



## Model of Human Occupation

### Archived List Serv Discussion

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#### Tool/Ideas for Practice

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**April 15, 2008**

Hello everyone,

My name is Lucas Milne. I am a sole Occupational Therapist working in an adult Community Mental Health Team in rural South Australia. I have been working in mental health for just under 2 years and have become increasingly frustrated by the generic nature of the role. Until now, I have performed the role of a case manager and just applied occupational therapy principles in my work with individual clients. The multi - D team which I work with consists of 2 nurses, 2 social workers and the team leader, who also happens to be a nurse. Whilst these clinicians are mostly very experienced, most have had very little, if no contact with occupational therapists in mental health. The general culture therefore is the belief that we all "do the same."

I have spoken with my team leader and expressed my desire to make better use of my time and skills by delivering a more OT specific service, with MOHO as the model for practice. Whilst he does not entirely understand how that would look, he is fortunately amenable to the idea of change and my job description allows for flexibility. My thought is that I would act as a consultant for the team and effectively 'case share' clients with occupational issues, whilst also retaining a small generic caseload.

I therefore would like some guidance re the following:

- Which tools are essential to be able to deliver a comprehensive OT service? I have recently completed AMPS training and am in the process of calibration. I also have used the OPHI in the past. I have ordered ACIS.
- What is the most effective way of informing the CMHT of the role of OT and is there a referral checklist/criteria available for use to pass on to other team members?
- Where can I find information about effective group programs that have been run by OTs using MOHO principles?

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Hope you can assist. Any other thoughts/ideas would be much appreciated.

Regards

Lucas Milne

**April 16, 2008**

Hello Lucas,

the question you pose is a good one. I hope you will get some equally good answers. I know that many OT's in the UK have faced similar challenges in mental health where "generic working" was a model and health care providers were viewed as interchangeable. I know there have been some presentations and perhaps also publications on how to overcome the generic role and do more OT specific intervention. So I am hoping you get some specific responses from the UK.

On the issue of use of tools, I think I can give you some guidance. The first step is really to decide what you want your role to be and what kinds of service you can realistically give. This will depend on your caseload and how much time you have available. But I always believe that the assessment should be chosen to fit the service role. The MOHOST would be useful as a general overview assessment. Since it can be flexibly applied (with multiple/mixed sources of gathering information, including active involvement of the client) it could be used across all clients. Also, it can serve as a screening tool to provide info about where more specific assessment such as the AMPS and the ACIS might be warranted. Both the AMPS and ACIS are very specific assessments targeting skill and should be used when it is clear there is a skill problem and detailed information is needed to guide treatment planning for a skill-oriented intervention. The MOHOST gives info on the person (volition, habitation, and skills) and on the environment and for that reason would be potentially useful for capturing the client's overall occupational status and needs.

The OPHI does give a broad overview of the client's occupational life and allows in depth exploration of the client's life history and narrative. It is most effective when you will have an extended and fairly intensive role with the client and with clients who can really work toward life planning. We have found in our research it is an excellent predictor of program compliance and productive outcomes. It requires a fair amount of time and is best used when you have

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available a fair amount and intensity of intervention time with clients. The OCAIRS is a briefer interview that also gives a wide range of information and because it is more efficient some providers prefer it to the OPHI; it is not a life history or a narrative interview but focuses on the here and now and where to go next.

The OSA is a client-centered and client-administered assessment that can give good information on the client's level of participation/performance and client satisfaction. Its a good assessment to use to involve the client in the treatment planning process and to facilitate collaboration. It can be combined with the MOHOST or the OPHI or done alone. The Role checklist is another brief self-administered instrument that can be helpful in assistant clients to think about their life roles.

As for appropriate referral, we have developed in the past some fairly straightforward checklists for case managers or physicians to use in referring clients to OT. You might for instance, if you use the MOHOST, create a brief checklist based on the main emphases of the MOHOST for referral. I also suggest when you receive referred clients to give an assessment report back to the referring provider so they know what you did and become more informed in what clients to send your way.

There are a number of group formats based on MOHO that have been published. You might want to use the evidence-based search engine on the website. Also you might want to download the free Enabling Self Determination and Employment Options programs from the website as some of the group formats we used for these programs would be relevant. See also the work Renee Belanger has done in Quebec and the work Carmen Gloria de las Heras has done in Chile (the Remotivation manual, available form the website would characterize some of Carmen's approach) that are discussed in the program chapter of MOHO book.

Gary Kielhofner

**April 16, 2008**

Hey Lucas,

My name is Rosie and I'm a community OT in CAMHS (Child and adolescent mental health) in New Zealand . I think the case manager vs. OT dilemma is a big one for OT's in comm.. mental health in New Zealand too and this is a challenge we face at my service constantly. I think its really important for you to link up with other OT's within your

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health board for supervision and peer discussion. Delivering an in-service presentation to your MDT is always a great way of letting them know what you do. My experience is that you need to develop your own criteria/checklist specific to your client group and be flexible with it, but be sure to outline what your service is NOT useful for (e.g.: It may just happen that you get a list of people that you need to find jobs for).

