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**Emerging Occupational Therapy in Mental Health Practice in Saudi Arabia: A
Qualitative Study**

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Abstract

Occupational therapy (OT) services within mental health (MH) in Saudi Arabia are not well documented. This qualitative study investigated the factors influencing MH-related OT practice in the KSA from psychiatrists' and occupational therapists' perspectives. Data collection was conducted with nine participants including occupational therapists and psychiatrists using semi-structured interviews. Four themes emerged: perceptions about MH-related OT practice; OT's professional identity in Saudi Arabia; challenges toward implementing OT services in psychiatry; and the promotion of OT services within Saudi MH. The findings suggested that awareness about MH-related OT practice is essential to enhance the profession's presence within MH field.

Keywords: Occupational therapy, mental health, Saudi Arabia, qualitative study, barriers to practice

Mental health (MH) disorders are prevalent worldwide and negatively affect daily occupations and quality of life (Al-Habeeb & Qureshi, 2010). The population of the Kingdom of Saudi Arabia (KSA) has rapidly increased, with a corresponding rise in psychiatric disorders, which has increased the burden on and affected the quality of MH services provided (Khalil et al., 2018). The KSA is considered a high-income country, and healthcare services are structured on a regional basis, wherein each region includes a variety of MH facilities to serve people of all ages and with different MH conditions. All Saudi citizens have free access to MH services in government hospitals, and expatriates have access to these in cases of emergencies or if there is no local private hospital available (Colliers International, 2018). Quasi-government hospitals are also operated by the Ministry of Health, but these are predominantly for employees of government organizations, such as the National Guard Health Affairs (Walston et al., 2008). MH professionals include psychiatrists, psychologists, psychiatric nurses, and social workers (Mental Health Care Law, 2014). MH care accounts for 4% of the Ministry of Health's total healthcare budget, and mental hospitals receive 78% of all MH spending. Currently, about twenty MH hospitals are operating in the KSA, with a limited number of available community-based services, such as day-care, residential, and nonresidential services (Qureshi et al., 2013). This scarcity of community-based care within the Saudi MH system is potentially detrimental to the provision of a variety of therapies, such as rehabilitation services (Al-Habeeb & Qureshi, 2010). According to the World Health Organization (WHO) (2003), there is a need for the financial support of MH funding, which is a valuable tool for policymakers to establish and shape effective MH systems.

The recently enacted Saudi MH law (Mental Health Care Law, 2014) represents significant growth in the delivery of MH services in the KSA (Carlisle, 2018; Qureshi et al., 2013). The Saudi MH care law adopted several statutes regarding MH policies and services, as

recommended by the WHO in the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Office of the High Commissioner of Human Rights, 1991). However, some Saudi legislation contradicts legislation afforded by the WHO and other high-income countries, such as the United Kingdom. For example, according to Saudi MH law, people with mental illnesses cannot participate and make decisions regarding their treatment plans unless they are deemed “capable” (Mental Health Care Law, 2014, article 9:1). This could potentially limit patients’ rights to access therapeutic services, such as rehabilitation (Mental Capacity Act, 2005; WHO, 2005).

Occupational therapists deliver valuable interventions to address occupational difficulties resulting from mental illnesses (Champagne & Gray, 2016). Occupational therapy (OT) is rooted in psychiatry (Burson et al., 2017) and has the distinctive value of improving individuals’ wellbeing and quality of life through the use of meaningful occupations (American Occupational Therapy Association, 2014). OT aims to help people recover from mental illnesses at various stages of their lives and provide several services, including, but not limited to, cognitive assessments and treatment; sensory strategies; the development of independent living skills, such as cooking; and return to work support. The latter was highlighted by Bejerholm and Areberg (2014), who found that OT-related interventions increased the potential for people with severe mental illnesses to return to work.

