Occupational Therapy Rehabilitation in a Developing Country: Promoting Best Practice in Mental Health, Zimbabwe

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Abstract: Mental illness is a leading cause of disability but remains unabated in most middle and low income countries. On a global scale, mental, neurological and substance use disorders are on the rise and projected to affect one in every four people by 2030 if no sound and evidence based measures are put in place. In Zimbabwe, mental illness is a major public health concern, worsened by the socioeconomic challenges prevailing. The mental health sector remains underdeveloped and underfunded compared to other sectors like HIV/AIDS and maternal and child health. It is in this context that we advocate for evidence based occupational therapy rehabilitation as a key profession in promoting the health, well-being, quality of life and social inclusion of mental health service users and their careers. In this opinion paper, we aim to discuss how evidence based practice can be promoted in occupational therapy rehabilitation (specifically vocational rehabilitation) in mental health practice for a developing country, Zimbabwe.

Keywords: Occupational therapy, mental health, best practice, vocational rehabilitation, Zimbabwe

1. Introduction

Mental illness remains one of the leading causes of ill health and disability (WHO, 2001) and this rising global problem which at one point in 2001 was said to affect about 450 million people globally, with one in every four people at risk of being affected by a mental or neurological disorder and substance use disorder at some point in their life (WHO, 2001). Zimbabwe acknowledges that mental illness remains amongst the major public health concerns and aims to create an environment that promotes mental well-being of individuals and society at the backdrop of both socio-economic and political challenges (Ministry of Health and Child Care, 2008).

The interplay between mental illness and environmental factors often puts people with mental health problems in the most socially excluded groups of the poor, unemployed, homeless, and isolated and they also happen to be the most stigmatised, discriminated against, marginalised, disadvantaged and vulnerable members of society (Johnstone, 2001). Unemployment is one of the major burdens faced by people with mental health problems in Zimbabwe and globally (Ministry of Health and Child Care, 2008; Arbesman & Loysdon, 2011). This unemployment affects the person with a mental health problem, the family, the workplace and the society at large (Arbesman & Loysdon, 2011). Education is an important adjunct to employment that is also affected and this increases the cost of the mental health burden.

Prevailing socio-economic challenges and its accompanying increases in unemployment and poverty levels have been linked to stress related mental health problems though the extend of this association is yet to be researched systemically (Ministry of Health and Child Care, 2008). According to the Zimbabwe Population Census of 2002 (CSO, 2002), 68% of the population of people with disabilities were prevented from maintaining significant economic activity or going to school due to disability and associated factors, of which we have observed this to be worse among those with mental health problems.

Occupational Therapy enables people to achieve health, well-being, quality of life, social inclusion and life satisfaction through participation in occupation (COT, 2004). Work and education are some of the key occupations engaged in by people with mental illness and said to maintain/support their health and social connections (Nagle, Cook & Polatajko, 2002). Paid work is recognised in occupational therapy for its value as both a means and an end to intervention. The promotion of best practice in occupational therapy rehabilitation in a developing country like Zimbabwe for vocational rehabilitation with people affected by mental health...
problems requires evidence-based practice that is sensitive to the dynamics and environmental influences of the practice context and client group.

2. Best practice in occupational therapy rehabilitation

In best practice, the call is to act in accordance with professional knowledge, principles, philosophies and the prevailing reality in the larger context informed by research, client needs and expert opinions (Dunn, 2011). In a developing country like Zimbabwe, considering the larger context would imply taking note of the socio-economic, political and cultural factors in intervention and outcome measurement. Dunn (2011, p. 1) clearly states that “best practices are a professional’s decisions and actions based on knowledge and evidence that reflect the most current and innovative ideas available”.

For best practice to be realised in a developing country context and in mental health vocational rehabilitation key areas to be explored and considered include the philosophical base of occupational therapy and the value of occupation; research evidence; policies and legislation; the client-centeredness of the profession, social model of disability and health; the available templates of decision making, the models of service delivery and context sensitive outcome measures. In considering these factors, occupational therapy best practice becomes an imaginative way of thinking over prevailing situations and creative application of knowledge to solve participation problems; evaluating effectiveness of intervention for informing future contextually relevant practices.

