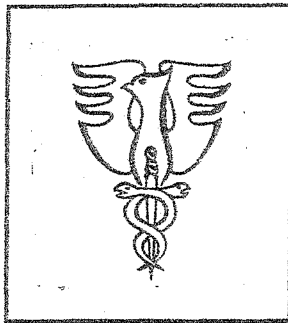


M.J.O.T.

Maltese Journal of Occupational Therapy

Editorial

At last we have it - our very own Journal of O.T. ! Indeed, this project has been long in the pipeline and now we can truly say that our profession is growing, maturing and becoming more and more professional.

After finishing reading this Journal, we would like you to be its partecipants. As professionals and future professionals it is in our own interest and especially that of our clients to ensure continuous education and higher standards.

In this edition...

Note by the President 3

The Beginnings of Zammit Clapp Hospital : The Out-Patient Service 4

Pyromania : The Clinical Picture and A Case Study 8

Formatting a Population Study at St. Vincent de Paule Residence 11

A WFOT Experience 15

ISSUED BY THE MALTA ASSOCIATION OF OCCUPATIONAL THERAPISTS

ISSUE NO. 1 MAY 1994

Message from the-President.

In writing this message, another milestone has been reached in the history of our profession. This is a moment of pride for all.

Following the recent recognition of our association and course of studies by the World Federation of Occupational Therapists, many long term difficulties have been surmounted in-placing O.T. at the forefront with other paramedical disciplines.

With the advent of the publication of the very first journal I am sure that by publishing empirical work on the role and values of O.T., the message-will be out through in a more integrated approach.

Mario Scicluna.
President, Malta Association of Occupational Therapy.
Principal, OT Services.

The Beginnings of Zammit Clapp Hospital :

The Out-Patient Service

Since before its renovation and re-opening, Zammit Clapp Hospital has been a focus of attention and a topic for discussion. One of the main issues was what the function/services of the hospital would be.

Zammit Clapp Hospital is the first specialised hospital for the elderly catering for patients between the ages of 60 years and over. It provides an in-patient and out-patient service, presently hosting 60 in-patients and an average of 35 out-patients per day.

Cynthia Scerri, O.T. in charge Zammit Clapp Hospital

Edward Cassar Delia, O.T.

Day Hospital/Outpatient Management

Day Hospital

The role of the Day Hospital differs from that of the out-patient service in that it caters for persons who will need to spend the whole morning at the hospital rather than just an hour or so. These include patients who will require the assessment and treatment of the whole caring team, whose family can benefit from respite care or patients who are living alone. They receive either individual or specialized group treatment.

The patients arrive at around 9.00a.m. and return home in the afternoon. A transport system and meal service is available for those patients which the management feels will require it. Mass is also celebrated at 11.00a.m. and some activities are prepared by the 'activity organiser' for those patients who need social interaction and stimulation.

The Day Hospital patients attend from Monday to Friday. The Day Hospital will need to have specialized team and location separate from the out-patients section to be more functional than the present.

Out-Patient Service

The out-patients are persons who have been referred by consultants /

general practitioners from their own homes, clinics, residential homes or are follow ups from our own wards. They come from areas all over the island. (Table 1)

The patients receive an appointment to attend at the Wednesday Clinic where they are assessed by the Geriatric Consultant or other doctors who in turn refer them to the other members of the Multi-disciplinary team (which include the nurses, physiotherapist, Occupational Therapist, Social Workers, Speech Therapists, Podologists, Radiographers, Pharmacists, Dieticians or dentists). Following the clinic, the team then meets to discuss the new patients and the follow-ups. Frequency of attendance, need for home visits, community care-services and discharge of the patient is also decided in these meetings.

Occupational Therapy Services

The O.T. out-patient department is run by two full-time Occupational Therapist who are assisted by a part-timer and one O.T. Aide. The O.T's carry out the assessments, identify the problems, establish the aims and goals and actualise the treatment.

The home visits are carried out by the O.T., P.T., S.W., and occasionally the Community Liaison Nurse. The role of the O.T. Aide is to carry out the ADL follow-ups (feeding, dressing, toileting and domestic skills) supervise some activities, prepare the materials required for group-therapy sessions, help with filing and other chores in the department (eg. transferring of patients, clearing-up, answering phone calls etc.)

