Use of MOHO in psychiatric intensive care setting

December 6, 2011

I've recently started a position in a psychiatric intensive care unit and have been using the MOHOST as a screening tool but have been finding that, because of the acuity of the client group, the issues that are identified are not able to be addressed adequately. I'd like to know what other OTs working in PICU settings are doing in terms of MOHO and its assessment tools as I'm finding it a very challenging setting to utilise MOHO. I'm (very reluctantly) considering using the cognitive disabilities model as it is in some respects it seems a better fit with the client group but is not occupation-focused. Any ideas or suggestions would be appreciated.

Cheers,

Moses Costigan-King
Occupational Therapist

December 8, 2011

Hi Sarah,
I'm glad to hear that I'm not the only person out there who has thought of using the ACLS within this kind of setting while concurrently (and predominantly) working within the framework of MOHO. I certainly find the cognitive disabilities model challenging to use and some of the assumptions that the model makes around the limited potential for change in cognitive status (and more broadly, recovery) I find bothersome but I think it might be useful for making short term decisions about how and which occupations I attempt to engage consumers in when they present with cognitive impairment in the context of experiencing acute psychosis.
In regards to using the MOHOST, I started using it as my boss (the unit nursing manager) requested that I complete a screening tool with all consumers admitted to the unit. I'm not sure that was necessarily an expectation that screening outcomes would inform the treatment that consumers receive as much of the intervention I carry out is group based. I think that I maybe need to consciously think about the screening outcome when planning how i engage with consumers and which occupations I engage to the extent that is possible in group based contexts. Would I possibly be able to get a copy of your adapted version of the MOHOST?

Cheers,
Moses

December 8, 2011

Sarah,

I would also LOVE to at least know which 6-7 items you are using in your adapted version of the MOHOST. My small department sometimes struggles to assess people in a timely manner as they are referred for OT services, particularly when trying to quickly assign patients to our treatment groups.

Thank you much!

Rick Ericksen, MOT, OTR/L
Director of Occupational Therapy

December 9, 2011

Dear all
I have been working on an ICU in a medium secure mental health. I use MOHO as my framework for practice. The assessments I use are - MOHOST full version
- occupational self assessment
- assessment of communication and interaction skills
- volitional questionnaire as part of re-motivation process

I find using MOHO as a good baseline assessment to identify the needs of the service users and plan interventions in a graded approach.

Regards

Lucy Chambers

December 9, 2011

I will send it out but I would ask you or anyone else not to take what we do but to choose what works in your setting. We interviewed MDs, RNs, SWs on our acute care unit when deciding what was needed so I believe this choice should be made according to individual practice areas and take into account what the OT thinks is needed as well as what others already collect. That said, here is the format we put in the chart. We use numbers vs the FAIR scoring (discussed this with Dr Kielhofner when we were considering this abbreviated format and he concurred that both shortening the assessment and using numbers were okay given our needs) as interdisciplinary staff seem to understand this better. The form is a word document that is copy/pasted into our electronic chart therefore when you are typing the areas expand so you can write as little or as much as you want to include.

Our initial screening is due within 72 hours of admission therefore we chose areas we felt we could realistically assess. We change them when our needs on the unit change – this is probably one of 6 versions but is what we have been using the last few years. The most difficult area to assess in the short time frame is Process Skills: problem solving. I should also say that if when observing/meeting with the pt we see other areas to assess we certainly do that. That info then gets included in the summary section.

UIC Mini Model of Human Occupation Screening Tool (MOHOST)

OCCUPATIONAL PROFILE

Scoring Key:

4: **Facilitates** occupational participation

3: **Allows** occupational participation

2: **Inhibits** occupational participation

1: **Restricts** occupational participation

NA: **Not assessed**

4	**3**	**2**	**1**	**NA**	
ENVIRONMENT:					
Pt	**we record info here that is related to the assessment areas and an "x" as below is recorded – there is an option to also not assess an area if we have for some reason not been able to collect that info**				
	X				**Physical Space**
MOTIVATION FOR OCCUPATION:					
Pt					
					Interest
					Choices
PATTERN OF OCCUPATION:					
Pt					
					Routine
					Roles
PROCESS SKILLS:					
Pt					
					Problem Solving
COMMUNICATION & INTERACTION SKILLS:					
Pt					
					Conversation

SUMMARY AND RECOMMENDATIONS: **Here we write a brief intro with diagnosis and reason for admission to IP and any details we want to add that are not written above . We also highlight the areas that need development in OT.**

TREATMENT PLAN:

Patients are assigned to groups based on their functional ability and the anticipated occupational demands in their life at time of discharge. Below are the Occupational Therapy and Music Therapy groups the Treatment Team has determined will be most beneficial, and individualized goals to address the patient's occupational needs. A schedule has been provided to patient with these and other milieu groups.

December 10, 2011

Hi Moses:

This is a very important discussion.

