The South African Model of CREATIVE ABILITY

A personal contextual perspective

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A Personal Contextual Perspective

Presentation will address the model from different perspectives as situated in a framework encompassing Health Care, profession and practitioner contexts in South Africa .

- The aim is to place model into a personal, historical and professional context.
- Approach topic by attempting to answer 6 questions (you may be asking) from own perspective.

Question 1: How am I involved with the MOCA and Vana du Toit? Who was Vona?

- **- Firstly a personal perspective**
  - Student of Vona du Toit (first cohort qualified during her headship at Pretoria College).
  - Worked closely over a period of 10 years.
  - Colleague - as a student teacher, and teacher at Pretoria College
  - Shared initial thoughts about 'stages of Psychical recovery.
  - Helped to crystallise and clinically apply theory in mental health care setting (operationalising theory)
  - Mentor
  - Colleague as member on several professional committees (eg, Education committee SAAOT)

A personal Perspective continued…

- Theory underlying model taught by Vona, accepted it as ‘This is how it is, how it is done’; no question about it!
- Applied theory to professional career, +- 25 years clinical work initiated development of application to large groups /long term psychiatric cases. Teaching +- 20 years, which included extensive clinical supervision.
- Presented numerous papers related to the model
- Chapter in 3 Editions of ‘OT in Mental Health and Psychiatry’ (Crouch and Alers)- use of model in Establishing Programmes for large numbers of Psychiatric patients.
- Enduring interest and love for the model

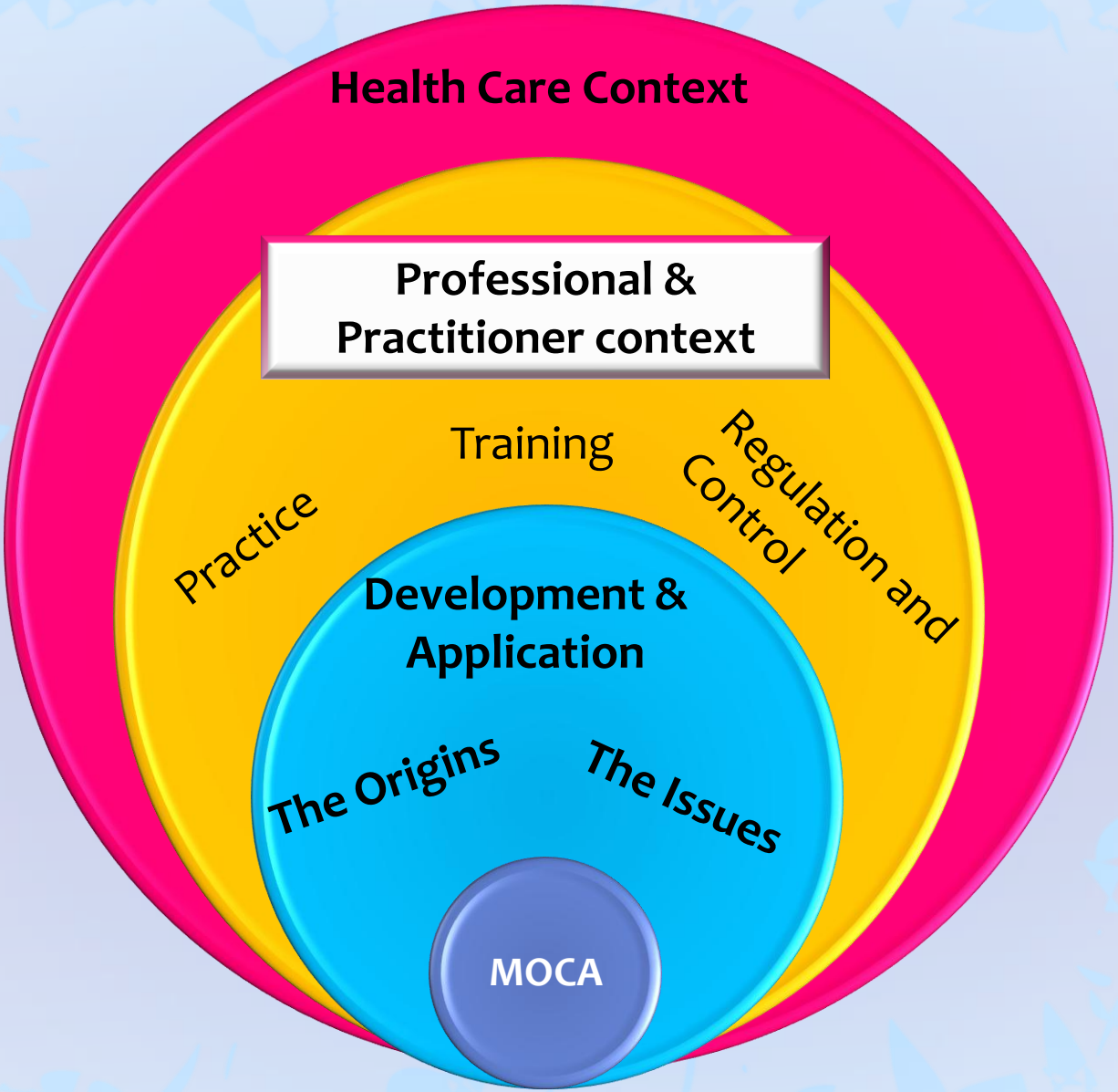
Secondly, Who was Vona du Toit?