TABLE 1

ADMISSIONS BY HOME AREA
01.01.93 - 31.05.93

Locality	No. of Patients				
Sliema	53	Gzira	9	Qrendi	3
B'Kara	24	Mellieha	8	G'Mangia	3
St. Julian's	22	Marsa	7	M'Xlokk	2
Valletta	20	Rabat	7	Fgura	2
Hamrun	16	Siggiewi	5	Kappara	2
Paola	13	Zabbar	5	St. Lucia	2
Zebbug	12	San Gwann	4	Naxxar	2
Mosta	11	Zejtun	4	Lija	2
Balzan	10	Floriana	4	Vittoriosa	2
Qormi	9	Msida	4	Other	20

The majority of patients that are treated in O.T. included: strokes, Parkinsons disease, mobility problems, problems in personal care/ADL's, psychosocial problems, dementia, problems in the home etc.

Every Thursday the O.T. and the students have a specialised group Therapy session which caters for patients suffering from dementia, disorientation and confusional states. These are patients who require a closed group system with a very structured and simplified plan. It varies from class oriented R.O. to reminiscence, music, art, memory games, multi-sensory stimulation, hygiene and self care, communication and social skills training, role play, physical/breathing exercises etc.

Statistical Presentations

Table 2 shows a statistical representation of the number of patients attending as out-patients in the various departments since the opening in September of 1991 and up to May 1993. The attendances have increased remarkably and there is a continual demand for further assessment and follow up treatments.

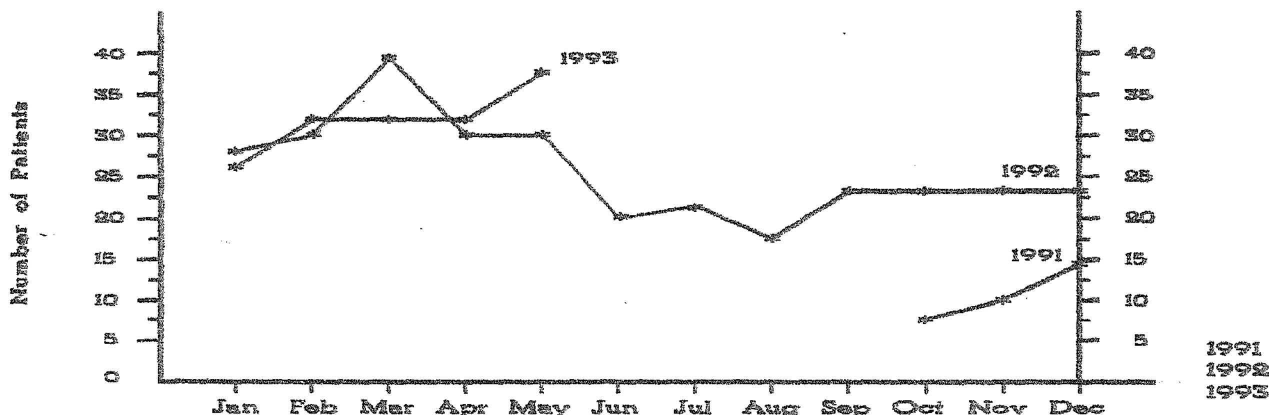
TABLE 2

DAY HOSPITAL ATTENDANCES

Month	New Pts. Referred			Tot. No. of Attending Per Month	Tot. Attendances Per Month	Average Daily Attendances	Range
	Community	Wards	Total				
1991:							
Oct	10	0	10	10	31	3	(1-5)
Nov	22	0	22	31	90	7	(4-10)
Dec	16	5	21	34	108	10	(1-13)
1992:							
Jan	19	5	24	50	139	10	(1-16)
Feb	17	6	23	48	150	14	(8-19)
March	22	1	23	55	179	11	(1-18)
April	28	10	38	67	188	13	(5-22)
May	25	14	39	69	222	14	(4-23)
June	23	7	30	65	213	11	(2-19)
July	29	11	40	81	247	11	(4-19)
Aug	26	8	34	78	261	12	(5-19)
Sept	32	6	38	76	252	13	(5-18)
Oct	36	7	43	86	301	14	(7-20)
Nov	39	13	52	94	303	14	(3-23)
Dec	28	11	39	102	307	15	(5-26)
1993:							
Jan	37	7	44	109	409	20	(13-30)
Feb	36	5	41	111	423	22	(11-34)
March	20	12	32	97	411	19	(13-30)
April	32	13	45	114	430	20	(14-32)
May	29	13	42	96	381	19	(13-25)
TOTAL:	526	154	680	1473	5045		

A statistical representation of the O.T. patients, treatment sessions and mean treatment sessions per patient per month, since the opening in September 1991 up to May 1993, are plotted below.

