CHAPTER 6: CONCLUSION

A model of high-quality services for people with RA should include support groups for patients and carers themselves working together. This should take into account the environment for the delivery of health care and the context in which the patients live. Care should be individualized for patients’ personal circumstances in a seamless service which extends across primary, secondary and tertiary health care. GPs and rheumatologists should work as members of a multi-disciplinary team including occupational therapists.

This is the first study by an occupational therapist to investigate the effects OT intervention on the occupational performance of RA patients in a resource limited setting like Soweto.

There is a growing recognition that assessing an intervention’s effect should not only focus on the statistical significance of the differences in health outcome between the experimental care and control group, but should also focus on the patient’s qualitative experience of these outcomes and relevance or importance of the intervention to them. This has been emphasised with the advent of the international classification of function (ICF) viewing the patients’ health in terms of aspects including functional status, patient participation, personal and individual differences and the environment. It has become the central therapeutic goal for all including health administrators, clinicians and researchers. The development of a common understanding of what Health Related Functional Status (HRFS) concepts mean and how these are best measured, interpreted and the importance of the magnitude of the change in terms of relevance to these concepts should be fundamental in the study of any condition, particularly one that is chronic, like RA.

This study therefore considered OT intervention which was measured using quantitative measures for functional ability (HAQ-DI), disease activity (DAS28) and HR-QOL (SF 36) as well as an extended intervention which considered the
subject's qualitative experience. As previous health services research has been heavily dependent on valid health measures e.g. of HR-QOL or HRFS these assessments were chosen as outcomes measures for this study.

Occupational Therapy intervention at CHBH, for patients with RA does show an immediate and sustained improvement in patients' functional ability after a one week intensive in-patient programme. One week admission is enough to sustain the improvement for a period of up to 20 weeks, with the functional ability having the greater improvement as would be expected from an OT programme focusing on this aspect. HR-QOL scores assessed after the one week intervention were significantly better in some aspects for an experimental group, related to the anticipation of follow up within 20 weeks. This demonstrated the importance of ensuring that the patients are provided with on going support after an initial intervention. The OT intervention also led to a significant improvement in disease activity lowering the tender joint counts. We were able to establish mild DI in the presence of moderate DAS28 with improved QOL.

As this is the first of its kind research in SA, further protocols of intervention need to be developed to give more conclusive evidence for the benefits of comprehensive OT intervention. The SF 36 was a very difficult and not a user friendly tool to administer and score. The results found using this measure were not consistent with the other outcome measures (HAQ-DI and DAS28) used in the study. Financially the scoring software for the SF 36 is also very expensive and probably not the best choice for a resource poor setting. Another generic health related QOL tool, e.g. the World Health Organization QOL questionnaire (WHOQOL) that is readily available might be a better tool for this type of study.

OT intervention for the first time included an extended programme in the form of out-patient treatment using focus groups and home visits. This added a client centred subjective experience which allowed the development of appropriately customised goals for each individual subject. This benefited the experimental group and helped sustain the treatment effect in terms of all aspects of the techniques taught and ensured subjects to take more responsibility in applying these. The research took into consideration intervention within the reality of the
subjects’ home environment enabling better understanding for occupational therapists to teach, treat and assist RA patients from Soweto in future. The structure and resources available to the RA patients, as assessed in this study, can be applied in the treatment of other patients at the CHBH RA clinic in a realistic approach for OT intervention in RA within resource poor/limited settings.

One can not ignore the significant impact in-patient rehabilitation has on functional ability. This intensive treatment allows for development of self-management skills that aid patients in coping with the disease. The use of in-patient treatment facilities is however increasingly being downscaled due to the financial implication. As it may not always be possible to offer patients in-patient rehabilitation, future research should focus on the effect offering intensive OT intervention in an out-patient setting using realistic methods of follow up. One can also look at patients with early RA and the application of this design to other settings. A bigger sample size which would have more power to detect greater difference between control and experimental groups are recommended.

The importance of daily exercise was once again confirmed in this study and the inclusion of a daily exercise programme should feature in all comprehensive OT and/or MDT intervention. As OT’s need to become more creative in finding solutions in low SES settings, a client-centred approach has become essential. The use of focus groups can firstly help patients identify their problems in areas of occupational performance, secondly it can aid in facilitating with problem solving strategies of these problems and lastly it can help create the environment in which change can take place. Inclusion of family members in focus groups will add support and active participation of family members in education programmes can influence their opinions of the patient’s capabilities positively and provide ongoing support for continues self-management behaviour. The qualitative information gathered from the focus groups should be used to help patients reach their desired goals for improvement in OP. This can be done during home visits to demonstrate to patients that solutions can be found within their environment and does not have to be expensive. The OT can adjust area, task and tool in a cost effective manner.
The implementation of a comprehensive OT intervention programme has lead to the direct improvement in functional ability, disease activity and HR-QOL, therefore having an improved effect on occupational performance. The research protocol that incorporated the use of both qualitative and quantitative methods in the study has shown to be positive. It is important to include this data as the nature of individual differs. It also ensures the full effect of the OT invention gets captured. Client centred intervention and the environmental context is essential for quality OT intervention and will lead to greater efficacy in rehabilitation\textsuperscript{20, 44}. 