The OT profession is relatively new in the KSA (Meny & Hayat, 2017). It was first taught at degree level in 2010 at a single university. Currently, four out of ninety-two government universities offer a Bachelor of OT (King Abdulaziz University, 2022, King Saud bin Abdulaziz University for Health Sciences, 2022; King Saud University, 2022; Princess Norah bint Abdulrahman University, 2022), and two of these are accredited by the World Federation of Occupational Therapy (WFOT). Data regarding the number of occupational therapists in the KSA and legal frameworks of OT practice is lacking. However, OT services

are commonly found under rehabilitation departments (Aleisa et al., 2014) and are mainly related to physical disabilities, equipment prescription, and environmental modifications (Meny & Hayat, 2017; National Guard Health Affairs, 2015). Although no available reports by the Ministry of Health specify how patients are referred to OT services, patients undergoing care and treatment in hospitals can receive OT services upon physician referrals from different departments. For example, a patient with physical injuries is referred to OT services by orthopedic or neurology physicians. The recently established Saudi Occupational Therapy Association (SOTA) is currently making efforts to increase advocacy and awareness about OT in Saudi society and raise the profile of its members' needs (SOTA, 2019). However, there is still no clear role for the association regarding implementing standards for both the education and practice of OT in the KSA.

Knowledge of OT practice has been established and influenced by Western culture (Awaad, 2003; Hammell & Iwama, 2012). Concepts related to seeking care in Middle Eastern cultures, including Saudi culture, are different from those found in Western culture (Heien et al., 2012). For example, Arab culture values social relationships rather than fostering individual independence, and family care and support are highly valued within the Saudi context (Al Mutair et al., 2014; Hammell, 2014). A study conducted by Al Busaidy and Borthwick (2012) sought to provide a case exemplar for inconsistency between Western and Islamic Omani cultures. They found that patient independence was not prioritized by Omani people; instead, the family's duty of care was more strongly emphasized, and the core concepts of Western OT practice, such as training in self-care activities, were not acceptable to Islamic Omani culture.

According to Iwama (2007), the founder of the Kawa model, which depicts the cultural difficulties of OT practice using a watercourse metaphor, if OT is practiced in a culturally irrelevant situation, the flow of the river might be impeded by cultural "rocks," which leads to a weaker flow. According to the WFOT (2016a), OT practice within a context is affected by

how the profession is perceived and accepted in the community, when it was first introduced, and how it has evolved. Therefore, it seems necessary for OT professionals in the KSA to develop culturally specific theories to enhance the profession within the field of psychiatry and ensure a more culturally sensitive practice for the Saudi community (Kondo, 2004).

MH-related OT practice in the KSA is significantly limited. According to Qureshi et al. (2013), in 2010, there were twenty-two MH practitioners per 100,000 people in the KSA, including thirteen nurses, three social workers, two psychologists, and one other MH worker, who might be an occupational therapist or other professional. Moreover, a recent report by WHO (2018) indicated that the number of occupational therapists working in the MH field in the KSA remains unknown. Such scarcity could be due to Saudi MH law, which does not recognize occupational therapists among approved MH professionals (Mental Health Care Law, 2014). In other similar high-income countries, such as the United Kingdom, occupational therapists are well recognized, and this positively impacts the availability of jobs for occupational therapists in MH offered by the National Health Service (Mind, 2018; National Health System Jobs, 2020). Although the profession has a well-established and highly valued role within MH field in some countries, such as the United Kingdom and Australia, and a sizable workforce, the WFOT (2016b) Human Resource Project reported that MH is among the most deficient areas of OT practice worldwide. Gutman (2011) argued that the absence or limited presence of OT services in MH practice in the United States could lead to the marginalization of the profession within that field.

Previous authors have addressed several factors that could affect the scope of OT practice within the MH field in different countries. These factors were mainly related to knowledge about the role of OT within MH (Carlson & Goetz, 2000; Darawsheh et al., 2018; Henderson et al., 2015; Muñoz et al., 2000), limited education at the university level (AlHeresh & Nikopoulos, 2011; Scanlan et al., 2015), and problems with professional identity (Ashby et

al., 2013). Currently, no single study has provided an examination of the extent of OT practice within the MH field in the KSA and the factors affecting its limited implementation for people with mental illness. Therefore, this study aimed to explore the factors impacting MH-related OT practice in the KSA with reference to the experience of psychiatrists and occupational therapists. The first objective of this study was to examine the participants' understanding of OT's role and its potential role within MH. The second objective was to investigate the occupational therapists' and psychiatrists' perspectives about the challenges and facilitators that could impact the provision of OT practice in the MH field in the KSA.

