Process Skills (AMPS) (Fisher, 2006) Cognistat test battery (Kiernan, Mueller and Langston, 1995), previously known as the Neurobehavioral Cognitive Status Examination
Affective	Difficulties in Emotion Regulation Scale (Gratz and Roemer, 2004) Rosenberg self-esteem scale (Gray-Little, Williams and Hancock, 1997) Mindful Attention Awareness Scale (Brown and Ryan, 2003)
Interpersonal	Thomas Killman Instrument (Thomas and Kilmann, 1978) Interpersonal Conflict at Work Scale (Keenan and Newton, 1985) Social Adjustment Scale (Bosc, Dubini and Polin, 1997) Social Problem-Solving Inventory – Revised (D’Zurilla, Nezu and Maydeu-Olivares, 2019)
Stress	The Sensory Profile (Dunn, 1999) Perceived Stress Scale (Cohen, Kamarck and Mermelstein, 1983) General Work Stress Scale (De Bruin, 2006) Sources of Work Stress Inventory (De Bruin and Taylor, 2005) Soweto Stress Scale (Mpondo <i>et al.</i> , 2021) Coping Self-Efficacy Scale (Chesney <i>et al.</i> , 2006) Locus of Control Scale (Rotter, 1966)
Activities of daily living	Kohlman Evaluation of Living Skills (Kohlman Thomson and Robnett, 2016) Activity Participation Outcome Measure (Casteleijn, 2012) Idyll Arbor Leisure Battery (IA LB) (Beard and Ragheb, 1983) Rookwood Driving (McKenna, 2009) Executive Function Performance Test (Baum <i>et al.</i> , 2003) Kitchen Task Assessment (Baum and Edwards, 1993) Multiple Errands Test-Revised (Morrison <i>et al.</i> , 2013) UCSD Performance-Based Skills Assessment (Patterson <i>et al.</i> , 2001)
Work	Minnesota Clerical Test (Kirkpatrick, 1957) Thurstone Questionnaire (original authors: Thurstone and Thurstone, 1989) Valpar Component Work Samples (‘Work Samples’, 2013) General Clerical Test (The Psychological Corporation, 1987) Psychiatric Functional Capacity Evaluator (Theunissen, 2016)

## Timing of assessments

The timing of assessments should consider the reason for the referral. As an example, risk assessments should be performed urgently with persons with depression with active suicidality or with a co-morbid psychotic episode. In contrast, work assessments should require medical stabilisation of more acute symptoms.

Certain assessments should consider that the level of activity performance may alter over time. As an example, diurnal mood variation may impact on assessment performance in the mornings (Malhi *et al.*, 2015).

Observational assessments can be performed in most settings, and during any time of the course of the condition. However, the validity of standardised assessments can be challenged by:

- The presentation of acute symptoms such as psychosis, mania, panic or extreme distress.
- Use of psychotropic medication or addictive substances which may impact on psychomotor activity levels and cognition.

## Prioritisation of Assessment and Intervention

In the DSM-5, severity is implied by the number of symptoms the individual has and the extent to which they are functionally impaired. Similarly, the effect on functioning is captured in ICD-10/11 with depressive episodes described as mild, moderate, or severe on the basis of the number of symptoms they are experiencing and the degree of distress this causes along with their impact on activities.

Mild depression	Moderate depression	Severe depression
Clients with mild depression may present with minimal functional impact which will be noted in task performance, stress tolerance, and the ability to self-manage and self-regulate.	Clients with moderate depression will present with more component-focused fallout. Cognition, mood, and interpersonal impairments will more likely be noted.	Clients may present with most DSM-5TR diagnostic criteria will have profound functional impairment. Clients will have significantly impaired cognition, as well as poor or inconsistent activities of daily living performance and management. Risk assessment will be a priority.

It is accepted that depressive disorders often fluctuate throughout its course, dependent on various clinical and contextual variables. Though the severity classification of mild, moderate, and severe is pragmatic and easy to understand, they must never be used in isolation to determine management. Assessments needs to take this into account and need to utilize other schemas, such as the ACE Model, which emphasises the domains of 'activity' and 'cognition' alongside 'emotion' (Malhi *et al.*, 2021). This ensures for a more consistent and detailed treatment plan.

Using the following table as a guideline, assessments can use the ACE model to prioritise care and provide quality services, notwithstanding financial resources. It is understood that this must be customised according to individual clients' needs and practitioners' experience. It is used to consider the key functional impairments that are likely to fluctuate.

