



## Model of Human Occupation

### Archived List Serv Discussion

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#### **MOHO for Adolescents**

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**October 6, 2008**

Hi all,

I am a basic grade OT working in an adolescent inpatient mental health unit for the last 9 months. I have been trying to develop the service so am looking for advice on what I can do.

I really feel MOHO fits this client group and have been using the OCAIRS quite often as an assessment and trying to fit the concepts into treatment programmes. I would like people's opinions on what other assessments would be useful for me to use especially something as a brief initial assessment tool and perhaps an evaluation tool.

I would also be interested in talking to OTs working in a similar area on their service-at present I see clients both individually and in groups. groups include Goal-Setting, Life Skills (looking at self-esteem), Pottery and Cookery. I would like to make these more occupationally focused. I would also appreciate any advice on what to focus on with clients individually-I mainly seem to be looking at routines and interests.

Any help would be greatly appreciated,  
Thank you.

Orla Darcy

**October 8, 2008**

I am currently working with an adult inpatient mental health unit, but spent several years working with adolescents. MOHO has been a useful model of practice in my experience.

Assessments I might suggest

- 1) AOSA - Adolescent Occupation Self Assessment
- 2) MOHOST - Model of Human Occupation Screening Tool

Both are good quick screening tools.

Group Designs I have found effective:

- 1) Work / Store - I developed a group that require participants to pass an interview process. Once "hired" they work for an hour long group 2x/week on work tasks (producing art for holiday cards, stuffing envelopes, assembling toys to donate to shelters, etc.). Employees get paid (a photo-copied dollar) which can be used to purchase

items from a store that is available to them 1x/week. The work group helps them to develop behaviors consistent with the role of worker and has been largely perceived by clients as highly motivating (the more real the work the more serious and focused the kids have been). The store supports real life lessons like saving money, impulse control, losing money and finding a better organization system, etc. I try to keep the work group as real as possible, including warning or firing kids who are unable to meet standards for acceptable behavior. This has provided "real-life" consequences for kids who have learned some important lessons as a result.

2) Attention Skills - Using the evidence from mindfulness based approaches (DBT, ACT, Morita Therapy) as a guide I have developed games and activities to improve attention skills. Though these theories exist outside of MOHO, I have found ways to apply the concepts in ways consistent with a MOHO framework. Please refer to my website [www.moritaschool.com](http://www.moritaschool.com) for further information and assistance. If you Google Dialectic Behavioral Therapy (DBT) or Acceptance and Commitment Therapy (ACT) you will likely find some helpful resources as well.

Best of luck. Hope this is helpful!

**October 15, 2008**

I've not heard of the AOSA. How do you get hold of it? I work in CAMHS and I use the COSA -Child Occupational Self Assessment and the OSA -Occupational Self Assessment but would find an assessment between the 2 very useful.

Sandra Town

**October 19, 2008**

Sandra and all-

The AOSA was an "adolescent" version of the OSA that was developed for specific client group with unique needs. It was designed through a collaboration with a clinician (Stephanie Conoway) and a researcher previously with the MOHO Clearinghouse (Dr. Amy Paul-Ward). It had items and occupations/issues that were specific to the needs of adolescents in inpatient mental health facilities, but who came with a history of family trauma, placement in foster and group homes, and/or abuse. Because the young adults came in crisis and were often highly distrustful of adults and the assessment process, the rating scales for competence and value were abbreviated- 2 point scales were more appropriate for this group, and facilitated their involvement and were not as overwhelming or threatening. Some of the items had line drawing pictures, and these core sets of line drawing items were used for the adolescent to identify goals for therapy. The AOSA has not undergone psychometric development or research, but in this specific setting, has good clinical utility. This brings up a great point about assessment validity- in this group, this assessment results in the most valid and meaningful decisions. Validity is not a property of the assessment, but of the interpretations that are made based on the assessment. Because the OTs who developed this were very skilled in their use and

understanding of MOHO, and were experts working with this client group, they were able to design an assessment with good clinical utility and clinical "validity". If you are working with a group of similar young persons, you may find that this assessment gives equally valid results in your setting. However, compared to the OSA and COSA, the items are much more specific, some of the sensitivity to track outcomes is lost (because it uses a 2 and not a 4 point scale), and the process of setting goals is confined by the set of core items (where the OSA and COSA is a bit more open ended)- for some client groups, although you "give up" these options, you gain by using an assessment that has more clinical meaningfulness.

I hope that Stephanie and Amy Paul-Ward will respond and provide you with their latest copy of the AOSA. In addition, I know that Dr. Ward has been doing some pilot projects with the assessment, and may have some information on the assessments' psychometric properties. However, there has been extensive research on the COSA and OSA with a wide range of client groups- check the evidence brief section of the MOHO website: <http://www.moho.uic.edu/generatingevidence.html> and also on the actual reference list page.

Best of luck to you!

Jessica

### **October 22, 2008**

We may be able to make the AOSA available to clinicians. Dr Kielhofner and I have discussed this and we will let people know if and when this is possible.

Sarah

### **October 23, 2008**

Excellent,  
many thanks,

Regards,  
Shona