To facilitate our discussion, we reviewed a systematic review titled “Occupational therapy for employment and education for adults with serious mental illness: A systematic review” by Arbesman & Loysdon, (2011).

The systematic review focused on evaluating the effectiveness of occupational therapy interventions focusing on participation and performance in occupations related to paid and unpaid employment and education as outcome measures. The reviewed research literature was mostly from the developed world. A variety of interventions were found to have been used to achieve the above mentioned outcomes and these included occupation and activity based; those targeted at addressing performance skills; aspects of the environment; activity demands and client factors.

Evidence was found to be strong for supported employment (SE) using the Individual Placement and Support (IPS) to achieve competitive employment and effectiveness was enhanced by providing cognitive or social skills training concurrently with SE. In education, supported education focusing on goal setting, skill development and cognitive training in educational pursuits resulted in increased participation. Unpaid work like volunteer opportunities, home management and child care were also considered as important outcomes though evidence was not strong.

In the review SE proved to be more effective than conventional vocational rehabilitation, as SE produced more job retaining and job efficiency, less time to find job and hence high employment rates. Social and daily living skills could not be separated from work as they enhanced skill acquisition.

The context of practice for the reviewed research literature was characterised by sound mental health, disability, rehabilitation and employment policies and legislation; a multi-sectoral approach to vocational rehabilitation, a wealth base of research to guide evidence-based practice and socio-political barriers to participation were minimum.


3.1. Use of the profession’s theoretical base to guide practice

Arbesman and Loysdon (2011) reported that the successful interventions used were based on the occupational perspective that drives the profession and the outcomes also fell within the profession’s goals of enabling participation and inclusion. The interaction between person-occupation and environment was considered in which the value of occupation in enhancing health and well-being was the focus.

One of the occupations utilised in intervention was work, which is major focus of adult life and identity (Meyers, 2010). With its therapeutic value, paid work can be central to all economic and social life and used as a means and an end in occupational therapy (Van Niekerk, 2004; Meyers, 2010).

Promotion of best practice in Zimbabwe when working with people affected by mental illness and aiming to enhance participation through work occupation, it is best for practice to be guided by theory and use frames of reference to bridge the gap between theory and practice. When an occupational perspective is applied in Zimbabwe mental health occupational therapy, people with
psychiatric problems should be viewed as occupational beings who value the importance of work in contrast to societal myths that they do not want to work, are not able to work or that work can cause a relapse (Van Niekerk, 2004).

In Zimbabwe, the mental health services have been dominated by a reductionist medical model centred around pharmacological management and less emphasis on rehabilitation. This is a challenge in applying occupational therapy’s knowledge which is moving more to the social model of understanding health and disability. Occupational therapy’s client centeredness approach and focus on abilities rather than problems can help achieve best practice in such a context and should be equally prioritised. Unlike in the review by Arbesman and Loysdon (2011), there is need for major environmental changes in Zimbabwe if the true core knowledge of occupational therapy is to be applied wholly for the employment and education of people with serious mental illness. Basics of which include enactment, resourcing and implementing a rehabilitation national policy.

Use of the profession’s core knowledge will enable the Zimbabwean occupational therapists to uphold international practice standards and promote the profession’s identity. The University of Zimbabwe is renowned for equipping its occupational therapy graduates with the profession’s core knowledge and skills, a foundation for best practice. However the later also need to review its curriculum to capture and reflect the developments in occupational science and human rights approaches as new drivers of the profession’s base of knowledge.

3.2. Research and evidence

Best practice entails evidence-based practice (Dunn, 2011) and it is research evidence which provides the foundation for occupational therapy practice (Duncan & Richardson, 2012). A systematic review like the one which was done by Arbesman and Loysdon (2011) is an ingredient for best practice as it brings forth that which is currently working. Research validates intervention, shows practice and research trends and supports future practice, Duncan and Richardson (2012) points it out as “the state of research, specifically, how much research is available and what topics are being researched with whom, and how, informs occupational therapy clinicians and researchers about priorities and values within occupational therapy, in interdisciplinary mental health practice and in society as a whole” (p. 62), which is an ingredient for best practice.