I would like to advice all of you to follow the therapeutic reasoning of MOHO.

Two weeks ago or so I gave some advise on which roles can an OT play in an Acute Unite. I hope you can find it in the Clearinghouse files..I have also given arguments few times about why ACL assessment does not meet the values of occupational therapy.

Please be very careful on evaluating needs of population you serve. Then your assessment process has to be selected thoroughly based on these needs. What ACL assessment can give about the person as an occupational being? How long the person will be in the service?..Are you able to do a systematized intervention or do intervention through the assessment process?? How about assessment process through family or other significant people? MOHOST certainly can give an integrative information, to follow up then when people are in other therapeutic settings (if it is a week or so of lenght of stay), and can help you to see people´s occupational status... The use of VQ, ACIS and other assessments are useful when you have more time with the person in an acute setting...

Remember than non structured evaluation is as much important. When the system asks you to implement a reliable and valid assessment, use MOHOST. In few days you can have a general vision of the occupational participation conditions of a person, if you organize well. N/A is available for items that cannot be evaluated.

I think, the most important point I want to make is that the person is first. Don´t get tempted on using an assessment that sounds fast and concrete just to classify people in levels, if is not client centered.

Try to study more about MOHO and all it offers. Study the assessments manuals. They are developed to integrate theory and practice and give you guidance on the hows, not only on the whats. When you get more trained through practice you see the reason behind what you do.

Last thing. Not all people are able to participate actively in occupations when they are in the first period of their illnesses. VQ and Remotivation Process manual can be of help...

With all my love and appreciation

Carmen Gloria de las Heras, MS, OTR

December 13, 2011

Thanks Anne…sounds great!

I am posting this for others to see as well, hope that's okay as I think it's important and I probably was not as specific as I should have been initially.

Sarah

December 13, 2011

Hi Carmen,
You raise some very important points that I think are relevant all acute mental health settings but especially psychiatric intensive care services (like the one I work in). In terms of the ACL assessment, I would certainly agree that it is not client-centered but it is essentially deficit focused, however, it can provide useful predictions of immediate functioning that can be used a starting point for facilitating the person's engagement in occupation. This process necessitates that you find out what a person values (which you rightly point out can not be determined using the ACL or any of the other assessment tools based on the cognitive disabilities model) first of all.
The service I work in expects that I complete a screening assessment with all consumers admitted to the PICU (in order to inform any immediate OT intervention as well as to provide feedback/recommendations to acute admission units and or community teams), I decided to use the MOHOST as I wanted a tool that provided a broad overview.
The information gathered through using the MOHOST is useful and valuable, however, I'm struggling to find a way of utilizing this information to the interventions carried out with consumers.
The VQ, ACIS and the remotivation process are potentially really useful but I have not used them in acute settings (only community). Do you have any suggestions/recommendations about using them in a high acuity inpatient setting?

Many thanks for the encouragement and support, it is appreciated!

Kind regards,
Moses

Decemeber 13, 2011

Hi Moses,

have you tried using the OT priority checklist? – a non-standardised MOHO based tool available on the MOHO website under 'other instruments based on MOHO.

Regards
Sue Parkinson

December 13, 2011

Hello All,

I am following the dialogue about how the ACL may not represent OT values and fascinated that 2 very different theories (Allen & MOHO) are being compared to each other in conversation. I would like to pose my perspective on this. As a mental health practitioner and academician who loves & teaches theory, I think the comparison of MOHO assessments to the ACL is like comparing apples & oranges.

In our OT curriculum at Quinnipiac University, MOHO is taught alongside other OT models that focus on the promotion of competent (healthy) occupational performance. The beauty of this model (in my opinion) is that it is a systems perspective and speaks to the multiple variables that impact motivation, change (after all that is what therpy is about) and occupational performance. It is our student's first learning about how the environment influences a client's internal processing. The open system cycle makes this phenomenon explicit for our students and they "get it" after applying it a few times to a case example. I have used MOHO extensively in my own private practice to guide my clinical reasoning for persons with disrupted occupational functioning, diminished occupational competence, faulty occupational identity, misperceptions re: competency & achievement standards & role functioning, etc. It truly embraces persons across all abilities, developmental stages, conditions/populations, etc. I also value how all the MOHO assessment tools explicitly represent the theoretical constructs and value highly their protocol & research study. I discourage MH OT practitioners who keep using their "own", home grown version of an assessment if it has not been researched - I am sure there is a MOHO assessment tool that could better serve clients and give credibility to the OT's role on a practice team.