GRAPH 1



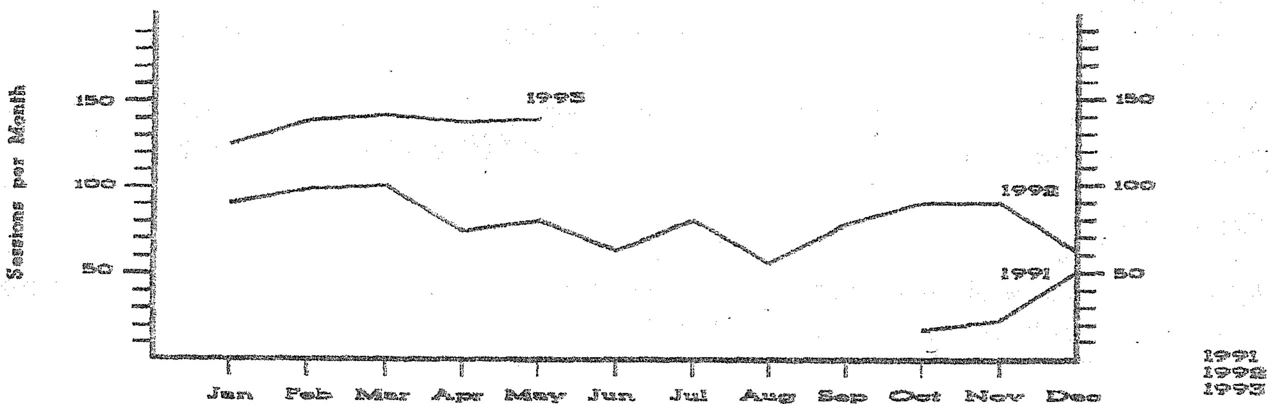
Results from Graph 1

There has been a remarkable increase in the number of patients treated between September 1991 and March 1992. The decrease in the number of patients between March and August 1991 may be due to:

1. Decrease in the number of O.T. referrals.
2. Decrease in patient requirements for O.T. follow up treatment after in-patient care.

Following this decline, there was an increase and stable plateau until the end of 1992.
1993 again showed a continual increase in the number of patients attending O.T.

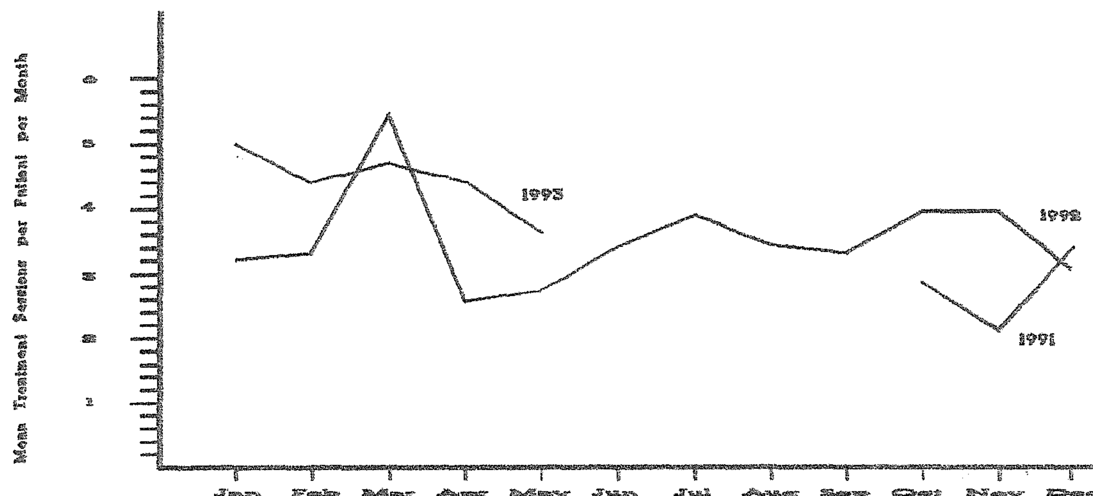
GRAPH 2



Results from Graph 2

Graph 2 shows fluctuations in each year in the number of treatment sessions per month due to difference in intensity and frequency requirements in the rehabilitation process. However, there was an increase of 50% per year reaching a maximum of approximately 150 treatment sessions in 1993.