- **Qualified primary school teacher**
- **Enduring passion and interest in children**
- **Earliest thinking and application of theory from perspective of the child**
- Qualified as OT 1946

- Established several depts. and services in Pretoria area.
- Developed syllabus for training- 3yr national diploma in OT at Pretoria college
- Principal from 1963 to 1974
- Professional Level -
  - **Archived international standing in OT during 'apartheid' years. Held executive positions in WFOT, vice president WFOT, chairman WFOT Education committee and awarded honorary fellowship in 1974.**
  - **President SAAOT, and life President**
  - **1st Chairman Professional Board for OT's –SAMDC**
  - **Involvement with many community organisations, community service awards.**

Question 2: Where did it all start? What was happening at the time in healthcare, the profession and practice?

- **A brief look at the situation during the 1960's-70's.**


Health Care Context
Professional & Practitioner context
Training
Practice
Regulation and Control
Development & Application
The Origins
The Issues
MOCA

Firstly, The Healthcare context-then.

- **Early 60's and 70's**
- Gross discrepency in levels of care for different sectors of population
- Early stages of development of rehabilitation; OT services only available for +- 15 years
  - **Polio epidemic impact**
  - **Leprosy**
  - **TB**
  - **Physical disability, including long term impact from WW2, also border wars in RSA**
  - **Institutionalised care for individuals with Mental Illness/intellectual impairment – common practice**
  - **Children with disabilities- some special schools, majority no input (assessment or treatment). No inclusive education**
- Missionary Hospital services providing limited services in out lying areas
- Military Hospitals providing extensive health services (due to border wars)
- Strong medical model approach

Secondly, what was happening in profession and practice of occupational Therapy

- The 1960's and 1970's were characterised by
- Use of arts and crafts as therapy –use of weaving looms for every conceivable problem through use of pedals, slings and springs; cane work for all hand, u/limb and 'work' problems; also doing carpentry, metal work, cord knotting and leather work!!
- Making of assistive devices and 'primitive splints'.
- Domiciliary OT
- Emergence of "specialised techniques- Bobath
- Individualised approach; doing what's "good", providing opportunity to develop skills, overcome disability.
- Practice in field of intellectual impairment viewed with suspicion
- Research extremely limited
- WFOT minimal standard stipulated 6 media of OT (including media graded to restore personal management, leisure, socialisation)
- Media graded to restore/develop creative ability leading to work capacity added to list after inputs by Vona du Toit
- Strong western medical model input, medical paternalism
- Isolation due to apartheid system rejection, limited exchange information
- Female dominated profession (OWLS)

Training in RSA- What was it like then and now?