ACE Area	Functional Items and ICF code	Assessment methods
Activity	<ul style="list-style-type: none"> <li>• Activities of daily living (d510 – d599),</li> <li>• Instrumental activities of daily living (d610 – 699),</li> <li>• Sleep functions (b134): amount, onset, maintenance, quality and functions involving the sleep cycle</li> <li>• Health management (d570),</li> <li>• Education (d810 – d839),</li> <li>• Work (d840 – d859),</li> <li>• Play,</li> <li>• Leisure (d920),</li> <li>• Social participation (d710 – d799)</li> </ul>	Assess engagement in occupation-based assessments (basic and instrumental activities of daily living, driving, work, socio-recreational, rest and sleep and social functioning)
Cognition	<ul style="list-style-type: none"> <li>• Thought functions (b160): pace, form, content and control</li> <li>• Higher cognitive function (b164): abstraction, organisation and planning, time management, cognitive flexibility, insight, judgement, problem solving</li> <li>• Energy and drive functions (b130): energy level, motivation, appetite and craving, impulse control</li> <li>• Attention functions (b140): sustaining, shifting, dividing, sharing attention</li> <li>• Memory functions (b144): short-term, long-term and memory retrieval</li> <li>• Psychomotor functions (b147): control and quality thereof</li> <li>• Perception (b156): auditory, visual, olfactory, gustatory, tactile and visuospatial</li> <li>• Calculation functions (b172): simple and complex</li> <li>• Experience of self and time (b180): experience of self, body image and time</li> </ul>	Use both standardised and performance-based assessments to focus on clinically significant impairment (such as initiation, cognitive processing speed)
Emotions	<ul style="list-style-type: none"> <li>• Emotional functions (b152): appropriateness, emotional regulation and range</li> <li>• Mood</li> <li>• Anxiety management (d2303)</li> <li>• Handling of stress (d240)</li> </ul>	Use of both standardised mood and behavioural scales and performance-based assessment to focus on behavioural sequelae of clinically significant impairment (such as distress tolerance, emotional regulation, self-efficacy and general coping skills).

## Intervention

When considering a client's current treatment, an occupational therapist must also consider the longitudinal care inclusive of this episode, what may happen upon discharge, and what could happen in the future especially as the relapse rate within the first six months following discharge is reported to be high (Moriarty *et al.*, 2020).

Acute occupational therapy intervention comprises of three steps, namely (1) planning, (2) implementation and (3) review. However, community integration and long-term planning is essential to ensure continuity of care.

## Intervention planning

In accordance with the OTPF-4, occupational therapy outcomes must be related to treatment that targets occupations, performance patterns, performance skills, client factors and contexts. Intervention should track improvements to the stated outcomes and should ultimately reflect the client's ability to engage in their occupations (American Occupational Therapy Association, 2020).

Occupational therapy outcomes should focus on occupational performance, prevention, health and wellness, quality of life and wellbeing, participation, role competence, and occupational justice (American Occupational Therapy Association, 2020).

The intervention plan, of which the focus must be related to functional outcomes, must be consistent with the occupational profile and assessment report. Regular treatment reviews must be included in the OT's treatment plan, which clearly indicate the expected time frame, criteria to be addressed, goal attainment and outcome measures.

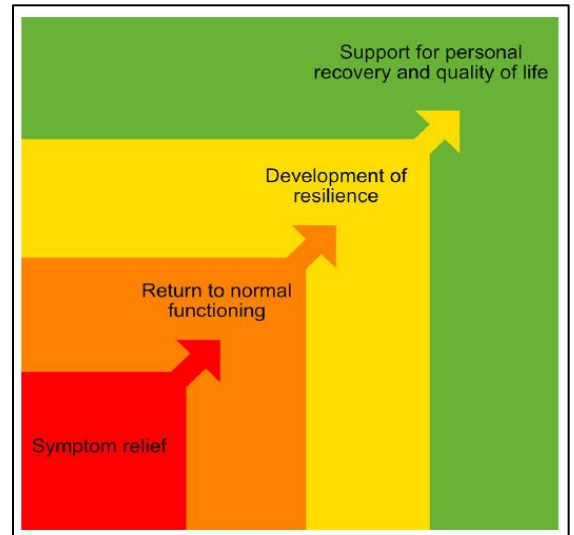


Figure 2 The spectrum of treatment targets in mood disorder management (Malhi et al., 2015)

