Hiya all

I’m struggling to explain scoring of the MOHOST to my student, and I think it is because of the way I’m explaining it. I have found that the reliability between practitioners has been very good with students and myself in the past, however with this student she is rating everyone higher than I would rate them e.g. F or A instead of I. She is following the manual whilst scoring, as I do also.

I think the question is about the definition of occupational participation, or more specifically what “norm” or standard are we comparing current performance to. My student rates him highly for volition and pattern of occupation because he is attending a gardening project and another mental health service based IT course. I have rated him lower because I feel he underestimates his abilities and expectation of success, and relies on mental health groups to structure his day. When I score I tend to think of what a typical man in his age range might engage in e.g. job, family etc, and consider that as the standard of occupational participation we measure against. E.g. his expectation of success and his choices are limiting him for applying for a part time job, which I feel he would be capable of. My student however points out to me that he finds these groups satisfying, expressed some satisfaction, has a routine and has realistically appraised that he is capable of them. If we are comparing them to their subjective view of what full occupational participation would be then he is doing well, but then if he is not realistically reflecting on his abilities then his viewpoint is to some extent invalid. Also if it is more subjective I don’t see how MOHOST can be used as an outcome measure beyond for one individual’s progress. To my understanding we do compare them to a norm of some kind, otherwise we are saying they are “doing well despite their diagnosis” and the manual says not to do that!

I don’t feel I’m explaining this very well, in the middle of a busy office on the ward!

I’m sure Sue will be able to suggest something!

Vicki Aiken

November 12, 2010

Hi Vicki,
as I understand it (and how I was trained to score on MOHOST) is that it is a snap shot of that particular moment in time (no doubt Sue will clarify further tho) - almost like you freeze frame. As you are observing your client "doing” different things at different times you should be able to get a more generalised picture of what is going on, hence there being a blank space for the environment in which you are assessing - i.e. my clients are ex service personnel, so I have to be very aware of almost tunnelling my vision in respect to scoring. I know they have relationships, some are in full time employment and live safely and independently when at home, but I rate them only on what I observe at that moment in time...from cooking on a 1:1 basis to them just socialising in the "activity" centre. Using the multiple observation sheets. At the end of their stay here I complete the full MOHOST (four pager) again, as an evaluation.

By sitting down with another member of staff and discussing the scoring, we do end up having a really good debate on how "we" the practitioners interpret what is going on, we have a rule to mark down in every case of un-sureness (is there such a word).

I think you are always going to get this discrepancy when working like this, as unlike AMPS we are unable to calibrate our scorings through a computer programme. Some practitioners do mark higher and some lower, but we satisfy ourselves and our fellow MDT that although there is this discrepancy sometimes, generally we are "spot on" as we find the "norm" for that client! As for using MOHOST as an evaluation, yes, I use it totally for that particular clients progress for that particular two week stay having already sat down with them on their first day and ascertained where they see they need to improve.

I like you apologise if my explanation is not clear! difficult to explain how it works, but easier to show!
You watch, Sue will come in now and blow us both out of the water with her brilliant explanation!!!

Karen Miles

November 12, 2010

Dear Vicki

You bring up many interesting points regarding the nature of assessment. We are taught as professionals that assessment or evaluation is an objective process, guided by the expertise that we acquire through training and everyday experience. However, we must continually ask ourselves the question- I assessment truly objective? Who is it who decides what to assess and how to assess it- what are their underlying assumptions about disability, what it means to live a valuable life, and what outcomes are important? Who is it that has the ‘authority’ to decide where a person can live and when they are ready-what cultural assumptions about independence influence that decision making process?

An example I always think of is developmental assessments that ask children to stack blocks into a tower- and different developmental levels are indicated by the number of blocks that can be stacked….however, as an assessor, what about the child who gets that 5th block on the tower, it wobbles, and topples- does that count or not? My decision as an
assessor is likely to be influenced by my assumptions about development (oh, stacking blocks is not a real life task vs. stacking blocks is indicative of important fine motor skills) as well as my personal relationship with the child (oh, I know this child can do this I have seen it before vs. I don’t know this child and not sure what her optimal performance is).

To me, assessments like the MOHOST and SCOPE enable us to challenge the assumption that all evaluation is purely objective. It enables us to acknowledge that everyday, as therapists and evaluators, we are making decisions that may appear objective but that always have a tint of subjectivity to them! For example, the SCOPE-the peds version of the MOHOST- explicitly states that each child should be rated in reference to their individual developmental trajectory- so the same item may have different meaning for each child, depending upon that child’s occupational history and potential, family goals, and potential for additional growth! This dynamic approach increases the relevance of the SCOPE for each individual child.

Now you do bring up an excellent point regarding consistency of evaluation across therapists. If therapists are using a different ‘frame’ when viewing each client, they may not achieve the same rating (this is referred to as ‘rater severity’ or ‘inter-rater reliability’ in research). The question you must ask yourself is “Is rater consistency something that could impact the decisions made about service provision for this client?” For example, if you have different therapists doing pre and post assessment, then differences in rater perceptions COULD impact client services- note that in a study I authored along with colleagues form the UIC hospital, they did have different therapists rating pre and post and only showed 2 levels of rater severity. What if you want to be able to do this? I recommend simply working as a team when rating several MOHOSTs, and discussing how your specific practice context and the challenges commonly faced by clients in your setting can be rated- often teams who share their reasoning process “converge” in their framing, and achieve more consistency.

Thank you Vicki for encouraging a stimulating discussion!