- OT training commenced 1945, 3 year diploma - University of Witwatersrand.
- Training done by "imported British OT's"
- Now 8 university training centres, all 4 year honours level degrees, M's & PhD's
- 1965 < 200 OT's in RSA; 2009 > 3500
- At time of "emergence" of model very few OT departments, OT not yet established or in its infancy (single handed depts.), few clinical training opportunities
- Strong medical model, paternalistic approach to training (institutional)
- Strong crafts focus – weaving, leatherwork, sewing etc… OT's highly skilled

Regulation and control, who pulled the strings?

1960's…

- Registers available at SAMDC, but no statutory registration (voluntary until 1992)
- Registered with SA Medical and Dental Council to practice
- First Professional Board for occupational therapy established +- 1973 (no powers)
- Health profession act geared to medical and dental profession- all the rest 'lumped together' as Para-medical/ supplementary health services with no decision making/ independence.
  - **all treatment only with medical referral/prescription**
  - **always represented by medical profession at governmental level**
- **1984** Registers for OT assistants and technicians introduced.

Question 3: What was Vona's point of departure? What were her foundational ideas, values and beliefs?

- Firstly of person ("man")
- And Secondly of occupational Therapy

Vona believed that:

- Each person is unique, the indivisible totally of psyche, spirit and soma
- Each person indivisible part of his/her world and the world an indivisible part of the self- continuous interaction dialogue
- Person spiritually needs purposeful activity and specifically to work, contribute to his/her world
- Interaction with the "world" integral to humanity, is stimulated by the environment (what's happening in and around the individual)
- Development take place on a continuum of identification and fulfilment of own needs and those of ever widening environment, culminating in responsibility to fellow man

- PARTICIPATION IN PURPOSFUL ACTIVITY (=OCCUPATION) will contribute to recovery, growth and development
- Relatedness for other persons (fellow man) assign meaning to life expressed strong sense of responsibility to fellow man.
- Person takes responsibility for what becomes own reality; decisions must originate from person self.
- "doing" (action) is reflective of "being" (volitional state)
- Repeatedly spoke about "freedom towards responsibility". Implying that 'ability actualised goes hand in hand with responsibility (result excessive responsibility to profession)
- She believed that the ultimate aim of any 'relatedness' to people, objects, situations was to experience an I-Thou 'Moment' which implied a total 'one-ness' and identification with absorption into the moment/activity/person. The "I-Thou relatedness" should also be sought in treatment

Question 3 also asks about Vona du Toit's views of OT

- Purposeful activity (occupation), can and will influence state of health and well being.
- The 'spiritual' component must be acknowledged in treatment. Seen as 'catalyst' to optimal holistic functioning of individual
- All treatment should strive to attainment of ever increasing maximal, total participation in life. INSPIRE participation
- Facilitation of contribution to the 'world'

- Hierarchy OT focus of treatment graded from attention to components (symptoms)

→ Basic ADL → Full participation in life and <u>especially</u> preparedness for occupation in work/productivity area.

- OT's must apply self (vitality, energy, sensitivity, responsiveness, INITATIVE) to all intervention, not just their skill and knowledge.
- OT must facilitate participation in purposeful activity through adaption of variables (environment, activity, handling, presentation)
- OT unique for each individual
  - **never just select an activity, apply a technique**
  - **activity must be inextricable part of role and tasks of individual**
  - **individual must indicate, cannot be 'done to' person; must 'do with'**
- Vona's beliefs and values about the person and our profession are integral to the MOCA, impossible to view separately.

Question 4. MOCA – What has happened over the past 40 years?

I will look at model from 3 angles, early developments, conceptual adjustments and developments in practice.

Going back to the model's inception and early years, some basics:

- Levels of volition first presented in 1965
- The different stages of "Psychical recovery" (1970) initially viewed as scale of measurement of 'doing level' of person
- Stages of volition (being) initially defined as destructive action, incidental creative action, explorative, imitative, personal creative and product centred responses.
- Later linked to stages of action (doing) and interrelatedness established
- Each stage represents "fluidity" – characteristics of previous as well as emerging stages, no absolute linear demarcation
- Each 'characteristic' grows in a spiral, ever increasing vertical and horizontal fashion & e.g., sense of self.
- Diagnosis less significant at lower levels
- Occurs in 3 cycles (preschool; school age and adult hood)
- Attainment of participation and eventual mastery in occupation is fundamental to progression to higher level/next stage

- Terminology changed from stages of "psychical recovery" to stages of volition (being) and action(doing) (1972). Term creative ability used as overarching term
- Definition still somewhat 'problematic' but significant components include:
  - **Creative participation reflects the doing component, and creative ability, the actualised creative potential.**
  - **Maximal effort and involvement**
  - **functioning freely without anxiety**
  - **"Doing" is evidence of relational contact with- persons, objects/materials, environment/situations**
- Further terminology change proposed (for alternative use) Pretorius (1976) – Indicates an overall performance level.