Allen's theory on the other hand, is taught as a frame of reference that has a much more specific domain of concern with a prescriptive set of matching assessments/interventions. Our AOTA Framework document supports the role of assessing client factors as one step in the whole OT evaluation process. Allen's theory is meant to be applied for a person with a cognitive factor of concern. This theory helps our students to gain an OT perspective on how neuroscience serves as a foundation when assessing functional outcomes. It's clinical scope is much different from the all inclusive OT models. Just like every theory, it is up to the OTR to artfully apply theory to practice including knowing when to use and not use a particular theory, and whom it is suited for. I have also used Allen's theory in my private practice with persons who have developmental disabilities and other mental health disorders like schizophrenia and dementia. I would consider it a huge loss not to have this theory and its set of assessment tools and intervention strategies for my MH practice as so many clients have this area of concern! Once I interpret the assessment findings, I can describe outcomes in medical model terms or in community recovery model terms - as an expert practitioner, I consider it my responsibility to make those treatment plans understandable to the client's continuum of care system.

In conclusion, I readily combine MOHO & Allen's theory together for clients. For example, whenever I have a client whose cognitive performance capacity needs to be assessed, I consider the ACL and RTI (among other assessment tools). I also include the MOHO assessment tools to appreciate other aspects of a unique, complex and multifaceted human being! Together, I gather a lot more data for my intervention plans.

My final point - one does not need to be exclusionary toward any OT theory as long as he/she knows the complementary nature of each (when using more than one) and can ethicially and judiciously apply the theoretical concepts as it was intended.

My best to you all and thank you for listening. I truly enjoy the OT perspectives that I have read on this list serve and welcome your feedback!

Regards,
Roseanna

December 14, 2011

Hi Moses:

I can give you a procedure for highly acute settings. In this I consider a short length of stay where the person is hospitalized in order to compensate symptoms:

1) As a comprehensive and very flexible tool use MOHOST. MOHOST has priorized items in crucial areas that can give an overall view of the occupational status and the factors that are impacting occupational participation, and how they impact on it. If people are not ready for interviews, there are non structured methods to gather information from significant others.

2) At the same time, as its way of obtaing data is observation in different occupational contexts in the environment where the person is, apply the VQ. The VQ helps youy to integrate knowledge about person´s motivation for doing. Therefore it can explain the team and yourself how much the person is ready to participate in occupations/tasks,- if they are ready or not- and how much emotional support/encouragement needs from others in order to do it-.

This helps therapists to:

- Visualize what kind of goals and interventions are feasible with a person- if the goal really goes to facilitate action or needs previous interventions before expecting active performance. This is important because we are urged by other people to keep people doing something even if they are not ready...We tend to feel that we are not accomplishing our role and cannot explain the team the real needs of the person. It gives you a deeper and wider perspective on your role.
- Understand based on people´s needs specific interventions for volition that are suitable for the person. Makes reminding us about the wide range of occupations

we consider in OT (rest, sleep included) and levels of doing in which people are able to participate)

Both tools, MOHOST and VQ are most useful for this highly acute population. Both tools can measure changes over time.

3) Remotivation Process has a complete manual where stages, steps and strategies of interventions for volition are explained in three modules according to the level of volition taht the evaluation process shows (exploration, competence, achievement). The VQ guides the intervention process. The stages of the Exploratory Module: details what possibilities of intervention you maight use according to people´s reality. The Module concludes with initial participation of people in tasks and facilitation of decision making and activities choice.

There are OTs from different countries that are using this with this population. Depends on the lenght of stay and persons conditions is what you can do, also in the way the system functions. If the place consider a follow up intervention you can extend your intervention giving guidance to the family and friends, or coordinating with OTs or other professionals in a place where the person is referred to continue treatment.

The remotivation process is applied together with other significant people, staff members, family for example. The OT can be responsible of the evaluation, intervention and guidance to others. The manual details examples, one of them is a person who goes through the acute stage.

Thinking of this population and our roles is important. Agood occupational needs evaluation of the population is very useful. Evaluating Environmental impact is part of needs assessment too which gives us the knowledge of different variables of where we are working, and where people will go from there..Then we centered our services in the reality. I know you have seen the big difference between working in community and working in a highly acute setting.

I would like to share a general view of our roles with MOHO in these settings (10 days):

- Evaluation Process most suitable for this population: Non structured methods. Structured methods: MOHOST-VQ. Assessment of occupational performance history with family or significant others.
- Companion using empathic relationship in relation to the lived body.
- Validation Stage of Exploratory Module- Remotivation Process-.
- Environmental education and management within the institution (staff and team education on people needs in terms of relationships, support and social expectations of participation generating a collaborative aliance; organization of the physical environment to promote, well being, occupational participation of the group (as normilized as possible)

- Family education and counseling on facilitating occupational participation and well being (this intervention can go hand by hand with the assessment process with the family).
- Conection and coordination with community networks
- Group support facilitating self help, information and guidance for discharge (if possible)
- Facilitating participation in basic routines.

This is a summary...

I hope other OTs can share experiences about their work!

If you need more specifics let me know!

Best to you

Carmen Gloria de las Heras, MS, OTR
Chile