



Model of Human Occupation

Archived List Serv Discussion

Evidence of MOHO on Secure Unit

July 11, 2008

Hi,

I work in the secure unit of a psychiatric hospital in Dublin , Ireland . We use some MOHO based assessments (AMPS, VQ, checklists and AOF-CV etc.) for our client group. I was interested to know if anyone could help me out to find more relevant evidences/ studies (including MOHO based) of best practice in mental health secure unit settings.

Kind regards,

Avinash Das

July 14, 2008

I am interested in knowing more about your population in order to comment. Do you have psychiatric inpatients on a locked units/s or is this a correctional/jail situation? What types of diagnoses do you see and what is your length of stay?
Sarah

July 20, 2008

Hi: I can share my experience working in different types of secure units. I will use the most typical one right now.

"Lock Unit for Difficult to Manage Patients". People with self abuse, aggression to others, due to psychotic symptoms or as (MOHO helped us to confirm), reactions to operant condition approach, and oppressive social environments..

Here we used the OPHI and OPHI-II (according to the years), the Volitional Questionnaire, the OSA, the ACIS. (The AMPS was used mainly to show the team the differences between volition and performance when we wanted to demonstrate the patient's skills versus his/her volition, when we needed to impact the court decision on declaring the person incompetent to make decisions).

We, as OTs were centered on the person and the impact of their environment on their occupational participation. Many times the use of the VQ helped to demonstrate the team that people needed to participate in normalized environments provided by rehabilitation services in order for them to improve their volition, and therefore their performance. This was a great process. I began with one person (externally controlled, passive in his volition at the ward and mostly involved in other occupational environments, so the team began to give us "permission to take other people" that had occupational therapy assessments done. At this time I was doing my research on the validity and reliability of the VQ, which confirmed the strong relationship that exists between volition and environment. We used the exploration module of the remotivation process in order to begin the process of people's getting ready for a change of environment and develop basic sense of capacity and trust on the environmental opportunities and some people. For that we change the physical environment in such a way that could "talk" to people, meaning that by itself could invite people to have initiative and feel different expectations for them. i.e. within the common room, we change (I mean therapist and clients) the way chairs were placed making different environments inviting to be by themselves, with others, and also inviting to engage in different activities, one corner was for reading, another for games, other for common projects, and other for TV. Before it was only one context in the room with chairs around and the only object was the TV. I coordinated this with nursing explaining them that nursing staff would have less stress and work because people would feel respected and calmer only with this new disposition of the environment. I ask for one volunteer from nursing staff for each ward. Only one that wanted to be part of it.. With these environments, OTs did individual and group work, assessed people and could apply the first steps of the exploration module. The rest was combined with rehab program outside the ward.

Role of OT was recognized by nursing and clients first, (even if at the beginning we had to change the physical environment everyday during three months because nursing staff changed every night).. Te rest of the team went to us for consultation and for understanding the person and his/her needs. Clients began to feel in control, and restrains and everything else like this diminished greatly.

We did this in every ward of the Hospital individualizing needs for each person. At the same time we developed meaningful OT programs based on MOHO, which provided a flow in a continuum of change. A great number of people who lived in these locked wards, could get to live in Halfway houses and participate in Clubhouse Community programs after following the flow of interventions.

If you need other experiences on forensic or acute units, let me know.

There is an article that was published in Mental Health OT Journal in march, 1983. called Application of Rehab. Models in a Public Psychiatric Hospital". de las Heras, Dion, and Walsh, where you can find a general description of the programs flow at that time. It does not explain details like this, but gives you a general idea.

I hope it helps
warm regards
Carmen Gloria de las Heras

July 23, 2008

Hi Carmen,

Thanks a lot for sharing your information about secure unit O.T services. Basically my workplace is a psychiatric secure unit with adult clients (some chronic and some acute). We provide few groups in the ward and when the client gets liberty to come out of the unit he attends O.T department services. We also have some environmental constrains in terms of available space and resources within the secure unit. So we are limited with our O.T. services especially about providing meaningful occupations to clients. I would appreciate if you could help me with more ideas and resources available to deal with these limitations and continue more purposeful O.T input for clients.

Thanks once again for your response,

Regards,

Avinash Das

July 23, 2008

Yes...Hi avinash. I have always worked with almost no resources...I have been creative on doing projects to raise money, in different settings. The example of the Unit I gave you was one of the realities in a Public Psychiatric Hospitals where money was restricted. When I arranged the only room that existed for them I did it with the same chairs, and the two little tables that were in there. I went to different professionals, to collect magazines of different themes, materials that could help to have meaningful projects that would connect people to the next step of their rehab. process, for example what was meaningful to the group in general was to get to be in control and get out of there. I had newspapers available in the project corner of the same room to connect their goals with environmental realities. I asked members of the Club Houses to come and share their experiences of own rehab. process with them and with that their accommodations to change, I could buy some supplies in some Units for art projects in general when I saw that was a common interest for some people. But not much. I arranged the rooms with what I could get donated or re-used or gave different use to the objects in the rooms. Also if you read the remotivation process, you could find an example of Lidia which was to one of these wards. As I was gaining the respect from others, I could get some budget to buy little but significant individual objects for people's personal space (the area surrounding their bed, because they slept together with other people) so they felt

validated in their interests and therefore in their identity. These details plus the use of self that is described in the remotivation process allowed the sense of capacity to build within residents/clients/people..That resulted on more personal control and for the rest "less maladaptive behaviors"... I did not have many resources. I had a reality with which I had to deal with, so within it I prioritized the main focus of what was possible to do, with clear goals on VOLITION...At the same time I trained nursing staff who was interested in this process and made them part of the team, they helped me twith information for rating the VQ, and felt more empowered. Using MOHO to understand other members of the team helped to understand how to go about facilitating the best social environment possible.