Psychical recovery		Creative Participation
Self Differentiation		Unconstructive level
Self Presentation	Constructive level	
Passive participation	→	Norm awareness
Imitative participation	→	Norm compliance
Active participation	→	Norm transcendence

Grouping of stages into 3 groups (de Witt)

- Group 1-stages
  - **Tone and self differentiation**

PREPARATION FOR CONSTRUCTIVE ACTION

- Group 2-stages
  - **Self presentation**
  - **Passive participation**
  - **Imitative participation**

BEHAVIOUR AND SKILL DEVELOPMENT FOR NORM COMPLIANCY

- Group 3-stages
  - **Active participation**
  - **Competitive participation**
  - **Contribution**
  - **Competitive contribution**

BEHAVIOUR AND SKILL DEVELOPMENT FOR SELF ACTUALISATION

- This grouping assists with directing focus of intervention

Question Four – What has happened over the past 40 years? Secondly looks at some theoretical 'premises' (conceptual issues as formulated by Vona du Toit, but modified through practice.

Theoretical 'premises' as proposed by Vona du Toit, and modified through practice.

- A "perfectly therapeutic session" can (as proposed) enable movement to a higher level BUT found to be only sustained through an environment (structure, handling and on going activity), in which principles are consistently applied, therefore a more "full day" is needed, repetition and ongoing facilitation (especially in mental health)

- Destructive response as described at tone and self differentiation is not "inevitable" often due to inability to identify/verbalise painful/uncomfortable threatening feelings/situation/person.
- du Plessis believed that in the case of a person with a severe physical injury/disability the newly differentiated " quantitive self" gave rise to frustration, aggression, excessive anxiety and destructive behaviour and withdrawal. Only with acceptance of the 'new' self (e.g. person with quadriplegia) does individual go into stage of self presentation.

Model well suited to “generalisation” and use with groups.

- Group can be managed through application of principles (i.e. Structure, activity selection handling, presentation) as applicable to majority or subgroups within group.
- Effective application as screening tool to determine overall level of performance (25-1000 individuals).
- Model very effectively used to do needs analysis, plan and implement cost effective services/programmes for entire populations (e.g. Home for aged)
- Model may, with training by OT, be applied effectively by OTA, OTT, Nurse, C.Hw, CRW.
- Motivation usually described in model as a positive is seen to govern action, not adequately acknowledged that action may be governed by various other factors such as external pressure, fear – therefore not directly motivated
- Action may also be limited by physical disability, poverty, cultural expectations and thus do not express motivational level.

- “Maximal effort" required to bring about a change in level/stage does not often occur consistently or even spontaneously (child ☑ individual with mental illness ☒). Maximal facilitation required; gains need to be sustained to be meaningful.

- **Task concept**- a very central concept to understanding of the model and has been further researched by de Witt, the task is described as having 2 components:
  - **Understanding activity as a whole**
  - **Indentifying with task (sense of engagement and product)**

- de Witt details 5 interacting aspects which are essential for productive action. These are:
  - **Task selection (choice)**
  - **Task execution (process and motivation to sustain)**
  - **Task completion (awareness completion)**
  - **Task evaluation (?quality, belief in self)**
  - **Task satisfaction (emotional Reponses to engagement/ end product)**

(Type of detail absent from original publications)

Question Four. What happened over the past 40 years? Thirdly looks at...