Methods

Methodology

Qualitative research explores the naturalistic inquiry of participants' lived experiences and comprehends and interprets the meanings of these experiences (Maxwell & Reybold, 2015). A qualitative research design was adopted for this study to explore the factors affecting the existence of MH-related OT practice in the KSA from participants' experiences. The qualitative descriptive approach was used because its main purpose is to understand and examine phenomena about which little is known by providing a straightforward but rich description from the participants' viewpoints (Seixas et al., 2018).

Recruitment

This study adopted purposive nonprobability sampling. Because purposive sampling does not require underlying theories, it is the best-matched technique for the qualitative descriptive approach (Bradshaw et al., 2017). Five occupational therapists and four psychiatrists were recruited through gatekeepers for this study. The primary author contacted the gatekeepers, who were OT and MH department managers, via email. Two main hospitals in a major city of the KSA were approached as they both have OT and MH departments. To be included, the participants had to have a professional background in either OT or psychiatry.

Professionals from other specializations were excluded. Psychiatrists were included because they are considered the main referral body for OT MH services in the KSA. The participants had to have had at least one year of professional experience. Occupational therapists were recruited regardless of their working area due to their scarcity in MH settings in the KSA. Two occupational therapists had previously worked in a MH hospital as an intern and a volunteer, and one psychiatrist had previously worked with an occupational therapist. This study was conducted as the partial completion of the primary author's master's degree at Cardiff University. Therefore, the participants were recruited after receiving ethical approval from the ethical committee at Cardiff University and the ethics boards of the hospitals where the study was conducted. Informed consent was gained, and participant information sheets were provided in both Arabic and English to ensure that the participants fully understood their content and, thus, voluntarily agreed to participate (Nijhawan et al., 2013). The participants' demographic details are presented in Table 1. The interviewees' names were replaced with pseudonyms to ensure their privacy and anonymity.

Table 1. Participants' Demographics

Name (pseudonym)	Profession	Gender	Work experience (years)	Work setting	Previous experience working with occupational therapists/ in a mental health facility
Rahmah	OT	Female	3	Neurorehabilitation inpatient	Previous experience working in a mental health facility
Malik	OT	Male	3	Neurorehabilitation inpatient	Previous experience working in a mental health facility
Huda	OT	Female	4	Wound care inpatient	No previous experience working in a mental health facility
Sarah	OT	Female	5	Neurorehabilitation inpatient/outpatient	No previous experience working in a mental health facility
Amani	OT	Female	5	Pediatric outpatient	No previous experience working in a mental health facility
Taim	Psychiatrist	Male	3	Inpatient/ outpatient	Previous experience working with occupational therapists

Amal	Psychiatrist	Female	15	Inpatient/ outpatient	No previous experience working with occupational therapists
Eman	Psychiatrist	Female	4	Inpatient/ outpatient	No previous experience working with occupational therapists
Mustafa	Psychiatrist	Male	3	Inpatient/ outpatient	No previous experience working with occupational therapists

Data Collection

Data were gathered via individual face-to-face, semi-structured interviews. A pilot interview was first conducted with an OT colleague to confirm the relevance and coverage of the formulated content and to stimulate the addition of further content (Ismail et al., 2018). Following discussions with the second author, the interview guide (see Appendix 1) was prepared by the first author to avoid limited or restricted responses and to motivate the participants to freely express their viewpoints and thoughts (Qu & Dumay, 2011). The interview guide included a set of major themes to be covered during the interviews to help lead the discourse toward the study objectives (Magnusson & Marecek, 2015). The interviews were conducted in the hospitals where the participants worked, and the average interview length was 30 minutes. The interviews were conducted in Arabic, as it was the participants' first language, and they were audio-recorded with the participant's permission. Verbatim transcripts were prepared, but for translation and publication purposes, minor changes were required to maintain the conversational style and word limit. The transcripts were not fully translated into English; rather, only selected quotes and relevant information were translated.

Data Analysis

To aid the analysis process, Braun and Clark's (2006) six stages of thematic analysis were followed as an approach that provides an understanding of the text by identifying themes and providing a rich description and interpretation of qualitative data (Neuendorf, 2019).

Because thematic analysis does not follow a particular methodology, it promotes a flexible method of analysis, which was the best match for the qualitative descriptive approach used in this study (Maguire & Delahunt, 2017). Because using computer-aided programs might have disengaged the researcher from the gathered data, the analysis was conducted manually by the primary author. The primary author was still studying at the time of the study, so the secondary author acted as the project supervisor. Therefore, the second author contributed to the conceptual thinking applied and review of the manuscript. The six stages of thematic analysis were as follows: becoming familiar with the gathered data, generating initial codes, searching for themes, reviewing generated themes, giving names and definitions to the themes, and writing up and producing the report. Significant data that consistently emerged from the participants' responses were coded and subsequently grouped into themes and subthemes. Codes were gathered and grouped into themes by the primary author, which were reviewed by the second author.

