



Model of Human Occupation

Archived List Serv Discussion

MOHO and Occupational Therapy

April 29, 2008

Hi,

During the last month, I have been approached by two individuals, one a personal coach and the other a professional who works in the substance abuse area. These individuals have expressed their interest in the MOHO, and more specifically, in using some of the MOHO-related instruments. What are the implications for occupational therapy if individuals who are not occupational therapists use the model and the instruments congruent with this model in their practice? Does this mean that one does not require occupational therapy training in order to provide occupation-based practice? I would like to have your thoughts, and perhaps experiences, regarding this issue.

Thanks

Chantale Marcoux

May 13, 2008

Hi Chantelle,

I've been putting off replying, wondering what other answers you'd receive. As ever, Carmen's response is wonderfully person-centred, reminding us all that our purpose is to serve the individuals with whom we work. I would also much prefer to work collaboratively with other disciplines, sharing our opinions and supporting colleagues to view people as occupational beings. I view sharing MOHO tools as part of a continuum with regard to sharing our practice - something that requires us to exercise clinical judgement when investigating the potential benefits.

On the one hand, as I understand things, there would be nothing to prevent another professional accessing the MOHO website and purchasing the manuals, which require all the necessary instructions to complete the assessments. However the beauty of the assessments is that they are

1. evidence-based
2. occupation-focused
3. and theory-driven.

If these 3 advantages are to be realised then one needs to consider the following issues:

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1. the evidence base for MOHO assessments rests on research that has been conducted (I think, though I'm happy to be corrected) among the occupational therapy profession. If so, there is no evidence as yet for other professions utilizing the tools in a standardised fashion. One could argue that thus far we have the evidence that the tools work well only when the assessors have completed their recognised occupational therapy training. This concern, could of course be disregarded if one is convinced that utility is more important than research findings in the clinical setting.
 2. occupation-focused assessments identify occupational needs which require occupational interventions (i.e. occupational therapy). One would need to be assured that these interventions were available if the assessments were to be used.
 3. in order to rate and analyse the assessments, one has to be familiar with MOHO theory. The ratings relate the practical experiences and observations to theoretical concepts and I understand that there is some evidence that without this theoretical understanding, the validity of the tools may be lost. (I once heard that an earlier version of the OPHI was not based on a theoretical model and that inter-rater reliability was not achieved). At a deeper level, I suspect that an understanding of the philosophy of occupational therapy is crucial, as it is the philosophy that breathes life into the model. ... Of course, the use of self-assessments is less problematical, though a clinical decision needs to be taken as to when these are made available.

In my experience the issue as to whether to share MOHO tools is often a political one as much as a person-centred one and the occupational therapist needs to be confident that their role is not going to be eroded by sharing their assessments. Where the occupational therapy role is valued then everyone has much to gain and the occupational therapy role may be enhanced by taking on a consultative and advisory status. In other circumstances, the unique role of occupational therapy may be better preserved if the therapists act as gatekeepers to these resources. Each occupational therapist needs to arrive at their own conclusion, having analysed their own situation.

I'd be interested to hear any further comments.

Sue

April 29, 2008

Dear Chantalle: One of the beauties of this model of practice is that it gives meaning not only to occupational therapy interventions but it makes other disciplines to be interested on it, they find it very useful to understand occupational participation. In my years of experience I have worked in both public and private practice, both in Hospitals and Community. Depending on the settings I have worked, I have shared, thought, collaborated with, been "helped", worked with, learned from etc. with many people; professionals, different disciplines, nursing staff, families, clients, Directors of Schools, educators teachers, employers...and depending on the needs.

First, I can tell you that any professional could learn from the other the related knowledge, and it is needed in order to work as a team and understand the person as a whole. This is something that occupational therapists need to work on, the openness to other disciplines vision, theories and assessments. In the other hand we can share our knowledge about MOHO, (some of them are interested to read the books, manuals and stuff) Why not???? I have done it with very good results. That does not mean that they have to be OTs, but means they are interested on doing a better job.

Now, there are assessments which many times require other people's observations, as MOHOST, SCOPE, VQ, , PVQ, ACIS. and we have to be able to teach and monitor the data collection from the others (remember also families, relatives, friends of clients, clients, all I named above) .

MOHO theory and application go to real life of people, and stands on people and environment constant relationship within occupational participation, this means that we have to recognize that we are not the agents of change, but we facilitators as part of the social context of individuals, and everybody else is. The OT approach should be to be centered on the client and work together. Occupational participation process and its facilitation implies that OTs don't be afraid of applying MOHO procedures with others, the opposite, many times we should be able to recognize which social group or individuals can have better impact on people. There are specific interventions of course that we need to do just ourselves, like other professionals with their own.

I also think that this issue need to be analyzed from different perspectives depending on the kind of team you are working on (multidisciplinary team, interdisciplinary team, transdisciplinary team...). In my work at an State Hospital, thanks to the application of MOHO from part of the OT department, we got to transform the nature of the team, a team that included as its most important member, the client/family, a team which had the OT as leading the context of treatment planning, and a team that collaborated on all processes of real life. We got doctors, nurses, together with many other workers participating at facilitating occupational participation. In many of the programs.

Working in the Community, Reencuentros, we made teams with each persons psychiatrist, social worker, psychologists, family etc. according to each person. We worked as a team with Community agencies, occupational contexts' social groups, in different ways.

This sharing and collaborating using MOHO requires knowledge and clarity from part of the OT. The ways this process can take requires a careful evaluation..on how to do it well..

I think MOHO has defined our role as occupational therapists. I invite you to reflect on our principles and our identity, and about the occupational nature of human beings. The clearer we have it, the least is the fear we have to work with others.