Practical developments in the APPLICATION OF THE MODEL

- Application first with children with Cerebral Palsy and individuals with chronic mental illness, focus entirely individual based.
- **Also intellectual impairment acute and medium term mental illness; persons with ABI.**
- **Considered in intervention of persons with general physical disorders- less acknowledged but adds rich dimension.**
- Application in school and psychiatric hospital setting
- **Also community settings, clinics, private practice ward, programmes by nurses.**

- Hands on application by OT
  - Now also OTA, OTT's, nurses, community workers (with training to use simplified version)

- New/more/way of thinking (1965) i.e. To apply a theory on the one hand proposed by du Toit as 'new approach' and just accepting the fundamental theoretical constructs and application as a "unquestionable fact" relevant for all intervention

- Various 'models' and approaches now being applied by OT's,
  - **Use eclectic approach**
  - **Do critical analyses and review of models**
  - **need for validity and reliability testing of all models and approaches**
  - **application in evidence based practice**

- Major shift – individual to group/population application

- **1977**

- Appointed at Smith Mitchell company, L/T 250 bed mental health care facility

- Expectation to provide “therapy” for entire population

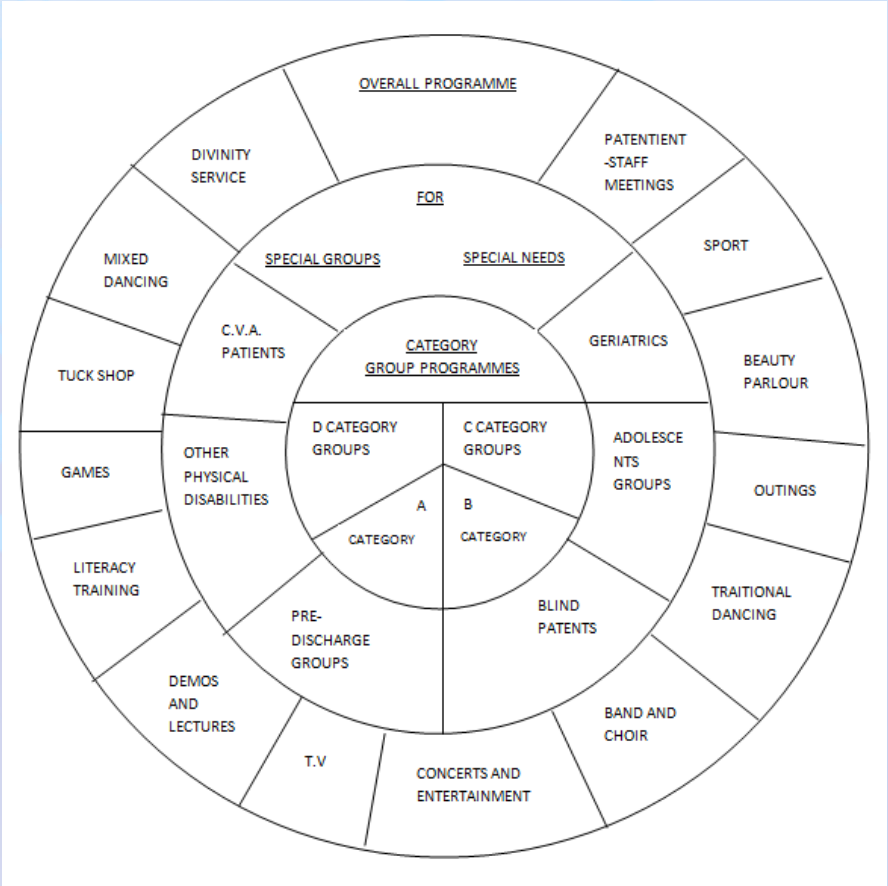
- Use MOCA levels to screen, classify, group and initiate intervention (OT planning, supervision, training-assistant nurses implementation) for total population.

1978:

- Appointed at 1300 bed MHC facility (300 children intellectual impairment, 1000 L/T mentally ill adults) also other OT's across country in similar settings.

- Develop systems' further ⟶ effective management of large numbers in daily programmes for all residents.