To maintain the trustworthiness of this study, member checking, reflexivity, and triangulation were used (Colorafi & Evans, 2016). The latter was achieved by recruiting participants from different settings and professions (King et al., 2018). Participant checking was conducted by emailing the participants with a transcript of their interviews in Arabic to assure the accuracy of the gathered data (Cope, 2014). As suggested by Birt et al. (2016), this active involvement of the participants helped to validate the findings. The researcher shared a similar cultural background with the participants, so reflexivity was especially important in this study because this similarity risked the researcher being perceived as an insider, which would have negatively impacted the study's findings (Burns et al., 2012). Therefore, a reflective journal was used by the researcher to keep a personal record of the process, key decisions, and feelings that arose during the research process.

Findings

Perceptions About Mental Health-Related Occupational Therapy Practice

A key finding of this study pertained to OT professionals' and psychiatrists' knowledge of the role of OT within the MH field. Despite the variations in OT professionals' level of knowledge about their role in MH, they identified common areas of OT interventions, including teaching coping strategies; enhancing independence; vocational rehabilitation; and the different MH settings in which OT services exist, such as hospitals and private centers. Occupational therapists' knowledge of their roles was mainly gained from their undergraduate studies. Of the four psychiatrists interviewed, one declared a lack of knowledge and diverted the questions back to the interviewer, while the other three expressed an understanding that the OT's role in MH mainly revolves around basic daily life activities:

From what I heard, OT is about how the patient takes care of himself in addition to personal care, how he can brush his teeth, how to put on his clothes: this is what I know about OT. (Eman, psychiatrist)

All the psychiatrists stated that they had not received any education about or clinical practice with OT during their academic studies. In contrast, the occupational therapists indicated that they had studied psychiatry-related subjects, but only at a general level, and their studies did not focus on intervention methods for dealing with patients with psychiatric illness.

I studied MH in general, like the beginning of the history of OT and the psychological aspect of it, but not about the disorders that are related to OT in MH, actually I don't remember much of what I studied because I did not practice. (Huda, occupational therapist)

Current Occupational Therapy's Professional Identity in Saudi Arabia

The next theme reflected how current OT practice in the KSA plays a significant role in maintaining the identity of the OT profession there. All the occupational therapists in this study generally agreed that a discrepancy currently exists between the OT services that are supposed to be provided and the services that are actually provided. This discrepancy was attributed to the novelty of the profession in the KSA. There was agreement regarding a general lack of clear standards of practice for OT in the KSA and a practice focus on physical disabilities.

Currently, we work more on the physical aspect and in hospitals that have a rehabilitation department ... this is not the OT role ... our role is bigger than that.
(Huda, occupational therapist)

The majority of the participants from both professions indicated that OT's involvement within the MH field is generally restricted. This was evident in terms of the limited contact and referrals between occupational therapists and psychiatrists, and the limited roles assigned to occupational therapists to deal with patients with mental illness. Occupational therapists based in general hospital settings contact MH departments only if cases warrant it or if patients need to be evaluated by a psychiatrist. From the psychiatrists, contact with occupational therapists is limited, and referrals are not directed to MH-related OT practice.

I received a referral for a child who had a conversion disorder—a mental illness that appears through physical symptoms—and this was the only child I remember because she was diagnosed under MH. The main idea was to work as if she had paraplegia, to work on the physical symptoms that appeared ... I do not remember anything other than this case. (Amani, occupational therapist)

We write a referral to the rehabilitation department, directed to OT services ... we refer patients who have psychosis and who need someone to take care of them, but we do not refer patients with anxiety ... I did not have contact with them [occupational therapists] before ... we refer, but we do not know the outcomes. (Eman, psychiatrist)

The occupational therapists indicated that there was no role assigned to them by MH departments in terms of dealing with patients with mental illness. However, occupational therapists can deal with MH symptoms only if a patient is referred to them for physical rehabilitation and shows secondary symptoms, such as depression.