GRAPH 3



Results from Graph 3

The graphical representation shows the mean treatment session per month per-patient.
In 1991 it ranges between 2.2 - 3.5 sessions/mth/pt.
In 1992 it ranges between 2.5 - 5.5 sessions/mth/pt.
In 1993 it ranges between 3.2 - 5.0 sessions/mth/pt.
These small range values in mean treatment sessions given is due to the fact that a minimum of patients require daily input, the majority require twice a week and a substantial number require once/weekly input. Therefore, results are shifted towards a lower mean value.

Conclusion

The advantageous of the out-patient/Day Hospital services include:
1. Encouraging earlier discharge from wards.
2. Providing continuity of care after discharge.
3. Keeping the elderly at home by providing support within the community.

NOTE: A follow up study will be compiled and released in a future issue to show the continually increasing O.T. services at Zammit Clapp Hospital.

References

Reference was made to statistics compiled by Dr. A. Fiorini and O.T. monthly and annual records from September 1991 up to May 1993.

PYROMANIA :

The Clinical Picture and A Case Study

Society is keenly interested to know how and why children set fires; yet there is not much information provided about these questions. This paper summarises some of the main findings and research dealing with firesetting children, and dwells on the case history and treatment of a young client seen for a period of 18 months at Mount Carmel Hospital.

Joseph Busuttil, DipOT, MSc.,
Occupational Therapist in charge,
Mount Carmel Hospital

From various studies (Strachan, 1981; Vandersall & Weiner, 1970; Nurcombe, 1964) certain common features emerge among children who set fires. Such clients are usually referred to psychiatric clinics for symptoms other than firesetting, the great majority being involved in fighting, disobedience and destructiveness. Most of them set fires at home and on their own. Boys greatly outnumber girls, and a high proportion of these children come from disrupted homes. A major shortcoming of the studies is a lack of specificity and consistency in diagnosis, but the broad outlines of the clinical picture are fairly well drawn.

Stewart et al (1980) found a series of antisocial behaviour in many of these children, featuring never admitting guilt, going out with bad company, persistent lying, stealing from family members, truancy, drinking without parents' permission, and precocious or excessive interest in sex.

In a study on 46 pyromaniacs, Stewart and Culver (1982) related the firesetting behaviour to variables such as age, IQ, and psychiatric disorders in parents, and to the distinction between children who present with firesetting as their chief problem and those in whom it is a secondary complaint. Thirty subjects were followed up after 1 to 5 years. The central finding of the follow up was that 7 out of the 30 (23%) were still setting fires. However, these fires

were less serious than the ones set before treatment. The persistent firesetters may have come from less stable homes and they tended to be more antisocial at followup than children who no longer set fires.

Case History

Client was admitted as a court referral in January 1992, aged 13. He had been involved in cases of arson of vehicles and property, as well as arson at home. He always liked to play with fire, as it gave him a feeling of a hero, as well as a feeling of pleasantiness. Regarding other antisocial behaviour, client used to throw objects at people passing by, stole money from home, and played truant from school since the age of 5 years.

Family History: his single mother married when client was 5, and the adoptive father was an alcoholic and physically abusive. Mother then separated when client was 9. There are three other siblings, and he gets on well with his mother.

Medical History: client suffered from severe epileptic fits since age 2. Scan investigations revealed agenisis of a larger part of the midline region of the forebrain (prosencephalon), extending posteriorly to involve the third ventricle as well as resulting in dilatation of the lateral ventricles.

Psychometric testing indicated that the client's intellectual functioning was rather dull but not subnormal. Certain traumas and social isolation had affected him negatively. Personality testing showed impulsiveness traits, as well as a slight feminine inclination.