- CA levels used to provide 'matrix' appropriate level of therapeutic activity within a full day patent care programme (not exclusively OT)



Patient care programme

- **Structured and offered according to requirements of level of CA- offered unique appropriate intervention for patents functioning at very low levels of functioning (e.g. Self diff)**
- **Higher levels are more individualised.**

1978:

- Develop analytical survey (MOCA as basis) as:
  - **Screening instrument (25-2000 individuals)**
  - **Evaluation of current programme**
  - **Planning for 'new' programme**
  - **Revitalisation of ongoing programmes**

- Develop short (2min) screening instrument (OT and nursing staff).

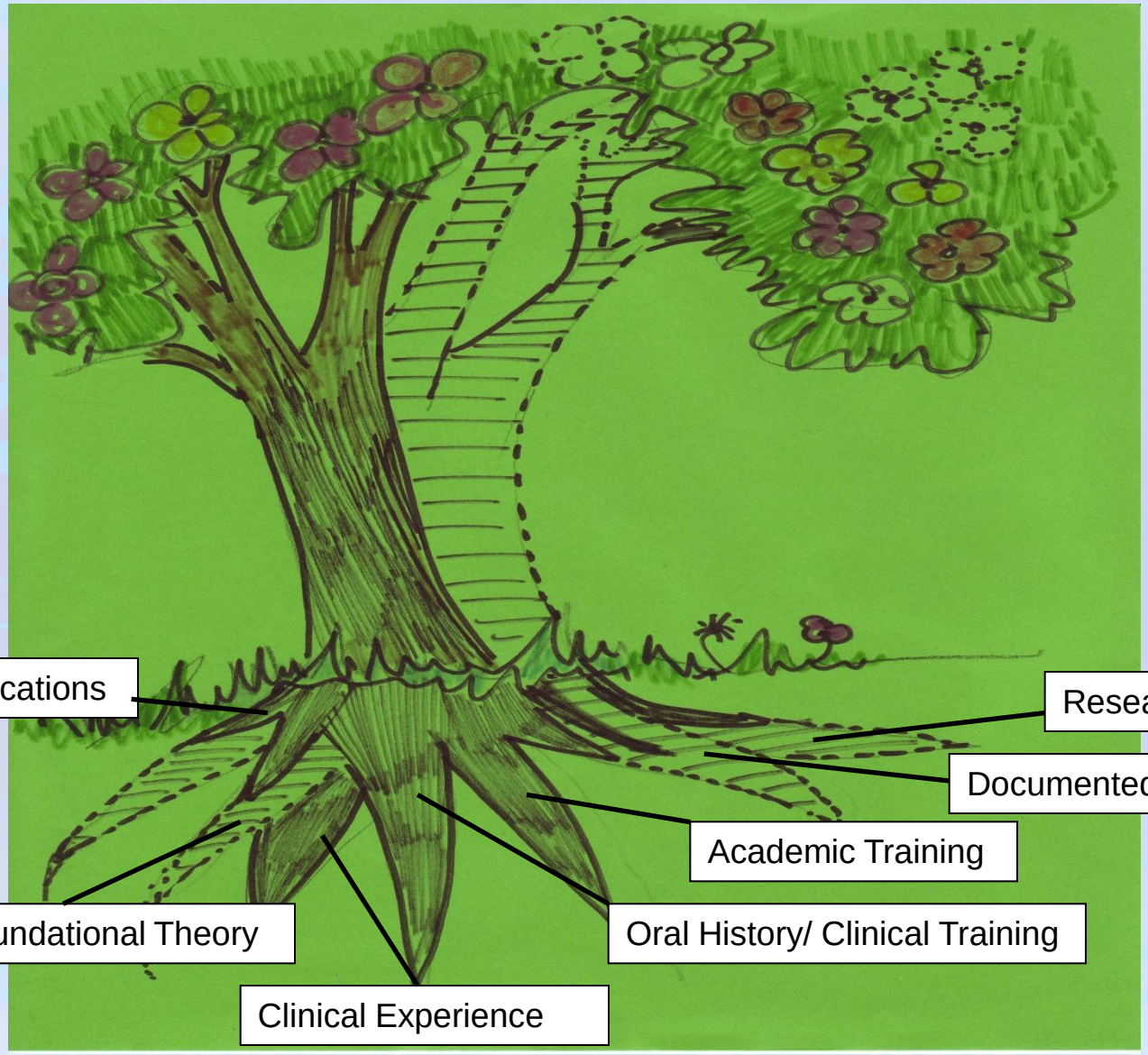
- 1979
  - Programmes introduced for large numbers of children with intellectual impairment (profound and severe impairment levels mostly)
    - **(Pretorius, Van Ginkel, Varney, Zietsman and others)**
  - Level of intellectual impairment shows strong correlation with CA levels
    - **Profound M/R → Tone/Self differentiation**
    - **Severe M/R → Self presentation**
    - **Moderate M/R → Passive participation**
    - **Mild M/R → Imitative participation**
  - Programme planned again using level of CA to offer sensory stimulation concept training, self care training, exposure to environment, interpersonal contact and pre academic training.