From the review of occupational therapy interventions for employment and education for adults with serious mental illness, it was demonstrated that there is a wide base of research evidence for SE and supported education combined with skills training. However research evidence is highly sensitive to context, hence in achieving best practice in Zimbabwe, contextually sensitive evidence is needed to guide practice. In this light, all responsible entities are encouraged to promote research agendas in line with providing locally relevant evidence for the rehabilitation of mental health service users in Zimbabwe.

The starting point might be for us to validate what has been found from systematic reviews by applying those interventions to practice and documenting outcomes and factors which need attention for such interventions to be successful. Secondly research has to be done in this client group and document and report on what best achieves participation in employment and education in Zimbabwe. For evidence-based practice to promote best practice in Zimbabwe we suggest collaboration between the consumer, clinician, researcher, educator, policy makers and other service providers in doing research and translating the evidence to practice.

3.3. Policies and legislation

Policies and legislations are important in occupational therapy as they can be used to facilitate practice (Auerbach, 2012) and as a resource for intervention and advocacy. The studies reviewed by Arbesman and Loysdon (2011) were in developed countries where vocational and SE programmes are legislated and funded (Van Niekerk, 2004) and also where international legislations like the United Nations Convention on the Rights of Persons with Disabilities (UN, 2006) are rectified, implemented and respected by all key players in disability issues.

To promote best practice in Zimbabwe, the occupational therapist should consider the policies and legislations which govern practice. One of the most important legislation which Zimbabwe has rectified is the UN Convention on the Rights of Persons with Disabilities (UN, 2006). Article 27 of this article talks about work and employment and states that work is a right and should be on equal basis with others despite disability. In practice this means Zimbabwean occupational therapists can base on this to facilitate choice in an open, inclusive and accessible and affirming environment for people with mental illness to participate in paid work occupations.
The Zimbabwe Mental Health Policy of 2006 aim to have rehabilitation and disability programmes that focus on the empowerment and social inclusion of people affected by mental health problems. Occupational therapy can use this as a resource for best practice though acknowledging that policies are difficult to implement in times of economic and political hardships (Coetzee et al., 2011). The other viable line of argument will be to consider that people with mental illness are active citizens with the potential for full participation in communities especially in the area of employment (Kirsh, Cockburn and Gewurtz, 2005).

Zimbabwe like South Africa has policies which position vocational service responsibilities in the department of labour and social services, while other services for people with disabilities are in the department of health (Coetzee et al., 2011) including the posts for occupational therapists. For best practice, vocational rehabilitation should be re-conceptualised at legislative and operational levels as an inter-sectoral model (Coetzee et al., 2011) in other words, should be mainstreamed especially for a developing country with limited vocational rehabilitation resources and services which are fragmented and with no sound referral pathways.

The concept of reasonable accommodations (UN, 2006) is considered in Zimbabwe’s Disabled Persons Act of 1992 and focuses on the reasonableness of adjustments needed to accommodate people with disabilities and should be funded by the service provider however it focuses mainly on physical accommodations. In this sense the psychological, social, political, civil and economic life is not fully addressed for reasonable accommodation. This Act can be a baseline for providing SE and supported education for people affected by mental health problems, though high level of collaboration is required.

In the case of no policies that speak directly to the needs of the population of people affected by mental illness, there will be need for awareness campaigns and advocacy with the involved parties in the areas of disability, human rights, work/employment/labour, health, rehabilitation, education, housing, social welfare, worker compensation, health funders and mental health to develop policies which represent the needs of the population and can be useful in promoting best practice.

**3.4. Collaboration**

In the systematic review done by Arbesman and Loysdon (2011) strong evidence for SE was a result of a well collaborated programme of rehabilitation which starts with placement of the client into competitive employment, then support is offered on an on-going process of collaboration with all parties involved, guided by the client’s preferences. Collaboration is more possible when the parties involved share the same common views and goals for the client. A supportive environment in all aspects is key to functional collaboration (Kirsh, Cockburn & Gewurtz, 2005).