Treatment.

The client was seen and treated by OTs when he was in the male admission ward, as well as when he was eventually transferred to the newly opened Young People's Unit. Treatment involves a multidisciplinary team approach, involving doctors, nurses, a social worker, a psychologist, and a teacher. The aim of the team was to formulate and implement a structural programme directed at improving his emotional stability and eliciting pro social behaviour.

The admission goals were threefold:

- control of his conduct disordered behaviour, with specific stress on firesetting activity
- improving communication abilities and other sociopersonal skills
- prevocational/aptitude test in view of future work placement

The treatment plan featured:

- a coping skills programme
- regular school attendance and followup (client was registered at an Opportunity Centre)
- evening programme (carried out with the help of volunteers too)
- group activities
- counselling sessions
- reintegrating into the community

Specifically, the OT involvement featured activities of daily living (appropriate tasks like bedmaking, sorting clothes, tidying up); personal hygience (for increase of self esteem); negative emotion control (impulsiv-

-eness and rage decrease through music); advice and counselling. Projective techniques have been ruled out as he felt threatened by the medium.

Evaluation

The client's programme was evaluated at regular intervals; a number of case conferences were held to gauge the effectiveness of treatment measures, with the participation of community agencies as well. Overall there has been a marked improvement in the behaviour and attitude of the client. Stumbling blocks to the future resettlement in the community include an unstable family home, as well as the non existence of an appropriate community facility where he can be referred.

Conclusion

There is a crying need for more details on children who set fires, the context in which they carry out their activities, and their motives. More urgently one needs to know how long this behaviour continues, and which children are likely to persist. Possibly the difference between those who stop and those who continue fire setting is found in the trend of those who stopped to have stable parents, or to have been taken out of their disrupted homes and put into better settings of foster and group homes. From research, the conclusion one draws is that the short term prognosis of firesetting in young children, at least in those who are admitted to a child psychiatry ward, is only fair, and that there are no reliable ways as yet to tell whether a child will stop setting fires or continue.

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Formatting a Population Study at St. Vincent de Paule Residence

In April of 1993 a study was carried out at St. Vincent de Paule Complex to statistically update the current situation of the elderly in this residence. The exercise was undertaken following a parliamentary question that sought to ascertain the number of dependent clients in this residence.

Rene' Mifsud, O.T. in charge St. Vincent de Paule Residence

Sharon Bonnici, O.T.

Antoinette Laferla, O.T.

Although the parliamentary question was directed solely towards ascertaining the number of dependent clients in the Complex, the survey compiled was more comprehensive. It included the collection of data concerning the number of residents who had a physical potential to improve further from their present state of physical health and to gain more insight of their level of activity. Before the format of the survey was drawn up, various discussions between the professionals involved were held to identify the most significant areas of assessment which would yield the most objective and significant results.

The collection of the data was carried out over a period of three days. Considering that over 1000 clients had to be evaluated, the exercise was quite intensive and hectic. The assessing team was made up of the doctor, nurse, occupational therapist and physiotherapist responsible for that particular ward.

The format of the survey was kept as simple as possible to facilitate the analysis of the data collected. Apart from the clients' particulars, the assessment sheet included the:

(1) Level of dependency

(2) Physical potential

(3) Level of activity.

Following is an illustration of the assessment sheet.

ASSESSMENT SHEET

Ward: ______ Date: ______ Page: ______

Name and Surname	Sex M/F	Age on 19.4.93	Ind.	S.D.	Dep.	B.R.	Physical Potential to Improve. Yes/No	Level of activity. No. Code	Remarks
1.									
2.									
3.									

Evaluation Criteria

(1) Level of dependency: Four categories of dependency states were identified, i.e. independent, semi dependent, dependent and bedridden. To categorise each client in this area, five functional aspects were considered- mobility, continence, transfer to/from bed, intellect and activities of daily living. (Table 1)