- Training of auxiliary staff to implement programmes based on MOCA. (major departure Vona du Toit's thinking)
- OT assistants and technicians run various groups with patents functioning at different levels based on carefully planned protocols for levels and each group.
- OT supervision, review and revitalisation
- Nursing staff trained to apply basic principles.

(details Crouch and Alers 1,2 &3rd edition)

- 1980's -1990's and currently: -
  - On going application with individuals and groups "Smith Mitchell "(later Life Care, now government facilities) programme adopted nationally used + 30 years
    - **Programme refined & staff training maximised, systems and protocols in place**
  - Thousands of OT's apply model as part of day to day practice, often alternatively with MOHO.
  - Minimal recording and reporting with isolated research projects conducted.
  - Application and enthusiastic development in UK (Sherwood)
  - Research limited but showing positive signs (Sherwood, de Witt, Casteleijn, Lingah)

Question 5: Where are we now? Diagrammatic Representation – Status/State of Model



Firstly What Have We Got?

- **A model which tells us:**
- What motivation is and how it can be measured and facilitated
- About interrelatedness of volition (being) and action (doing)
- The nature of task performance and the critical significance of "mastery/ success"
- About manifestation of ability and performance (development, recovery, regression, deterioration) at sequential interdependent levels.
- Significance of participation in purposeful activity (human occupation)
- Improvement/ development / recovery is always possible if a 'challenge' is offered at appropriate level in appropriate way.
- A model which gives us: a therapeutic and rehabilitative approach from a constructive (low) to competitive contribution high level of performance and shows us how to effectively deal with persons at different levels of motivation/ action
- A wonderful model by virtue of its unquestionable clinically proven value to assess and effect substantial change in levels of performance of individual/groups.

- Highly experienced, committed practitioners, efficiently and effectively using the model. Based on collective memory of the model.
- Extensive experience, clinical models and records. As well as papers presented, teaching material spanning 40 years, not recorded.
- A model which makes OT's the only professional group able to actively provide effective intervention to individuals functioning at low levels.
- Training at different levels/detail, at 6/8 training centres; critical comparative analysis with other models E.g. MOTTO
- Reductionist but critically venerable application of model in management of large numbers.
- Literature/ theory (hard and electronic copies) are too limited to substantiate existence of a model.
- Valuable tool for use by other professional groups (nurses –ward programmes)

Secondly – what doe a more analytical approach show us?

A Quick 'SWOT ANALYSIS' (a)

Internal

Strengths	Weaknesses
Established as a **'CLINICAL MODEL'.**	Recorded and published theory not substantial enough for status as model.
More than 3,000 OT's applying model in RSA, value unquestionable	Foundational theory base not sufficiently recorded
Extensive clinical experience and expertise, clinical models of application	Clinical models/experience not sufficiently recorded
Established Training Programmes, 6/8 T.C.	Consensus **ALL** fundamental concept/terms not yet reached
Consumer friendly application (with training)	Research/literature/publications limited (10 articles, 3 book chapters, 3xM's, few presentations)
Culture, age, diagnosis, institutional and community friendly	No authoritative textbook
Effective and efficient in different practice areas, all levels of performance	Lack national collaboration and sharing
Effective individuals, groups, large numbers, cost effective	Intellectual property not claimed/clarified
Vona and Marie du Toit Foundation as guardians	

A Quick 'SWOT ANALYSIS' (b)

External

Opportunities	Threats
RSA-UK Collaboration Combined resources and energy – revitalise Research project (International) Evidence based practice requirements CPD requirements	Reduced to a technique to screen and group clients Divergent developments nationally and internationally, not consistent with fundamental constructs_ ? New Model Inappropriate use by other professional groups Stagnation, development not in keeping with international trends.