We see them [patients with depression] not as a basic diagnosis: we are only allowed to offer a simple role ... those patients will be referred to the MH department before they turn to us, so they will have a separate treatment plan that they do not return to us with. I can provide my suggestions, but I cannot change it [the treatment plan]. (Sarah, occupational therapist)

Challenges Toward Implementing OT Services in Psychiatry

This theme captured the participants' perspectives on the factors that specifically challenged the implementation of MH-related OT practice. One of the main factors was related to the attitude of the Saudi community toward the OT profession, as it does not value OT services that focus on enhancing independence or the client-therapist relationships required to provide interventions related to daily occupations.

The majority of people here want something tangible that they can see, but if you tell them that he [the patient] could not dress himself, they do not care about that. Many of our clients do not want to learn how to dress themselves because they have someone to

do it for them, so they do not consider it [dressing] as something that they are supposed to do by themselves. (Rahmah, occupational therapist)

We have a psychiatrist, her fellowship was in France, she used to sit with the patients, she goes out with them, this is acceptable in France but not here, so I expect this [client-therapist relationship] will be a dilemma, I do not expect that our society will accept the idea of OT services. This doctor from the day she came here, it has been impossible for her to go out with patients to fix their eating habits. (Amal, psychiatrist)

Processes and policies relating to treatment methods and the formation of MH teams were seen as barriers to the existence of the OT profession within psychiatry. The MH system in the KSA largely depends on pharmacological management; it is less focused on rehabilitation services.

As psychiatrists, the biological part, which is the topic of drugs and changing medicines, the subject of the diagnosis—we get lost in all the biological details, so we do not have time for counseling ... abroad, there are rehabilitation centers ... in the future, there may be vocational rehabilitation, but at present, we try to do what we can. (Taim, psychiatrist)

The common composition of the multidisciplinary team within the MH field, as perceived by participants, included a psychiatrist, a psychologist, a social worker, and a nurse. The scarcity of occupational therapists working within the MH field is due to policies concerning the availability of jobs.

Once you open the field, things will develop, but the field is not open at all to join MH ... the Ministry [of Health] itself, along with its officials, does not understand the role

of OT in psychiatry because they basically did not open up a route for us to join psychiatry. (Sarah, occupational therapist)

The findings of this study indicate that the roles of occupational therapists and other professionals seemed to overlap, and OT floats among other disciplines, which could be a challenging factor for the implementation of OT services within the MH field in the KSA. Other professionals are currently offering some of the usual OT services within MH, such as dealing with daily life skills, counseling, and teaching ways to help people return to work. These professionals are physical therapists, social workers, and psychologists, with the latter being the most frequently reported. A lack of knowledge about the OT profession in general and for people with mental illnesses was seen as a factor behind the limited appreciation and overlapping roles of occupational therapists and other professionals.

When I was working at the MH hospital, I asked for a patient to work on activities of daily living, but they [psychiatrists] told me that was what the physical therapist has been doing for a long time, and to leave it for physical therapy. Our role for them is zero... we should work as a multidisciplinary team, but the team does not know our role. (Malik, occupational therapist)

Promotion of OT Services Within Saudi Mental Health Care

Another key finding of this study was the need to raise awareness of the OT profession within the MH field. The majority of participants agreed that awareness and increased knowledge about OT were the primary influencers for enhancing OT services in the MH field. Moreover, many of the participants agreed that occupational therapists are responsible for raising awareness of the profile of the OT profession within the MH field.

We have no idea about OT, which is the responsibility of occupational therapists themselves; they need to make a personal effort to market their specialty and explain [it] to people. For example, after I got a sub-specialization, a lot of people did not know about it [her specialty], but when I introduced myself to them and explained the cases that I see and the common cases, the referrals began to come. They were asking “we have that case—is it suitable for referral?” so, I expect it is about awareness of OT. (Amal, psychiatrist)

Several participants declared that increasing awareness of OT would require support from policymakers and national OT associations. Ways to raise awareness about OT services for people with mental illnesses varied. However, improving the education system for both medical and OT students, conducting awareness projects, and using social media were seen as the most influential methods.