When developing the intervention plan, the following must be taken into consideration:

- Consult with the client (client-centred approach) and set realistic treatment goals. Consider practicalities such as the client's ability to attend sessions regularly or afford therapy.
- Define the time frame for improvement and progress to ensure quality intervention, based on practice-based evidence.
- Determine the best treatment approach to use (e.g., remedial or maintenance approach).
- Determine the most appropriate occupational therapy model and frame of reference to guide intervention
- Decide on the applicable treatment plan, for example individual and substance rehabilitation group programmes.
- Determine other support to be included, such as support groups offered by the South African Depression and Anxiety Group (SADAG) or Alcoholics Anonymous (AA).

When providing treatment to a client with depression, the intervention offered must reflect the client's needs and priorities, and the assessment findings. When considering the stages of recovery, occupational therapy treatment must aim for improvement in the depressive symptoms experienced by the client, improvement or maintenance in the client's daily functioning and prevent/limit relapse. With regards to treatment modalities, the client's occupational performance areas are to be treated, namely personal management, education or work (vocational rehabilitation), sleep and rest, social participation and leisure, as each area is impacted by the depressive symptoms experienced. Thus, occupation-based interventions directed at improving the client's experienced deficits in body functions, activity and participation and environment are paramount. Occupational therapists use various conceptual models to conceptualise their understanding of the client (such as the Model of Human Occupation, du Toit's Model of Creative Ability and Person-Environment-Occupation-Performance model), and to ensure a client-centred approach is utilised. In terms of frames of reference, cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), behavioural activation (BA) and graded exposure has been proven most effective to enable occupational performance in depressed persons (Higgins, 2019). Clients are taught effective coping strategies and skills which are applied to their context and personal experiences (i.e. occupational performance areas).

As described above, depression exists on a continuum. This implies that there is a need to provide care according to a staging model, inclusive of health promotion, and prevention on primary, secondary, and tertiary levels as well as acute care and rehabilitation. A shift in approach from hospital-based care of acute episodes to preventative, community-based, multidisciplinary psychiatric care (early intervention, prevention of functional impairment, prevention of relapse, prevention of hospital admissions, prevention of abuse, exploitation, homelessness and incarceration) is advocated for by the National Mental Health Policy Framework and Strategic Plan 2023 – 2030

(Department of Health, 2023). As such, assisted, involuntary, and forensic admissions should be rare and a last resort (not the mainstay of care).

Treatment may be divided into 3 phases with corresponding aims (Malhi *et al.*, 2015, 2021):