The collaborations should be there to support the client, family and community at large, if best practice is to be achieved (Dunn, 2011). In a developing country like Zimbabwe, to achieve best practice in occupational therapy rehabilitation for people affected by mental health problems, the starting point will be to raise awareness from the consumers to all parties involved about the goals of intervention and abilities of the client group of concern so as to bring everyone on board. Stigma and discrimination are barriers to address which I have observed to hinder collaboration especially with non-health oriented departments in the vocational rehabilitation programmes. This can be addressed through education of the involved parties about mental illness and the value of paid work in those affected and the community at large. Attitudinal barriers are best addressed through education (Van Niekerk, 2004). Zimbabwean occupational therapists should work together with Disabled People’s Organisations and Non-Governmental Organisations to lay this important foundation for collaboration.

In a bid to use collaborative, problem solving relationships, bringing the employer’s perspective through education and partnership building will enhance collaboration and increase the consumer employment opportunities (Kirsh, Cockburn & Gewurtz, 2005). Community based mental health occupational therapists do well in this area of collaboration and there is need to create or advocate for such posts in Zimbabwe to promote best practice.

For collaboration with the clients and families, client-centered approach and a strengths-based model is needed (Dunn, 2011). We have observed that in Zimbabwe some people with mental disabilities have learned helplessness and are demotivated to work, though the area needs further exploration as some of them blame it on medication side effects. When dealing with such a client group Meyers (2010) suggests that a lot of flexibility and patience is needed if they are to collaborate and results be achieved.
Multi-level collaboration is needed for vocational rehabilitation to be sustainable, this collaboration has client as the centre of focus and collaborates at mental health, vocational services and mainstream community levels (Auerbach, 2012). In Zimbabwe intra-sectoral and inter-sectoral collaboration is needed as was suggested for South Africa by Coetzee et al. (2011) to promote best practice in occupational therapy rehabilitation. An inter-sectoral model to vocational rehabilitation has the potential to break the barriers that limit the scope of service delivery and hinder the outcome of competitive employment (Coetzee et al., 2011). Collaboration can be suggested among the following rehabilitation players in Zimbabwe, that is the health team; people with disabilities; disabled people’s organisations; governmental organisations; NGOs; education team; researchers; labour organisations; politicians; community leaders; community; media and other service providers.

3.5. Service models

Conventional vocational rehabilitation, SE specifically IPS, supported education and skills training were the service models reported and supported in the review by Arbesman and Loysdon (2011). The service models aid best practice by situating the theories, evidence, policies, legislations and collaborations into an effective way of problem solving and enabling participation (Dunn, 2011).

Strong evidence in enhancing employment among people with severe mental illness was found for SE (Arbesman and Loysdon, 2011) which is regarded the new best model for providing vocational rehabilitation services (Moll, Huff & Detwiler, 2003). IPS, a model of SE was found to be more effective than conventional vocational rehabilitation (Arbesman & Loysdon, 2011).

In a context like Zimbabwe where conventional vocational rehabilitation, a gradual process of training and assessment for work placement is still the most utilised model, it will be difficult to achieve best practice using IPS in employment for people with mental illness without some major environmental or system changes. Trial run for IPS and findings reported for future practice can be a starting point in using IPS as best practice in the client group of concern. The other major barrier in using IPS as best practice will be the culture of poverty and unemployment and learned habits to live on welfare (Meyers, 2010) since IPS builds on the client’s preferences.

Occupational therapists in Zimbabwe can adopt the current practices from research for achieving competitive employment like SE and use effective collaboration to achieve goals. Van Niekerk (2004) suggested some ways of accommodating people with psychiatric disability in employment which include adjustment of work time and leave; provision of specialised supervision, training and support and educating employers and co-workers about psychiatric disability. Decent work which dignifies and does not demean should be promoted against that which exploits and perpetuates poverty and lack of dignity (WHO, 2010) when delivering SE. However the high rates of unemployment which prevail even among those without mental health problems hinder the implementation of SE as a service model.

In a developing country like Zimbabwe, Community-Based Rehabilitation (CBR) can be the best practice strategy to enhance both employment and education concerns of people with mental illness and society at large. CBR programmes can encourage, empower and facilitate engagement in work occupation to improve the economic and social situations of people with disabilities whereby skill development and livelihood needs are addressed (WHO, 2010). Integration of educational programmes in the CBR programme will be on the premise that work opportunities are enhanced for those with an educational background (WHO, 2010). Zimbabwe should revive its CBR programme to achieve this.