I think it's a good idea to get information about other successful group programmes but be sure to look to your client population for group objectives and aims. Also look to your community for ways to incorporate integration back into the community for your groups (gyms, internet cafes, assisted employment, community halls etc for cooking, etc)

But most of all good on you for stepping up and trying to create an OT service for your clients, it'll be a challenging journey but well worth it!

Rosie Brown

**April 16, 2008**

Lucas-

Dr. Kielhofner touched on a lot of great ideas, but I will provide one more.

In the UK, clinicians working at Derbyshire Mental Health Trust developed an OT priority checklist, which is posted at

<http://www.moho.uic.edu/mohorelatedrsrscs.html#OtherInstrumentsBasedonMOHO>

You may find this useful.

Best of luck to you

Jessica

**April 18, 2008**

Hi Lucas,

I work in the UK in Community Learning Disability with previous experience in mental health. I have no idea if this is helpful but I will share my most recent experience.

I have been with my current team for a little over 8 months. I use the model as my practice guide. My personal view is that you will have a greater impact through demonstration of the value of OT. My team like many others knew they needed an OT but didn't really know why. My strategy for establishing an OT specific role was as follows,

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Identified what the service was trying to achieve and through clinical contact started to establish what the clients wanted to achieve.

Through participation at team meetings I identified the nurses who I thought would be most open to joint working and who were feeding back issues which I identified as potential having potential through OT intervention. I then used the model and the terminology to explain “doing” behaviour and most often why clients were having difficulty with occupational participation and performance. It's interesting that the team are starting to talk to me in “occupational therapy language” if not always overtly then conversation has had that flavour.

My third strategy was in the report writing. I produce OT reports based on a framework from previous employment which nearly always remind clients and professional of the link between occupation and wellbeing and then explain current occupational behaviour in terms of motivation, habituation, performance skills and environment. The reports have gone down really well and for some it has been like a “light on” moment.

Finally the assessments have been key in demonstrating change and support needs for our clients. This has often been validated in greater success in support provision post OT intervention and our MDT experience of client change

Not every intervention has been a success but our referrals have started to become more OT focused, and at MDT meetings referral discussions are centred on issues

concerning “doing”. OT was described as the “missing link” for the team last month. Rightly or wrongly I took that as a compliment!

I firmly believe that the MDT, carers' external organisations will conceptualise what they see, so I am firmly in the learning through experience camp.

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Good luck

Alan White

**April 18, 2008**

Hi Lucas,

I'd like to echo Sarah's message, and confirm my own experience of how using MOHO tools has helped the multi-disciplinary team to understand the focus of OT. The MOHOST can be useful because data is gathered from multiple sources, including the wider team, so by completing the MOHOST with a colleague you can validate their observations, at the same time as gently educating them regarding your focus. However, in the community teams where I work, the OCAIRS and the OSA are the initial assessments of choice because clients are usually able to participate in interviews and self-assessment processes. (The OPHI 2 is fantastic too and those who work with clients on a long-term basis are investigating this tool). The clinicians find that their clients are able to confirm that no-one else has asked them the questions posed by these assessments and that clients start to have 'light bulb moments' during the course of the assessment - making connections about how their current circumstances affect their mental health, and in some cases going on to immediately set their own goals. Occasions like these are fantastic, and by sharing your excitement with the wider team, you reinforce the successes of being able to work as an occupational therapist. In fact, I've heard some examples of team members needing no support to recognise the value of OT; where, after seeing a MOHO assessment, they have commented "So that's how you get the results that you do", " So that's what you focus on", "That would be really useful for my client" etc etc.

We continue to struggle with pressures for generic working, but without MOHO, I don't think we'd have been as successful in maintaining our OT role as we have been, (I recommend that you read Stewart L, Wheeler K (2005) Occupation for recovery. Occupational Therapy News, 13(11) 24-25 to see how my colleagues Louise and Karen tackled this issue with a graded group programme to integrate clients into the community - contact me if you are unable to trace it). MOHO has given us a language that can be used across the organisation (80+ OTs spread across 40+ sites), so that our colleagues are able to recognise what we have in common as OTs instead of noticing what we do differently. Our practice is becoming more standardised (with a small s) too, so that we have moved away from 'anxiety management' to 'life management' (lifestyle redesign) and in older adult and learning disability services we are no longer known for our expertise in 'aids and adaptations', but more for our skills in 'occupational adaptation'. In some areas, we are now much more likely to get a referral for a specific occupational therapy assessment rather than a requests for a specific intervention. On this issue, whatever the referral requests, we need to take responsibility for gathering the most

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appropriate information before we embark on an intervention, and so it's always wise to start off with an assessment that covers all the MOHO concepts (OSA, OCAIRS, OPHI 2 or MOHOST) before diving in with an interest or role checklist, an ACIS, VQ, AMPS, WRI or WEIS etc.