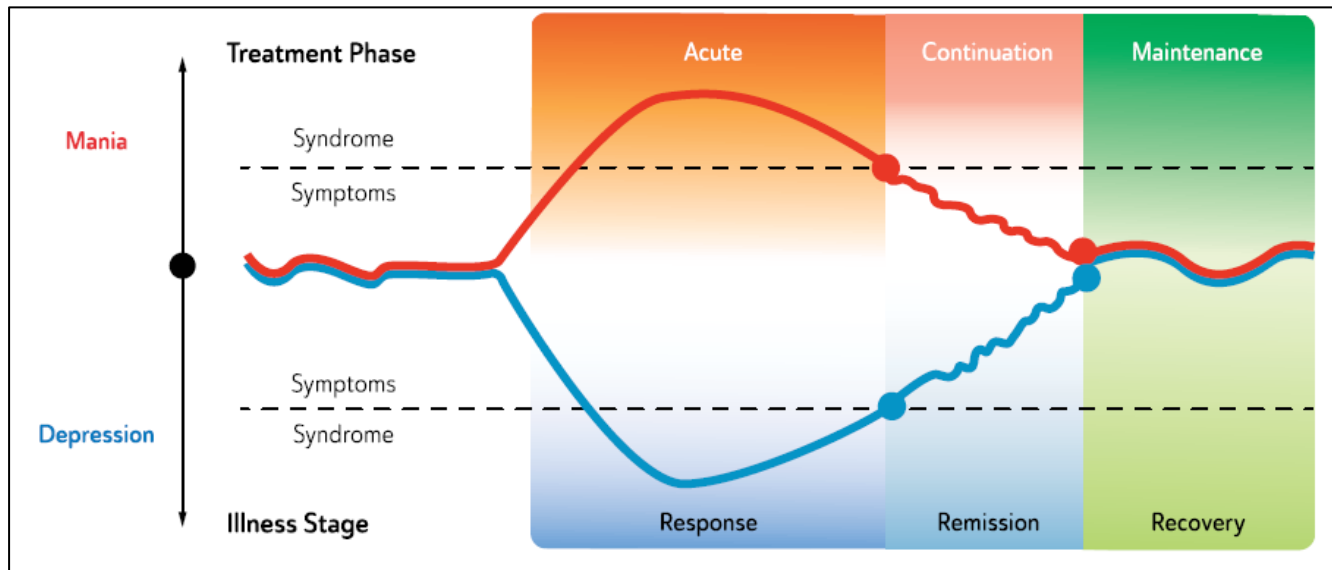


Figure 3 Mood disorders stages of illness and phases of treatment (Malhi *et al.*, 2015)

1. The acute phase will focus on remission. Treatment may last 6 weeks to 3 months, and initial treatment may be done within an inpatient setting and continue as an outpatient at an appropriate service delivery site. Response to treatment is the initial aim during this phase. A response to treatment is also considered effective and is classified as a 50% decrease in symptom severity. Partial response is a 25-50% decrease in symptom severity.
2. The continuation phase is characterised by residual symptoms and the client is not yet fully functional. The continuation phase is from month 4, following the acute phase, until month 9. Relapse prevention is critical during this phase and the treatment aim is remission or recovery to the client's premorbid state. Remission is defined as no to minimal symptoms.
3. The maintenance phase aims to prevent a relapse and improve resilience and self-efficacy. Focus will be on preventative strategies and the reestablishment of all functional domains.

Throughout the occupational therapy treatment for a client with depression, it is recommended to have regular and consistent reviews to ensure the correct course of action is underway.

Quantifiable and measurable outcomes from the occupational therapy process should be recorded in the client's file. A clear time frame, the criteria against which progress will be assessed, such as goal attainment and outcome measures are recommended. Thus, the decision to adapt, continue or terminate occupational therapy intervention can be based on the progress made. Periodic reassessment is therefore required.

The use of an outcome measure may be beneficial in monitoring treatment outcomes as well as symptom severity. Appropriate outcomes measures for occupational therapists to use for clients with depression include:

- Activity Participation Outcome Measure (APOM)
- Canadian Occupational Performance Measure (COPM)
- Goal Attainment Scale (GAS)

## Intervention implementation

While no exhaustive list can be provided, occupational therapy interventions for depressed persons often focus on:

- Individual interventions
- Group intervention (utilising Yalom’s curative factors) (Falk-Kessler, Momich and Perel, 1991)
- Home programmes (with appropriate treatment principles applied and considering the feasibility thereof)
- Return to work programmes
- Prevention and health promotion strategies
- Appropriate assistive devices
- Psychoeducation around the impact of the disease on functioning, how relationships and roles are impacted and how prescribes and self-medication may impact one’s functioning
- Understanding of co-morbid conditions, their impact and knowing when to refer elsewhere.

Mild depression	Moderate depression	Severe depression
<p>Clients with mild depression may need a low intensity therapy programme. They will be in the continuation phase, transitioning into maintenance.</p> <p>Treatment focus will be on managing mild symptoms and ensuring that the client continues to be functional within their occupations. The re-establishment of one’s roles, habits, routines and rituals appropriate to one’s social context need attention. Effective coping strategies, stress management, self-regulation, and skills development will be a priority in treatment. Clients should have the opportunity to use these skills in real life situations and then return to treatment for feedback and adaption.</p> <p>NICE recommends 10 therapeutic sessions (CBT or DBT) with a combination of aerobic exercises for up to 12 weeks (National Institute for Health and Care Excellence, 2022).</p>	<p>Clients with moderate depression will likely need high intensity therapy and may be in the acute phase of treatment, transitioning into the continuation phase.</p> <p>Reintegration into society with independence and self-sufficiency being the priority in treatment, and ensuring socially appropriate occupational behaviour in all domains is important. Cognitive remediation, mood stabilisation and emotional regulation skills through engagement in therapeutic activities will be appropriate treatment aims.</p> <p>Research suggests that successful return-to-work is essential for a sustainable reintegration (Ramano, Buys and de Beer, 2016). Occupational therapists are well placed at providing short-term, realistic accommodations to facilitate the return-to-work process.</p> <p>Psychoeducation, promotion of health and preventative strategies are also important to reduce, improve insight and support wellbeing..</p> <p>NICE recommends 16 therapeutic sessions (CBT or DBT), individual and group therapy, spaced over 3-4 months (National Institute for Health and Care Excellence, 2022). As a component of universal health coverage, such therapy can be provided as an out-patient or in facilities on the primary platform.</p>	<p>Clients with severe depression will be within the acute phase of treatment and may need an admission. Stabilization and risk management will be a treatment priority.</p> <p>Functional goals may include improved, consistent, and independent initiation and completion of activities of daily living, the development and recognition of supportive systems, and psychoeducation of the symptoms and impact of the disease. Community reintegration will need to be prioritised as the client transitions into the continuation phase of treatment.</p>