Question 6: In conclusion

What would Vona have to say?

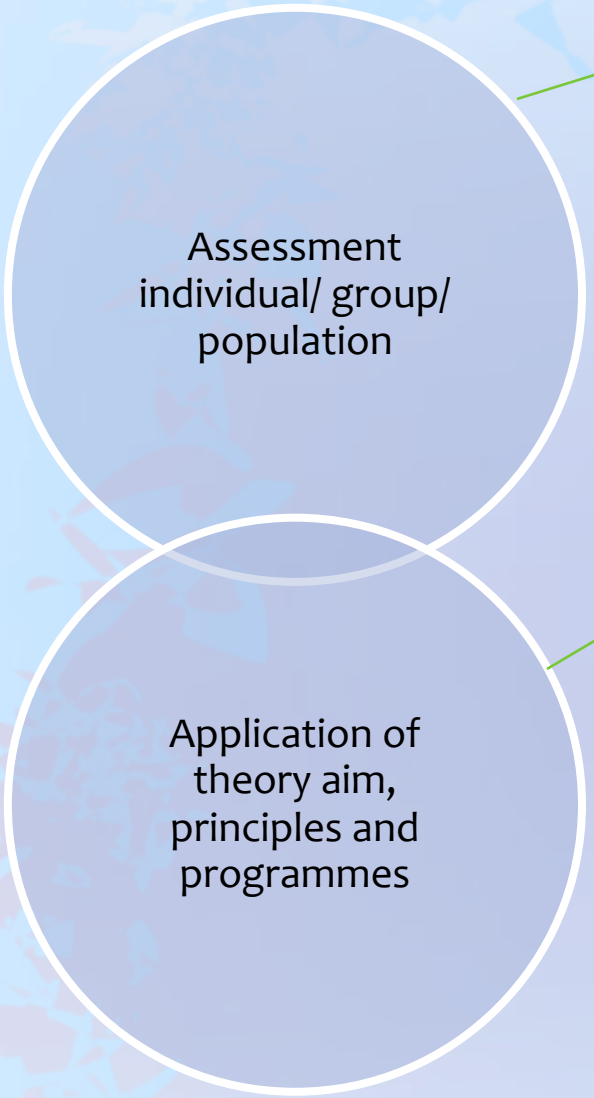
- "Get back to basics- MOTIVATION AND ACTION, clarify and record first then validate"
- "Get on with the jobs and complete the model"
- "Use your initiative"
- "Think creatively and apply maximal effort"
- "Believe in the unquestionable value of the model"

Critical Points of Discussion

- How do we want the MOCA to develop?
  - A 'model' for practice and/or different practice areas/ diagnostic groups/ populations?
  - A screening technique to apply to individual groups/ populations with recipes for application- multi disciplinary?
- Will the proposed "jobs to do" guarantee a clinically and theoretically defensible model?
- How do we manage expansion internationally?
  - Clarify needs
    - RSA
    - Internationally and address specifically

What are the issues? What needs to be done?

- Clarify links with phenomenology/ existentialism, developmental theory
- Make links with occupational science
- comparative analysis of other models
- Uniformity of terminology
- Confirm/ elaborate theory base, record; share teaching material, collect all material, workshop, text book



- Uniform procedure/ format, detail considerations, forms.
- Validity/ reliability
- Clarify manifestations of all stages also paeds/ preson with physical disorder/ mental illness
- Substantiate principles, procedures
- Written case/programme studies –text books- presentations- conferences
- Application in group therapy
- Application for different age groups, practice areas, diagnostic groups and detailed protocols.
- Application for populations plus protocols (facility/institution/community).

- National/ international research plan
- Clinical recording and reporting
- System introduction
  - Nature
  - Extent application
  - Procedures
  - Efficiency
  - Evidence based (DC)
- Monitoring training and practice CPD (OT, OTA, OTT, ??)
- P/G
- Intellectual property/ copy right