TABLE 1

Guidelines on state of dependancy

	Mobility	Continence	Transfer to/from bed	Intellect	A.D.L.'s
Independent	A stable gait without physical help. (Absolute Minimum) N.B. May utilise the help of a stick/tripod/frame.	Continent and goes to the toilet. (Absolute Minimum)	Transfers Unaided. (Absolute Minimum)	Not confused. N.B. A mild confusional state not effecting an independent daily ward routine is not failing. (Absolute Minimum)	Eats and dresses unaided. (Absolute Minimum) N.B. May require weekly bathing supervision. May utilise special equipment for independent eating/dressing.
Semi Dependent	Mobile with physical help. May utilise a walking aide or be mobile on a wheelchair. (Absolute Minimun)	Continent or Incontinent.	Transfers with some help. (Absolute Minimum)	May be normal or confused but not requiring an increased level of supervision. (Absolute Minimum)	Eats unaided. N.B. May utilise special cutlery aides. (Absolute Minimum)
Dependent	Mobilised out of bed. (Absolute Minimum)	Incontinent.	Transfers with a lot of help. Not bedridden. (Absolute Minimum)	Normal or confused, including cases who require an increased level of supervision.	Dependent.
Bedridden	Bedridden.	Continent or Incontinent.	Bedridden.	Normal or confused, including cases who require an increased level of supervision.	Usually dependent.

(2) Potential to improve: No specific guidelines were chosen for this area. It was left up to the discretion of the assessors to decide upon the client's potential for rehabilitation.

(3) Level of activity: The criteria for this section were coded in a descending order:
5 being the most active clients going out of the residence regularly;
4 being mainly hospital bound but involved in various activities (e.g. at the O.T. department, hairdressing salon, Mass etc.);
3 refers to activities at ward level only (e.g. helps on ward, follows hobbies on the ward);
2 includes clients who are socially active on the ward only; and
1 the lowest level for those people who are mainly inactive and do not involve self in any activity or social interaction.

Statistics

Tables 2, 3 and 4 show the statistics emerging from the survey.

TABLE 2 Breakdown of the population according to sex.

Males	-	332	residents	(32.9%)
Females	-	677	residents	(67.1%)
Total	-	1009	residents	(100%)

TABLE 3 State of dependency (see Table 1) according to sex.

	Males	Females	Total
Independent	116 (34.9%)	252 (37.2%)	368 (36.5%)
Semi dependent	129 (38.9%)	166 (24.5%)	295 (29.2%)
Dependent	51 (15.4%)	117 (17.3%)	168 (16.7%)
Bedridden	36 (10.8%)	142 (21.0%)	179 (17.6%)
	332 (100%)	677 (100%)	1009 (100%)

TABLE 4 Breakdown of the level of activity of residents according to sex.

Level of activity	Males	Females	Total
5	75 (22.6%)	75 (11.1%)	150
4	43 (12.9%)	112 (16.5%)	155
3	86 (25.9%)	94 (13.9%)	180
2	58 (17.5%)	222 (32.8%)	280
1	70 (21.1%)	174 (25.7%)	244
	332 (110%)	677 (100%)	1009 (100%)

Inferences derived from study

Comparing these statistics to a previous study held in 1985, it was concluded that the percentage of residents less than 60 years of age has diminished from 15% to 8.9%. This can be taken to comply that this residence has reinforced its identity as a geriatric service.

It is evident from the state of dependency data that clients residing at St. Vincent de Paule can be approximately equally divided into three categories (dependent and bedridden being considered as one category), with the greatest proportion (36.5%) being the independent status.

When considering that one third of the clients are independent, it is very alarming to discover that nearly 50% of the population at St. Vincent de Paule exhibits the lowest two levels of activity implying disseminated apathy and social isolation. Several trials were made to involve clients in group activities at ward level but response was poor despite the input.

Although other statistical comparisons were carried out, only those pertinent to Occupational Therapy are utilised in this article. Data could have been more significant if it had been correlated with previous studies of the residence, but this was not always possible as the criteria used were different.

Conclusion

Referring to St. Vincent de Paule as a residence is to a certain extent a misnomer, as a good proportion of the clients have notable medical conditions that merit acute intervention. As a consequence the complex requires more financial backing to continue its service.

The study highlighted the fact that the present number of staff is inadequate to cope with the needs of the residents. Proper deployment is a very important issue to provide the best possible service by the skeleton staff available. The need for complimentary staff in the form of nursing and paramedical assistants was also stressed. Such personnel will be able to relieve the professional staff by carrying out routine duties whilst allowing the professionals to concentrate on the more acute problems.