The ACE model (Malhi *et al.*, 2015) may be used to help prioritise treatment aims as the below table details:

ACE Area	Functional Items and ICF code	Treatment Goals	Treatment focus areas with the outcome to improve/maintain:
Activity	Activities of daily living (ICD code d510 – d599), instrumental activities of daily living (d610 – 699), Sleep functions (b134): amount, onset, maintenance, quality and functions involving the sleep cycle Health management (d570), Education (d810 – d839), Work (d840 – d859), Play, Leisure (d920), Social participation (d710 – d799)	Ensure re-engagement in IADL and meaningful pursuits Health promotion and wellness Address occupational risk factors Enhance quality of life including activities health	Sleep hygiene Day programme planning (behavioural activation) Balanced lifestyle skills and habits Re-engagement in purposeful and appropriate leisure pursuits Job analysis for accommodation purposes Work habits Vocational rehabilitation Social re-engagement Communication skills Conflict resolution skills Community living skills such as realistic budgeting, use of transport and management of personal business
Cognition	Thought functions (b160): pace, form, content and control Higher cognitive function (b164): abstraction, organisation and planning, time management, cognitive flexibility, insight, judgement, problem solving Energy and drive functions (b130): energy level, motivation, appetite and craving, impulse control Attention functions (b140): sustaining, shifting, dividing, sharing attention Memory functions (b144): short-term, long-term and memory retrieval Psychomotor functions (b147): control and quality thereof Perception (b156): auditory, visual, olfactory, gustatory, tactile and visuospatial Calculation functions (b172): simple and complex Experience of self and time (b180): experience of self, body image and time	Improve functional cognitive capacity in keeping with occupational needs	Time management skills Cognitive remediation Cognitive hardening Cognitive ergonomics Task adaptation Assistive devices Self-development (such as confidence, identity, sense of self, awareness, insight into self)

ACE Area	Functional Items and ICF code	Treatment Goals	Treatment focus areas with the outcome to improve/maintain:
Emotions	Emotional functions (b152): appropriateness, emotional regulation and range Mood Anxiety management (d2303) Handling of stress (d240)	Ensure appropriate insight and behaviour despite emotional experiences and stressors Prevention strategies to facilitate the early detection of a relapse, and the prevention of another hospital admission	Psychoeducation (within scope of profession) Promotion of health literacy Health promotion strategies such as self-care, relapse prevention, treatment compliance, healthy living, crisis management planning and drug prevention Strategies to deal with risk factors Strategies to deal with intrapersonal, interpersonal, and community-level stigma (Javed <i>et al.</i> , 2021) Life skills such as self-awareness, emotional regulation skills, distress tolerance, stress management and mindfulness

## Intervention review

Intervention review is a continuous process of the treatment plan, its effectiveness and progress towards outcomes. It should include collaboration with the client, and may lead to adaptation of the intervention plan. Outcomes are directly related to the interventions provided and to the client-specific and targeted occupations, performance patterns, performance skills, client factors, and contents. The progress plotted on the outcome measure may therefore be useful in this process. Discontinuation of services and/or referral to other services may be needed.

## Discharge planning

Successfully transitioning or ending the therapeutic relationship between the therapist and the client is a crucial aspect of the occupational therapy process (American Occupational Therapy Association, 2020). Discharging a client from occupational therapy often coincides with their discharge from a treatment facility, however it is important to note that these are two separate processes. It is paramount that the decision to discharge a client from therapy is in the best interest of the client. As such, concluding therapy should be a collaborative process between the client and therapist. It is important to consider different processes to conclude individual therapy processes versus group therapy processes that the client has entered into.

