



Model of Human Occupation

Archived List Serv Discussion

Memory Groups and MOHO

June 17, 2009

Dear All

I am an OT working in Older Adult mental health services. I am aligned to the early memory needs pathway. We are currently investigating starting a memory group as part of the programme of interventions offered.

I would be really interested to hear from anyone who has experience of running such a group within a MOHO focus. Issues I would like addressed include:

Structure/content of sessions

Selection criteria

Outcome measures

As a service we are currently moving our practice towards using MOHO so would be particularly interested to hear how this could influence the group.

Thanks in advance for your help.

Allison Crichton

June 23, 2009

Hi Allison,

Hope you don't mind, but I've cc'd my work colleagues into this correspondence. The psychologists are taking the lead in setting up a group within our memory service, and very kindly asked for the teams contributions.

I recently started working for a memory service. Prior to my new post, I have had ideas for memory groups for a long time now, from an OT specific perspective. Without sounding pedantic it's a group which specifically addressed difficulties performing or participating in occupations secondary to memory/cognitive difficulties- the emphasis returning to occupation, not symptoms.

Anyway, I created a group based program (although it may have likely been done before?) whereby the sessions themes were based around the MOHOST categories. I included an introductory session to set aims, get baselines, priorities, set goals etc (from an occupation perspective, not symptomology), and set the forthcoming agenda. After each session a goal (homework) was set- to achieve by next session. The whole program finished with a repeat of assessments (outcomes) and an evaluation of aims. It also included opportunity for client and carer to feedback via VAS scales to rate satisfaction with the program and VAS scale to rate satisfaction with any shift in knowledge and skills etc.

Example program might be:

Session 1: Introduction to the program.

Intro (the promotion and importance and contribution occupations play towards health and well-being. Our theory and philosophy basically! Get your clients on board!), baseline assessment, set aims and short term goal for following week.

Session 2: Motivation for Occupation.

Education on the importance of remaining motivated/interested in occupations- having/maintaining interests, finding new ones (with realistic expectations), exploring if anyone has stopped/reduced their level of interests, set a goal (eg. restart or find a new interest and incorporate it into your week).

Session 3: Pattern of Occupation:

Emphasizing the benefits of using current routines, structure, familiarity, usual responsibilities and roles so as to "get into the habit" of doing them so it becomes more automatic. All to help "anchor" occupations. Examples might be meal times, sleep routine, your shopping day, relative visits, housework day etc. Set a goal (eg: write down your usual weekly routine. Is there is room for more? or just more structure to it?).

Session 4: Communication and Interaction:

Explore "hands on" and "hands off" approaches to assistance (when and how to help and when not to help). Examples might be suggesting standby/distant supervision or agreeing to split a particular task, or the carer allowing extra time. And knowing when/how to intervene eg: when frustration builds or when the task is "breaking down". Finding tasks that are achievable yet still remain challenging. Set goal (eg: find a task that can be shared and examine how it's currently done- Does the carer intervene too much, thereby limiting the chance to fulfill potential and practice/maintain skills?)

Session 5: Process Skills:

The importance of simplifying tasks if/where possible (eg: signs on particular cupboards to aid search strategies OR de-cluttering the work tops OR setting up one work top to reduce using a variety of work tops- thereby reducing and simplifying the number of steps in the task OR putting up a sign which where you'll see it which goes through the basic steps of a task- incase you "lose-where-you-are" midway in a task). Set a goal.

Session 6: Motor Skills:

Resolving the difficulties a client has as s/he moves through a task. I've noticed that many people with dementia fumble with items and tools- "grip slips" and reduced mastery to manipulate items which once were not a problem. An example is opening containers such as can/tins! Explore the alternatives if they wish to continue with meal preparation (microwave meals?). Some have difficulties carrying/transporting items (eg cup of tea). Would a trolley help? Set a goal.

Session 7: Environment:

Explore safety (eg: gas supply, fire alarm), vulnerability (in/outdoors eg: visits to the bank/carrying money), I.D, contact (telephone?) security (house keys!!) of home and self in the home/outdoors. Explore the home environment's level of stimulation (TV, radio, lighting, leisure resources). Explore the resources in the community and can they be accessed- especially in winter? Examine social networks and promote the importance of engaging in social occupations. Set a goal.

Session 8: Outcome measures (repeat assessments) and evaluations of clinical and service quality.

OCCUPATION BASED OUTCOMES? Why not:

COPM

MOHOST

VAS scale client (eg: measure pre/post program the level of knowledge/level of satisfaction with life post-program/level of satisfaction with the program). Done so via a 10cm line (to dissect with a line the measure) or numbers 0-10 scale.

VAS scale carer (same as with client).

Check your long term aims and goals also!!!!

(BARTEL, other ADL measures are measures of dependence- not ability. Not performance +/- or participation).

Personally I think it's important to emphasize that if you are specifically treating occupation or running an occupation based program then that is what you should assess; that is what you should treat; and that is what you should measure. But, personally, I think if you are going to address quality of life then one would assess, treat and measure quality of life not occupation. Likewise with memory/cognition- if you are going to address memory/cognition (underlying symptoms), then you would assess, treat and measure cognition (I'd personally would argue that's not unique to OT or the role for OT). I would personally emphasize that quality of life and cognition are not aspects that we as OTs can uniquely contribute to/add to. Other professions treat impairment/symptoms within activity. I believe we should ADD to, not double up.

Finally though (nearly there, sorry). There are opportunities and benefits to working within a group program that addresses and brings together occupation together with other aspects of life (and brings, fuses the inter-disciplinary team together). Such things are raising awareness/education on the condition, cognitive strategies, behavioural strategies, medication, carer support.... It's an opportunity to all promote health and well-being together as a united team. Each can bring along their unique contribution-leading/facilitating on the week it's that particular professions speciality. After all, we all have a duty to work together, if there's the opportunity. It also promotes each others profession. For what one profession does may have a "knock-on-effect" with the other professions interventions, so working interdisciplinary, I would argue is best (not generic working. I believe that de-skills. And not in isolation). The only way to work interdisciplinary is with open communication and collaboration amongst the team.

I wish you all the best Allison, whether you chose to go OT specific or inter-disciplinary (not generic- YIKES. That' one reason why OTs are disappearing or leave the profession!).. I hope you get a good response.

I'm really interested to know how it goes.

Iain Stringer Band