The result of the level of activity have far reaching implications about the quality of life encountered within the residence. Although this marked inactivity could correlate with such factors as dependency, general level of physical function or possibly strictly cultural factors, it could also indicate that there is inadequate opportunity for the residents to enjoy recreation and social interaction. This situation could easily be improved by a general change in the attitude of the staff and the public. Clients should be treated as individuals and allowed a certain degree of decision making and autonomy.

A WFOT EXPERIENCE

Our most amiable Nathalie talks of her adventure in Scotland as the first ever representative of our MAOT. And what an experience! As Neil Armstrong once said "This is one small step for ... (Nathalie), but a giant step for ... (the Maltese Occupational Therapy profession).

Nathalie Magro,
Occupational Therapist

It was around 6.00pm when the train slid to a stop at Edinburgh Station. After contemplating various awkward possibilities on how to pull down my luggage from a rack a good way above my head, a friendly Scot gave me a helping hand. After managing to drag my bag down from the train, I decided to draw out a letter sent to me by Clephane Hume - one of the organisers and a WFOT delegate who had patiently corresponded with me all along the preparations and who had sent me worthwhile instructions on where to meet a WFOT representative. It was a fretful realisation to remember that this important letter was not in my handbag but at the bottom of my luggage.

I stopped still in the midst of many travellers in the station trying to recall the contents of Clephane's letter and contemplating whether I should undertake the tedious task of opening my luggage and retrieving this valuable piece of paper or to just wait. I really felt like doing the latter, but realising that waiting was not the solution to arrive at Pollock Halls I decided to do the former. I was looking around trying to spot a vacant bench where I could rest my luggage when a lady with a welcoming smile came up to me. It was with a sigh of relief that I saw her wearing a WFOT badge, as she introduced herself as Lesley.

In fact Lesley was only the first of over 60 multicultural, diverse and

interesting, friendly people I came to know throughout the whole week between the 10 - 15th April 1994 spent at the 21st Council Meeting in Edinburgh.

Malta was for the first time represented at this council meeting and it was a great privilege for me to be the one to represent the local Association of Occupational Therapists.

Delegated from over 26 member countries were present and these included Sri Lanka, Zimbabwe, Malaysia, Italy, Canada, China, Nigeria and others.

This meeting is held every two years, and different countries offer to host this event. During this week delegates have the opportunity to learn more about the profession in other countries as well as acquire a better understanding of cross-cultural aspects and implications such as O.T. education, research and other.

It was very interesting to note that despite cultural differences the problems O.T's face are common worldwide, yet each country has problems specific to its culture and politics.

The sharing of ideas between various delegates is an enriching process as one country can seek help from other countries having similar problems.

During the council meeting in fact, the delegates spend two days in full council - the first and the last. The other three days are spent partly in council and partly in sub committees. These sub committees are formed on the second day of council and include education, legislation, congress, professional practice and publications committees. These function over a period of two years until the next council meeting. Different delegates choose a committee to work in and my contribution will be in the Education Committee for the next two years.

The 21st council meeting will always be one of note in the history of the MAOT, since it was during this gathering that the Malta association was accepted as a full member of the WFOT after almost 8 years of associate membership. This was realised after both the constitution and the curriculum were approved by WFOT.

It was a tremendous sensation when council voted unanimously for us to be accepted as full members (with increasing palpitations and adrenaline level!). Once a programme is approved, the School's administration must go through a self-monitoring process and turn in a detailed report to WFOT every five years. This approval is crucial to the profession as stated in O.T. Week April 14, 1994 vol. 8 No. 15 - "International standards for O.T. programmes should prove to be even more crucial in the coming years, as more and more therapists seek work outside their home countries."

On ending this article I would like to add that this was a very enriching experience though a tiring one. The personal and professional contacts made will definitely help me give a significant contribution in helping our association develop further and promote our profession both on a National and International level.

Is there anything you'd like to tell us?
Comments and suggestions? Letters? Articles?
We'd like to receive them. Write to:

"The MAOT In-Tray"
c/o Occupational Therapy Department,
St. Luke's Hospital,
G'Mangia MSD 07 Malta.

Editorial Staff: Antoinette Powell Sharon Bonnici Stephanie Vella
Design & Graphics: Darren Douglas