Therapists must assess the client's ongoing treatment needs before initiating termination. Thus, discharge services often include referrals made to other health professionals. The referral letter is an essential tool to ensure continuity of care for the client and should include relevant information such as the reason for referral, baseline assessment findings, personal and medical background, further recommendations, or goals of therapy (e.g., follow up, for functional assessment or disability grant assessment, placements or for further management). Collaboration between practitioners is essential to ensure safety, well-being and optimal outcomes for the client (American Occupational Therapy Association, 2020).

For the client, the discharge process or transition process from one facility to another can represent a sense of loss of attachment with the therapist and what they represent. This should be appropriately managed by the therapist (Fragkiadaki and Strauss, 2012).

## Discharge considerations

When concluding therapy with a client who has experienced a depressive episode, it is imperative that the client's ability to engage in their chosen occupations and take up previously held life roles is considered.

A risk assessment must be done on discharge. Clients that still present as a suicide risk cannot be discharged from treatment. Continued treatment or a referral to an inpatient facility may need to be considered.

Other risks that may be present on discharge include (but are not limited to):

- Chronic risk of self-injurious behaviours
- Risk of harm to others or harm to self by others (e.g. aggressive behaviour)
- Risk of exploitation due to vulnerability

In all cases of risk, referral to a psychologist, psychiatrist or other medical professional may be appropriate if the client can no longer benefit from OT.

The OT may play a role regarding the client's adjustment to their home, work or school environment with regards to:

- Family education (burden of care)
- Referral to community pathway for return to work/school
- Employer or school engagement
- Balanced lifestyle strategies
- Health promotion and wellness strategies
- Preventative strategies (on the primary, secondary and tertiary levels)
- Maintenance of appropriate assistive devices/technology, such as:
  - Medication compliance
  - Diary/organiser/Mood diary
  - Emotional support animal
  - Apps/memory/mindfulness/breathing techniques
  - Wearables (e.g. smart watch with above-mentioned app)
  - Weighted blankets

Occupational therapists often find home programmes to be useful in encouraging independence and role responsibilities. Skill-, occupation- or cognitive-based home programmes are often effective for clients with depression. These should be used in consultation with the family and caregivers to ensure the home programme will fit with the family life, responsibilities and support of other family members.

## Monitoring community integration and continuity of care

Community integration considers the continuum of care following a period of hospitalisation, discharge and down referral to services that support the client's reintegration into their home and community context, either as an outpatient, or at the primary health care level (Mirza *et al.*, 2008). While clients with depressive disorders are usually 'medically stable' upon discharge from a facility, they are not fully recovered or functional at their premorbid level, and are vulnerable to relapse (Furukawa *et al.*, 2008). Full recovery rates for clients with depression vary from 3 months to up to a year or more (Furukawa *et al.*, 2008). While clients with depressive disorders respond to pharmacological management, evidence suggests that they are best served by personalised approaches that deconstruct the factors that have contributed to their depression and by implementing treatment plans that adequately address these factors to reduce the need for hospital admissions. From an occupational therapy perspective, the outcome should include active participation to achieve maximum independence in their occupational performance within their personal, social, school or work and community contexts. Thus, a team approach has been recommended.

## **Coding and billing**

The World Health Organisation (WHO) uses the Family of International Classifications (WHO-FIC) as a framework to determine disability and disease impact at both an individual and population level (World Health Organization., 2001). The International Classification of Disease (ICD) is used to provide knowledge on the cause, course and consequence of disease. The International Classification of Functioning, Disability and Health (ICF) is a classification of health, health domains and how functioning and disability affects an individual. The International Classification of Health Interventions (ICHI) refers to interventions carried out by providers over the full scope of health systems. National Pharmaceutical Product Interference codes, or NAPPI codes, are used to identify products or consumables such as assistive devices, craft activity resources. The ICD, ICF, ICHI, NAPPI and billing codes are used concurrently to determine reimbursement in accordance with a diagnosis, impact on function, and treatment plan going forward, which can be billed appropriately.

WHO-FIC codes may be accessed below:

- [ICF](#)
- [ICD 11](#)
- [ICHI](#)

The South African health coding system is under review. The National Health Council has approved the WHO-FIC for the future billing system which is in the process of development. Until such time these are implemented, occupational therapists must refer to the OTASA procedural and coding guidelines for occupational therapists in private practice (OTASA, 2022).

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