Surprising outcomes: Achieving a lot with many, despite limited resources

Photo Class 1975. 36 years ago.

We were one of the 1st groups who moved into the new Tygerberg Campus and Miss Anne Dyke was the head of training. Miss Margaret Mitchell was head at Stikland Psychiatric Hospital.

Miss Dyke became Mrs O`Shae in the same year. My mum made the Blushing Bride bouquet

The move to Randfontein

Marion said I must share my journey with you. Ansie was born in 1976 in Goodwood and she also became an OT.

My husband, Mauritz, worked for the Department of Justice and he was transferred to Randfontein in 1976 and we moved around the Free State as well until we returned to Randfontein in 1980.Susan was born in Virginia in 1979 in the Free State. She owns her own hair salon in Parktown North. I worked at Sterkfontein Psychiatric Hospital from 1980 until 1982 and then joined the Smith Mitchell group in 1983. The company provided care and treatment for very large numbers of chronic psychiatric and TB patients. Rand West Sanatorium had 3000 beds. They had a system of grouping and grading of patients and nursing staff ran the groups. This was very problematic and we started to train OTAs to run rehabilitation programmes. Alet was born in 1985. She lives in Cape Town and is an IT consultant for the Hospitality industry.

The company were taken were taken over a few times and presently it is called Life Esidimeni and is part of the Life Healthcare group.

It is a Public Private partnership with the department of Health and I work at Randfontein Care Centre which is a 500 bed facility providing care, treatment and rehabilitation for long term mental health care users. This means that we must deal with mental illness as well as the effects of institutionalisation. The latter is a challenge since some of the users have been institutionalized for more than 50 years. I work part time and have 8 OTA/OTTs.

The new Mental Health Care Act (17) 2002 had a major influence on the way in which we have to deliver OT service. The Act defines rehabilitation as a process that facilitates an individual attaining an optimal level of function.

This had a few real practical implications;

1. We need to determine each of the 500 users` level of function.
2. The assessment must be user friendly for all the staff members who know the user.
3. We must be able to determine SMART rehab objectives for each level.
4. I had to develop balanced rehabilitation programmes for each level to enable users to start to function in all areas of occupational performance.

The Rehabilitation process is displayed as follows.

Cone

I like the way Ruth Watson says it is development through life span.

I developed the Therapeutic Functional Level Assessment (TFLA) based on Vona du Toit`s Model of Creative Ability. It describes function on the following 10 domains.

1. Mental Illness
2. Orientation
3. Self care
4. Appearance
5. Continency
6. Social behaviour
7. Activity participation
8. Domestic activities
9. Responsibility
10. Employment potential

The comments are important. Another implication of the MHCA is that periodical reports are written to the Review board and they need to make an informed decision regarding the user`s future. It is important to inform

the board of the content of delusions and hallucinations might a person relapse.

The outcomes are reflected on a graph.

It is used four times in different colours.

A score out of 50 determines the programme level.

We are always challenged to provide evidence that we are making a difference. This is also true when a new company takes over and we have to explain that expensive therapy staff makes a difference especially in the lives of users functioning on a low level.

Vona du Toit described 9 levels of Creative Ability and stated that an adult functioning on one of the first five levels will need care, assistance or supervision. The TFLA assesses these 5 levels and users are then grouped together according to their functional level. Groups are not larger than 25 and programmes must be available for the total population on a daily basis.

The next challenge is to develop programmes for the 5 levels.

1. Tone
2. Self diff

Users on this level are usually described as restless, they do not understand what is said to them, they do not recognise themselves or others and they are often considered to be mute, are incontinent and are a heavy burden of care. Brain function is poor. The senses are in tact but the brain does not process information from the senses. We always did sensory stimulation of some kind. I remember I would pass a group and the staff would jump up to appear to be busy and I would feel guilty that I could not give them meaningful programmes. This changed when my road crossed with Flo Longhorn and Sylvia Birkhead in 2006.

Multi Modal Sensory Stimulation

Flo Longhorn is a Belgium Special Educationist. She works with intellectually and physically challengened children from birth. She came to Woodside Sanctuary in Johannesburg a few times to train staff. Sylvia Birkhead saw the

potential to apply the same principles for adults. At a training session by Flo I realized her aims were a perfect match for users on a level of tone and self differentiation. The 7 senses are stimulated by the multi modal sensory stimulation routine and the final aim is to stimulate brain function. We introduced the sensory stimulation routine twice a week for 40 minutes since 2006 and had remarkable results.

Explorative Programmes

Activity participation is about interaction with objects, material, people and the environment and not about an end product.

Programmes for 4&5

We developed Income generating workshops to provide prevocational training as part of a balanced programme for users on a higher level of function.

Finally we developed an independent living centre to prepare users for specific placement at a NGO or home. A high level of independence is required. One must also determine how much assistance or supervision the users will need. We visit NGOs to ensure that we prepare users for specific placements.

The final challenge is to assist users to take up their adult role in the community and to provide them with life skills in often very poor living conditions.

To summarize: The benefits of the TFLA. TheTFLA provides the basic structure for the rehabilitation process at RCC and the Multi modal S.S. continues to make the difference in service delivery for users on low levels of function. We use the S.S. routine as step 1 and when we observe that brain function has improved we involve the users in a balanced programme applying the same principles.

Thank you for sharing my journey with me.