Best-

Jessica

November 15, 2010

Good points...been there! We discuss scores more often when staff or students are beginning and refer back frequently to the manual.

Sarah

November 15, 2010

Hi Vicki -
I think you explained that all very well!

The two key issues are - what to use as the 'norm'; and what the purpose is of the assessment...

It seems to me that what your student is doing is understanding and empathising with where your client is currently 'at', and therefore recognising and reflecting on the efforts (etc) they make on a day to day basis to engage in occupation (which is no mean feat when struggling with depression and anxiety for example). When reflecting on progress with the client, this could in turn have a positive impact on motivation and confidence when he is able to reflect that he is doing well (and therefore he might gradually start to be prepared to take more 'risks' with trying new things which could eventually lead to him reaching his fuller, although as yet unrecognised by him, potential).

However - if the aim of using the tool is to gain a clinical picture of his occupational performance etc., with a clear indication of key areas of need as well as strengths to inform future intervention, then I'd agree with you that the 'norm' against which the client's current levels of performance are taken should be what you would expect the average person of that age, gender, culture, intellect etc. to be doing.

If this client has, prior to this current episode of illness, been living an average Joe Bloggs lifestyle, then that gives an even better indication of what intervention may be aiming towards, and thereby a truer picture of the impact of the current illness (some 'problem free talk' with the client about what life was like before the problem arose should give a good picture - although I realise that for many clients the 'problem' may have been a long term feature of their life).

In terms of your assessment of the student (I know you didn't ask about this but I just thought I'd throw my penny's worth in anyway) I would be exploring with the student if they feel that, because the client is (according to the student's assessment) scoring well on the MOHOST - what would they hypothetically do about that as the therapist - would they consider 'job done' and step back, or would they recognise that there is still quite some way to go in terms of recovery, and therefore be tailoring their intervention accordingly. Is the student able to understand your clinical reasoning on the best use of MOHOST (whether or not they agree that it is the best use of the assessment tool); or do they really NOT understand (in which case as a supervisor alarm bells would be ringing).

I'm sure you will get more MOHOST specific answers from others on the listserv; but I hope my thoughts have been helpful in some way.

Good Luck!

Claire
November 15, 2010

Hi Vicki and Karen,

Hope you are both well. I've spent the weekend celebrating my husband's 50th birthday and am far from sure that I'm going to be able to suggest anything at all, never mind giving a brilliant explanation! Thankfully, the weight of expectation has been lessened by Jessica's reply which neatly contrasts the search for objectivity with the need for reflexivity, and the value of calibrating the severity of raters with the utility of having an off-the-shelf assessment.

Research into the psychometric properties of the MOHOST showed that the 'therapists were able to use the MOHOST in a consistent, valid manner' and Jessica's study of the utility of the MOHOST for detecting client change showed that the 'MOHOST was used in a consistent and interchangeable manner by occupational therapists working in inpatient rehabilitation' but Karen is right in that there will always be some therapists who are lenient raters and some who are harsh, as well as the occasional therapist who will use an assessment in an invalid way. This has to be balanced against the utility of having an assessment that is relatively easy to use and therefore more likely to be used as an outcome measure that one which is costly or complicated to implement.

That said, there is still merit in ironing out differences through discussion - especially when working with students and those who are learning how to use the MOHOST. It was partly because I always experienced a strong sense of agreement when rating the MOHOST in discussion with others that I first dared to hope that it had inter-rater reliability. The fact you have always experienced a similar degree of accord should give you confidence in your own assessment skills Vicki!

I think the comment that I would most like to add to the discussion is the fact the MOHOST is not purely observation-based and that it summarises the whole person.

The single observation MOHOST is very much a snapshot of a moment in time (I like the phrase, 'freeze-frame' that you use, Karen). It is completed after a single intervention which may or may not include any conversation and so may be entirely based on observation. However, the full MOHOST is a summary of the whole person - everything that the therapist has learned within a defined period of time (usually within 2 weeks) - with information gathered from talking to the person and others involved in their care. This information still needs to be contextualised in the environment in it was generated, but I am with you, Vicki, in that it needs to reflect the life beyond the mental health service. I take occupational participation to mean participation in valued life roles and we must beware of setting low expectations for our clients.

'Participation' is defined by the MOHO textbook as 'engagement in work, play or activities of daily living that are part of one's sociocultural context and that are desired and/or necessary for one's well-being' (p109). So 'participation' is something that can't be freeze-framed in the way that 'performance' (of an activity) can be. 'Participation' is
forward-looking. It implies commitment to involvement in occupations over time. All of us participate in different occupations because we have different life situations and so one needs to think about whether 'Appraisal of ability' or 'Expectation of success' will facilitate occupational participation given the individual's circumstances and roles.

When we talk to our clients and significant others, we are able to find out, not just whether they expect to perform well in a particular activity, but whether they expect to succeed in their lives as a whole and this is what the MOHOST tries to capture in the item Expectation of Success. The criteria refer to the 'future', and 'feeling in control of where life is heading'. This is still worth contextualising within a particular environment in which the information is gathered because it may be that their expression of 'appraisal of ability' or 'expectation of success' is influenced by their current environment - it may be stifling the person or giving them a false sense of their own ability.

Finally, we need to take into account that for some people, long-term involvement with health services might be viewed as a necessary part of maintaining their well-being and for others there needs to be recognition that it leads to institutionalisation and dependence. So on top of everything else, one needs to consider the 'individual's developmental trajectory' that Jessica mentions.

It's not easy, and yet I really do believe that occupational therapists are skilled in being able to take all the different variables into account.

Keep on discussing your analyses with others!

Sue