If it is [SOTA] properly activated, it can, in turn, simulate and address, as an official body, the psychiatric facilities so that they activate our role, to speak with the Saudi Commission for Health Professionals to open the way for OT professionals to join. (Sarah, occupational therapist)

You can try to make it as part of medical studies: for example, a mandate or part of the curriculum in medical school, or if it is at least one to two weeks, as a brief orientation about OT. (Mustafa, psychiatrist)

The incorporation of more education about OT and MH interventions within the curriculum was seen as important. This could be achieved by specifying a separate MH subsidiary route for undergraduate OT students. Accordingly, this would promote students’ understanding and motivation to practice and seek jobs within MH settings.

If they [OT students] understand MH, it is possible that they will ask for OT in MH ...

If there is a sub-specialization in MH for occupational therapy students, then that will help and enable them to work properly. (Rahmah, occupational therapist)

Discussion

This study aimed to investigate emerging OT services in MH practice in the KSA by examining the perceptions and perspectives of occupational therapists and psychiatrists and the factors that may impact the provision of OT practice in the MH field. The participants' perceptions of the of OT role to people with mental illness varied, with psychiatrists being less knowledgeable than occupational therapists. As indicated by the majority of the participants, the role of OT is limited within MH practice. Several distinct challenges appear to have impacted the implementation of OT services in the MH field, including the attitude of the Saudi community toward OT services and processes; the KSA's MH care-system policies; and the issue of role overlap. Raising awareness was deemed the most important step in moving OT practice forward in MH.

It is widely accepted that the contribution of OT services to patients with MH problems extends beyond addressing the basic activities of daily living, which include multiple occupational aspects, such as work, social participation, and leisure (Pendleton & Krohn, 2013). Interestingly, however, the findings of this study showed that psychiatrists have a narrow understanding of the role of OT for patients with MH problems, which revolve around basic daily life activities. This could potentially have an impact on the presence of OT services within MH, especially in light of physicians' responsibility to make referrals in the KSA (Aleisa et al., 2014).

It was apparent from the findings that OT undergraduate students rarely receive placements in the MH field. In agreement with Scanlan et al. (2017), this would have a detrimental effect on OT students' acquisition of adequate knowledge about MH practice.

Although limited MH placement opportunities for OT students resonate with the standards set by the WFOT (2016a), which do not obligate OT programs to set MH placements, it is worth mentioning that other academic institutions might have variant standards in terms of balancing practice education experience between physical and MH placements. Moreover, the psychiatrists interviewed for this study indicated that they had not come across the OT profession during their academic education. According to Tariah et al. (2012), failure to educate medical students about OT might result in the development of mistaken impressions about OT's role in their future clinical practice.

Another key finding from this study was that there is a lack of clear standards of practice for OT in the KSA, and the OT role is commonly practiced within rehabilitation centers for physical disability. The latter is noteworthy, considering that the OT role encompasses aspects other than physical disabilities, including psychological and cognitive aspects (American Occupational Therapy Association, 2014). Indeed, such narrow OT practice could undermine the profession's identity and inhibit the establishment of a clear identity within MH settings (Ashby et al., 2013; Hughes, 2001).

The findings of this study indicated that contact between occupational therapists and MH team members impacts the knowledge gained about OT services and the accuracy of referrals. OT services can be provided for people with a wide range of MH conditions, but this did not appear to be the case in this study: psychiatrists did not contact occupational therapists, and they only made referrals to treat people with psychotic conditions on the physical activity level (American Occupational Therapy Association, 2020). Similarly, a previous study (Pottebaum & Svinarich, 2005) found that psychiatrists' limited contact with OT restricted their opportunities to gain knowledge about OT and affected the number of referrals they made. Therefore, it could be argued that limited contact and knowledge about OT impacts referral

rates to OT services and, thus, could negatively influence the OT profession's involvement in MH practice in the KSA.

It was apparent from the findings of this study that occupational therapists were not specifically assigned to deal with patients with MH problems; rather, their practice work seemed more generic. In contrast, occupational therapists from other countries provide a valuable and specific role for people with mental illness. For example, occupational therapists in the United Kingdom work with patients with MH problems to engage them in meaningful occupations through employment and vocational rehabilitation, which is essential to MH recovery (Royal College of Occupational Therapy, 2017). According to Hughes (2001), occupational therapists working with MH teams frequently struggle to preserve a strong professional identity, their position is frequently misunderstood, and they are frequently pressured to operate in a general manner in the spirit of being a good team member.