I hope my thoughts are clear enough...If you need more, please let me know
Warm wishes
Carmen Gloria de las Heras

May 18, 2008

Dear List Members

I am interested in this discussion because I am a social worker and and OT. I am working as a training officer in Learning Disability in the UK. The current policy is for integrated teams of nurses, OT's. SPLT, Physio, Social Worker and Clinical Psychologist to work together.

There is a strong behavioural approach well researched, that is used by psychologists to understand challenging behaviours as communication. This model is the multielemental model developed by Gary W. LaVigna, Ph.D. and Thomas J. Willis, Ph.D. The focus is on seeking out the environments in which challenging behaviour does not occur and working for the individual to have more opportunity and a better quality of life based on his/her choices. Motivational aspects of the model are not, in my view, well developed.

In my view it is a great model to work as a team to move forward with professional consensus into seeking an environment which meets the person's need. Often a house of his/her own or shared with others. However I wish the team would then respect that a phase had been completed and so move onto developing a meaningful life with the individual using MOHO. Unfortunately most teams I know do not have OT's. Social workers, who are the care managers, do not know the MOHO model as it is not taught in their practice. However behavioural models are taught in social work practice under the generic name of positive behavioural support and as a topic within systemic practice - Behavioural family therapy. This means that the care manager continues to rely on practitioners with behavioural expertise, who once the clinical psychologist has finished are usually the community learning disability nurses. They may not have had the longitudinal training in the multielemental model and so do their best with a less complex behavioural model. This focus on behavioural work is then compounded by the training that I offer support workers in a topic unfortunately called "Managing Challenging Behaviour" (Unit 115 Level 3 LDAF). This is a two day course for support workers working with people who challenge. The staff afterwards completes an assignment which is marked.

In my view the net effect of all this focus on behavioural models is that for a significant proportion of service users in learning disability services, who are need assistance to express themselves, the

activities they enjoy are written up in a person centered plan. The person is then supported by the support workers to engage in the activities described in their plan. However these activities may have little meaning in terms of the person's development and thus the 'meaning of life' for the person is lost. Person centered planning is a tool, in my view it is not a model within which clinical practice can be pursued.

I would really appreciate it if someone could author a MOHO text for the other professions in the integrated or multidisciplinary team. I think MOHO has come of age and we have a marvelous model complete with many tools and that it is a meta-model within which other professions can locate their practice, when the focus is on increasing the independence of the client.

I would love to see a MOHO text for members of the multidisciplinary team.

I am also training officer for an employment team for adults with a learning disability. They again have no OT. The manager is interested in the MOHO model but currently I cannot commission a course for staff to learn how to use MOHO if there are no OT's involved. The manager recently sent me an invoice to pay for one of his staff who had had training in Systematic Instruction. He said he would have preferred the staff member to have had a course in MOHO.

I did let Rob Grieg the former director of Valuing People know that I felt that things would only happen for service users if Occupational Therapists were harnessed to the implementation. I do not think he understood what I meant, as in my mind understanding and using MOHO is essential if the Valuing People White Paper is to be effectively implemented with service users.

Jess Mortimer

May 19, 2008

Thank You Jess for your thoughtful contributions to the MOHO list serv, and for sharing your experiences as both an "insider" and an "outsider". MOHO has certainly been taught to and used by other interdisciplinary professionals with success in the past, but as you mentioned, still most publication AND education occurs within the OT context.

I believe some people have chapters about MOHO in other areas- for example, I believe Dr. Kielhofner worked with some scholars in Canada working on a book on occupation (I think?!) and also I know my colleague Susan Cahill, faculty here at UIC, contributed a chapter about MOHO and students with CP (again, I believe- hopefully they can weigh in on this

discussion).

In your training, have you introduced any MOHO assessments as potential solutions? Have others found them useful? If we can provide you with any resources or information, or if others can contribute, please do let us know.

Best to you-
Jessica

May 20, 2008

Hi All

I am working as a part-time sole OT in an adult community learning disabilities team in Wales. I do agree with Jess that using a MOHO approach with this client group offers a huge potential and often fills a gap that is there in terms of actually "activating" a meaningful personal plan. However I also agree with Sue in that this is a political issue too. In my experience the general public and other professionals/ managers understanding of what we can offer as an OT is not a true representation of what we can do. It has taken me 4 years in my present post to educate others that my role is more than giving out slings and equipment, even with the support from Valuing People (Fulfilling the promises in Wales) and statements from the COT LD special interest group. They do recognise the wider role I can have, but many still focus on referrals around equipment as they see it as the OT's "specialist" role. My thoughts are that MOHO is a fantastic tool to educate others - public, clients, and professionals, about the true potential of OT intervention and could be used to promote the profession. I strongly believe that a collaborative approach is best, but would have concerns "losing" our unique contribution and risk eroding the OT role and posts further in areas of LD and Mental Health. As a profession what could we learn from the pioneers of CBT and Solution Focused/Brief Therapy to highlight the uniqueness and potential of our profession?

I also wonder if we as a profession sometimes underestimate the theoretical synthesis that has taken place to enable us to be competent practitioners. How many times have you heard an OT say "Oh, OT its just common sense"? Why the urge to undermine the complexity of the job we do? I do believe in collaborative work and sharing roles and responsibilities (I am happy to be a case manager if appropriate) but am concerned that offering MOHO on a plate to others with different background training could be another example of belittling what we do. Or may be I am being too precious! What I do know is that when I have spoken to OTs who was nurses prior to that, they have described the transition much more difficult than they expected. They explained they had to "unlearn" much of their previous roles in order to begin to learn as an OT. Therefore would providing extra knowledge to professionals/workers have a significant impact on the intervention that is offered? The type of OT/Nurse/Social worker/Support Worker that we are, is it not more than the information that we were provided in training?

Catherine Hadrill