Zimbabwe has an informal economy which can have more work opportunities for people with disabilities (WHO, 2010). The goal of gainful employment can be achieved through consumer-run businesses, affirmative business and micro-enterprise (Van Niekerk, 2004). Considering the current position of the occupational therapist, there can be use of pre-employment placements before competitive employment including sheltered employment, in-house jobs and transitional employment (Auerbach, 2012). Key elements for work in people with disabilities suggested in WHO (2010) livelihood component of CBR guidelines include skills development; self-employment; wage employment and financial services and these can be used to guide best practice in a low income country like Zimbabwe. The people affected by mental illness should be encouraged to advocate for their rights through the DPOs to benefit from the current empowerment programmes being run in the country.
3.6. Outcomes

In the systematic review on occupational therapy interventions for employment and education for adults with serious mental illness (Arbesman & Loysdon, 2011), the outcome focus was on participation and performance in occupations related to paid and unpaid employment and education for individuals. These outcomes are in line with occupational therapy domain of practice guidelines (AOTA, 2008).

For promoting best practice within a similar service model and client group in Zimbabwe, the outcomes expected would range from individual to population, independence to interdependence and performance to social inclusion. The practice should benefit a broad spectrum of consumers (from clients to health funders) and aim to make all consumers active collaborators or allies (Auerbach, 2012). Paid work and education are more valued and are important occupations for health, participation, economic security, identity and social inclusion (Kirsh, Cockburn & Gewurtz, 2005) and this is also true in Zimbabwe, hence should be the targeted outcomes. Unpaid work is of less importance or taken for granted in Zimbabwe. Other immediate outcomes for occupational therapy employment and education interventions in Zimbabwe should include awareness raising, removal of participation barriers and creation of occupational opportunities.

Functional outcomes such as schooling and paid employments speak the value of occupational therapy best practice to peers, administrators, policy makers, health funders, community organisations and the community at large (Auerbach, 2012) hence should be the goals of intervention. Client’s values and preferences should always be considered in the outcomes as was the case in studies reviewed by Arbesman and Loysdon (2011).

3.7. Socio-cultural, political and economic factors

Best practice in occupational therapy implies taking the daily routine and what influences them into account (Dunn, 2011). When there are minimum barriers emanating from socio-cultural, political and economic influences, best practice becomes easier to achieve, hence a supportive environment is needed. In choosing occupation, physical, psychological, as well as cultural practices, values, beliefs come into play, hence culture specific practices are needed for best practice (Kondo, 2004). Although the right to work is there in Zimbabwe, it is often not respected and people with mental health problems face numerous barriers in trying to find and keep work (WHO, 2010), hence awareness raising is needed.

To tackle the misconceptions that people with mental health problems are incapable of learning skills and working (WHO, 2010) and also that their problems have only spiritual explanations and remedies, community education is needed. The prevailing political and economic challenges being faced in Zimbabwe can hinder the delivery of occupational therapy services. So there is need for acknowledging political structures, partner with them, DPOs and NGOs to promote best practice.

3.8. Curricular

Equipping the occupational therapy professionals and graduates with the necessary skills, knowledge and evidence will serve as a template for best practice. The areas to target in Zimbabwe will be the occupational therapy curricular and continuing professional development programmes. Aspects which need consideration to promote best practice in occupational therapy rehabilitation include an occupational perspective to health, client-centered approach, policies and legislation, human rights, the politics of occupational therapy and application of evidence-based practice.

4. Conclusion

Promotion of best practice is achievable in occupational therapy intervention for people with mental health problems in Zimbabwe. For best practice to be a reality, intervention should be based on the profession’s core knowledge, using explicit models, validated practices, informed by best available research evidence, in a supportive environment with relevant policies and legislature in place. The provision of high quality and cost-effective services with multi-sectoral collaboration to promote social inclusion of people affected with mental health problems is what best practice should entail in a developing country like Zimbabwe.

5. References