Consistent with a previous study (Al Busaidy & Borthwick, 2012), the findings of the current study showed that primary OT concepts, such as working toward "independence" (Baron et al., 2019), are not widely endorsed by the Saudi culture. This could be because such concepts originate primarily from Western culture, which has a different way of thinking (Hammell, 2014). Thus, it might be necessary for occupational therapists working in the KSA to translate these Western concepts, which are a poor fit with Saudi culture, to develop a more culturally sensitive practice. For example, Saudi culture prioritizes helping others rather than helping oneself (Hammell, 2014), so occupational therapists in the KSA could prioritize enhancing patients' engagement in occupations by enhancing the concept of interdependence and altruism rather than independence.

It was apparent from this study's findings that occupational therapists are not generally among members of MH teams. This could be due to MH law in the KSA, which does not consider occupational therapists to be professionals who work within the MH field (Mental

Health Care Law, 2014). This is of concern to the OT profession in the United States. Gutman (2011) pointed out that the limited recruitment of occupational therapists could eventually drive policymakers and other health professionals to fail to comprehend the contributions of OT services within MH practice. Therefore, government legislation should endeavor to offer positions to occupational therapists to enhance their presence within MH practice (Guru, 2013). This could be started by modifying Saudi MH law to include OT as a contributor to the MH field, thus leading policymakers in MH to establish and expand recruitment opportunities for occupational therapists.

It is apparent from the findings of this study that other professionals can unintentionally take on part of the OT role in terms of dealing with patients with MH problems and result in other professionals' misunderstandings of the role of OT. Similarly, Smith and Mackenzie (2011) indicated that the limited perception of OT's contributions might cause other professions to assume the role of OT. According to MacDonald et al. (2010), when responsibilities are shared by different members of MH teams, tensions might develop among team members that affect the quality of the services provided. However, such tension could be resolved by developing adequate knowledge about the role and responsibility of each profession (Caldwell & Atwal, 2003).

In line with previous literature (Eleyinde et al., 2018; Meny & Hayat, 2017), the findings of this study showed that educating people about OT is essential to promoting the profession's services in psychiatry. Such awareness should target people in both hospitals and within the community by conducting public speaking and using social media. The latter activities help to foster changes and resource allocation decisions within social systems and institutions and thus could enhance the implementation of OT services within MH settings in the KSA (WFOT, 2016a). Moreover, the current study's findings suggest that occupational therapists are mainly responsible for increasing awareness about their profession and their role

within MH practice. Dhillon et al. (2010) similarly acknowledged that occupational therapists are experts in their profession, and this makes them responsible for advocating others in terms of their unique contributions. However, as the current study showed, occupational therapists need support from other parties, such as the national OT association and policymakers, to achieve effective advocacy. Similarly, Gutman (2011) and Eleyinde et al. (2018) emphasized the need for local OT associations to try to reach local authorities and for decision makers to raise awareness and increase opportunities for the profession in areas where it is considered scarce.

Moreover, the introduction of a subspecialty of MH for OT students could be a way to expand OT students' knowledge about their role within MH. Similarly, Bannigan et al. (2011) suggested separate education tracks for OT undergraduate students, one of which would be MH, and to allow for the foundation of OT skills and information, followed by one or two years devoted to the profession-specific skills and knowledge required in the chosen track. However, the latter suggestion might result in OT undergraduate students being less knowledgeable of the distinctive skills of OT profession. An alternative to the separate MH track for OT undergraduate students is to focus on fostering clinical training in MH facilities and dealing with patients with MH conditions (Scanlan et al., 2017).

Conclusion

This study provided new insights into the scope and challenges of MH-related OT practice in the KSA as well as raised many questions for future research. The participants showed different levels of perception regarding the unique contributions of OT to people with mental illness, with the psychiatrists being less knowledgeable than the occupational therapists. OT's identity is essentially non-existent within MH practice, as indicated by the majority of participants. Such loss of identity was evident in the current practice of OT, the limited contact

between OT and MH team members, the limited referrals to OT, and the limited role assigned for occupational therapists to work with patients with MH problems.