I suggest you evaluate volition on people of the UNIT or UNITS and prioritize which has been the occupations or tasks that have been meaningful. Many times we are not able to provide those opportunities on a secure unit, but we can provide a way to work together on their steps to get to them within their reality. For example, a person who love to sky, you don't have the mountains, neither the equipment to do it there, but you can provide in the mean tieme other ways to be connected to those interests such us a poster (related) in their space and magazines that he could read sports topics. Simple things to validate those interests. Projects mean continuity, they are not isolated activities. Projects involved paralel and cooperative groups, which are achieved within theme frames. They could include, making bulletins with information for other people in the Hospital, (using basic resources) and sending this for example to rehab Business center to type or making it better and then together solve problems, related to the goals of the projects.

All what we did in the OT Department (when I got there I was the only OT for 500 people, rest in rehab were mental health workers, little by little having students and then as we showed results hiring them. It grew with clear goals , using MOHO across the Hospital, creating resources, and then asking for more support when they saw results.

We don't need to have all resources to apply MOHO. MOHO represents real life, and real life is lived solving problems, making decisions with clients, and building a program with them.

You tell me you have some acute patients in your Unit. Having the physical environment offer messages that validate their needs and basic social support for that , is part of what they can use at that time of their process (if they are in crisis) and also validating what they feel, while their medication begins to work. After they feel better, you begin with next step.

There are more examples, let me know....

I have been developing programs all my life as OT (26 years) and always with no resources, we made the programs together with people. An example of Reencuentros, a Community Program well recognized in Latinamerica and the world is featured in the 2002 MOHO BOOK.

Big hug, and keep asking if you need more precise ideas...

Sincerely

Carmen Gloria de las Heras, MS, OTR

Santiago, Chile

July 28, 2008

Avinash,

Sorry I am responding so late. I started this email and it has gotten buried in my "draft" file as I wanted to give you the few other reference people we use.....

Maybe some of our experiences may be helpful as ours is a 37 bed acute care (short term here being 1-3 weeks hospitalizations generally) psychiatric locked unit.

We currently are using a brief version of the MOHOST (Model of Occupational Screening Tool) which is good for our fast turnover as we assess each patient in 72 hours after admission. We used to use the OCAIRS, which I prefer, however it is time/manpower prohibitive. I like an interview tool as it helps establish tx goals, rapport, and gives the therapist and pt a direction/purpose. We occasionally do the AMPS with people where there is a question from the treatment team around type of living situation that would be most beneficial/safest for the pt. We also use the following occasionally when indicated: Sensory profile, ACL, and the old simpler version of the Interest Checklist.

We have 3 tracks of groups for different levels of patients as we find dividing them for specific groups necessary as the unit is so large as well as helping us meet individual needs more effectively. We do have some groups open to all where a varied population works as a plus.

We use MOHO as our overarching theory to direct practice but I have noted other authors we use in a couple of groups below. Group content is chosen based on people that will be in a particular group and we try to cater to individual needs and interests as much as one can within a hospital group setting that presents multiple limitations.

Here's a breakdown of our groups:

OT and MT Groups open to all designed to facilitate socialization, collaboration:

Exercise Group*

Music Listening*

Recreation

Track I: For patients needing 1:1 due to confusion, limited intellect that makes inclusion in higher functioning groups detrimental. Groups focus on focusing attention and gathering assessment data: (these pts also attend the groups open to all.

Structured Music*

Structured Leisure

Track II: For patients who are psychotic, disorganized and/or seriously depressed where thinking is disturbed. Groups have structured topics and or skills that are the focus. materials are presented in a concrete manner to facilitate learning.

Relaxation - highly structured/concrete exercises

Leisure Options

Focused Music*

Work Group

Track III:

Assertive Lifestyle - communication skills and optimizing daily routine (Alberti & Emmons, Bower and Bower, Eifert, McKay, & Forsyth)

Constructive Living - mindfulness focused (Thich Nhat Hanh, David K. Reynolds, Gregg Krech)

Leisure Development

Music Therapy*

I am fine with sharing any of our group protocols if people email me separately so you could get a better idea of group content but the names are fairly descriptive. Where they are not, I have added a little info.

We document on each patient after each group using MOHO specific formats which I sent out earlier. I believe these, the assessments, and formal/informal communication with interdisciplinary staff are crucial to educating staff about what we do and can offer the patients. We would love to be more active in dc planning. Currently we make recommendations however limited supervised living facilities and day programs make it very difficult for Social Workers to locate appropriate follow up and we have a lot of recidivism. Most recently we are beginning to look at developing some groups around this issue.

The majority of groups meet multiple times/week. I can send anyone a copy of our overall schedule if you like as SW runs 1 group/week, an advanced nurse practitioner runs 6 groups/week, and a few others run single groups during the day shift. Nursing does groups on evenings.

* facilitated by our Music Therapist and her 2 students

Sarah

Sarah T. Skinner