A number of distinct challenges seemed to affect the implementation of OT services within the MH field, including the attitude of Saudi community toward OT services, processes, and policies within the MH care system in the KSA and the issue of role overlap. Raising awareness was seen as the essential step to drive forward OT services in MH. Although raising awareness about OT was a shared responsibility, the onus was primarily on occupational therapists. Nevertheless, the findings showed that occupational therapists need support from authorized bodies and from the national OT association to achieve such awareness. The participants explained that enhanced knowledge about OT could occur in different ways, but mainly through strengthening the structure of academic education for both OT and medical students. However, using social media and organizing conferences were also seen as important ways to raise awareness among the Saudi community in general.

Limitations

Given the nature of qualitative research, which requires the researcher's deep involvement, bias may be present (Hadi & Closs, 2016). This is because the primary author comes from a similar culture as those taking part, and therefore, there is a risk that the author's preconceptions have been applied, which may somehow lead or shape the study findings. However, the primary author endeavored to address issues relating to in-sider bias by implementing sufficient measures including member checking and reflexive journals. Generalizability of the outcomes from this study cannot be achieved due to the small sample size, and the study's exploratory nature. However, as this study provided in-depth insight about the research topic, the findings might be transferable to a wider population, albeit probably only within Saudi Arabia's context. The interviews were conducted in Arabic, and the data included within this study were translated into English; thus, the rigor of the results might be

affected, as accurate meanings might have been lost during the translation process (Van Nes et al., 2010).

Recommendations

Since this study was the first to be carried out in relation to MH-related OT practice in the KSA, and considering the findings that emerged, the following recommendations can be made:

- This study highlighted the need for occupational therapists to raise awareness within the community and among healthcare professionals and policymakers about their profession and the contributions that they could bring to MH settings. This could be through conducting in-service to show the effectiveness of the profession. OT associations, in line with policymakers, should also share the responsibility for raising awareness.
- Occupational therapists may have to consider their awareness efforts to promote practices related to Saudi culture and transform Western mainstream concepts into different meanings that are compatible with the Saudi culture. This could be through appreciating the social relationship and valuing the concept of interdependence rather than independence.
- It seems essential to strengthen educational programs for OT and medical students in the KSA. Collaboration between OT and medical school educators should occur by promoting interprofessional education to ensure that medical students gain knowledge about OT in a way that will help them deal with occupational therapists in future clinical practice. For OT students, it is also advisable to consolidate the structure of MH-related courses with training and practice in the real world of MH facilities. This would give the students an idea about what contributions they could provide to people with mental illness and might motivate them to seek jobs within MH settings.

- Occupational therapists and OT associations, such as the SOTA, should implement efforts to reach policymakers at the ministry of health to make amendments to the Saudi MH law by recognizing OT as one of the professions working with patients with MH problems. This will enhance the recognition of OT among employers in MH settings and thus encourage them to collaborate with OT departments and further request occupational therapists to fill the gap in the services provided to patients with MH problems.
- Future research should endeavor to raise awareness about OT and investigate the effectiveness of creating such awareness. Quantitative studies could also be applied to measure the effectiveness of awareness raising, through which a larger number of participants could be included.

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Appendix1: Interview Guide

Interview Guide

Introductory questions:

Now after I introduced myself, I would like to know more about your background as a therapist/ Psychiatrist...

1. For how long have you been practicing the profession?
2. In what areas of your profession (Mental health/ OT) do you have experience?
3. What is your current area of practice? (adult, paediatrics, ...etc)
4. Do you work in an inpatient or outpatient setting?

Main questions:

1. From your experience, what is the role of OT within MH services?
 - How could you define the OT profession in general?
 - From your experience, what are the main areas that OT work with about MH?
 - Have you learned about the role of OT in MH? If yes, what have you learned
 - Have you worked before alongside OT/ Psychiatrist? Could you explain more
 - Which type of information resources is best for you to learn about OT? |
2. From your perspective, how do you evaluate the importance of OT profession within MH field?
 - What is your rationale behind this evaluation?
 - Have you experienced any case that you felt your patient needs OT (for psychiatrist)/ to work with mental health team for one of your patients (for OT)? Could you provide some examples (prompting question)?
3. From your perspective, how is the role of OT being implemented in KSA?
4. From your perspective, tell me about the current OT practice within MH field in KSA?
 - if there are barriers to implementing OT practice, could you explain more?
5. From your perspective, what are the factors that might facilitate the existence of OT in MH services?
 - How could these factors be implemented?
6. Could you conclude this interview with recommendations or further information regarding the research topic?
 - Would you like to discuss or share any further opinions or thought regarding the matter of the study?