Finally, we are now able to use the data collected from MOHO assessments to try and influence our managers. We have found that in those areas where OTs work mostly as OTs, at least 80% of their assessments are occupation-focussed, whereas for those whose workload is mostly generic, the reverse is true and at least 80% of their assessments are generic. If we cannot use occupation-focussed assessments, then how can we demonstrate the effectiveness of occupational interventions? (My colleagues and I are currently working on revising an article that has been accepted for publication in the British Journal of OT, which describes the results of these audits in greater detail).

To summarise: we need occupation-focussed assessments to build our evidence base - I very much hope that by demonstrating your effectiveness using occupation-focused assessments, you will be able to shape your workload to the benefit of all - your colleagues as well as your clients.

Best wishes

Sue Parkinson  
Practice Development Advisor for OTs  
Derbyshire Mental Health Services NHS Trust

**April 20, 2008**

Dear Sue and others-

It has been very encouraging to hear your reports from the UK and elsewhere about OTs role in community mental health and other settings and the use of MOHO and how it has helped you and the people you work with.

I work at UIC with Dr. Kielfhofner, and study the OT workforce and job market. Here in the U.S., the number of OTs in mental health settings has declined over the years. Although it is clear we have an important role in community mental health programs, the pay scale is often less than what is paid in other facilities, and that is one factor that has contributed to the decline in OTs in those settings.

I am wondering how wages are structured in those (lucky) countries that do not have our profit driven system. Are salaries comparable for OTs in different practice areas? Are they set by the government centrally or is there local variation?

I know this isn't your typical MOHO related question, but the difference in what we are able to do with MOHO here in the U.S. is constrained by

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these issues. Any insights would be appreciated.

Gail Fisher

**April 20, 2008**

Hello Gail (and others!),

I can tell you that in Quebec, Canada, the health care system is primarily government managed and unionized so the wages are set by union contracts and thus, the same for all OTs, regardless of the areas of practice. For those who work privately in a clinic or have their sole office, hourly rates are pretty much set by the market. What is certainly different than in the US is that OTs in mental health make the same salary as OTs working in other areas of practice.

I can share with all of you that the MOHO is a model we are encouraged to implement (for example by our OT regulatory body) in our practice in mental health so that we keep our OT identity strong. Currently, in Montreal, where a major system reorganization is taking place, the tendency is to limit planification of interventions on strong scientific evidence (and most comes from psychology who have those RCTs). If there is no scientific evidence, then it is seen as useless. We are still seeing some psychiatrists imposing on health care professionals, including OTs, what to do. Many of my colleagues are promoting very strongly the MOHO in their multidisciplinary teams and when other professionals learn about it, they discover something about OT they did not know and find very interesting.

Have a nice day,  
Nadine Larivière

**April 20, 2008**

Dear Gail

Here in NSW Australia all OTs who are employed by the public system are paid at an 'award' rate which is fixed according to level of responsibility of the OT position. Most of the other states in Australia have the same systems which mean that OTs working within the health system all get the same grading no matter what the speciality. Pay awards are negotiated between the state governments and the Trade Unions. In Australia, the main specialist area which falls outside of the 'state award system' is occupational rehabilitation in which the majority of OTs are working for private rehab companies or for insurers.

Many mental health services are provided by non-government organisations and OTs do work within these services. However, the NGOs tend to pay at a lower rate which makes recruitment of OTs difficult for them. In other rural areas and in regional towns where

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recruitment of OTs is sometimes difficult posts which were originally OT/social work etc posts are advertised generically as mental health worker positions to assist with recruitment. This can lead to the loss of allied health specific positions as they become filled by nurses who tend to graduate in larger numbers. When new grad or other OTs then fill these posts they can fill isolated. However, in my experience when OTs patiently explain our role and what we can do to improve consumers occupational lives team members are happy for OTs to do discipline specific interventions. I think we need to remember that other team members would also prefer to be discipline specific work including nursing, social work roles e!  
tc.

Many OTs in NSW are wanting more information about MOHO assessment tools. I provided a workshop last year at the NSW Mental Health Forum on MOHO and assessment tools, and am providing in-service training for two health services in Sydney next month. The main reason for the request for these workshops are services seeking occupation-focused assessment tools to guide practice and to provide outcome measures.

regards  
Sam

**April 21, 2008**

Hi Gail

I'm no expert so others feel free to correct me, but my understanding is that in the UK, most OTs either work for the National Health Service, or Social services (both statutory, government funded). In the NHS there are fixed (centrally determined) pay scales so there are no pay differences within specialities. I think that in social services, which I am less familiar with, there are some minor variations as each locality has more autonomy over its budget.  
Hope this is of some help  
David

**April 21, 2008**

Hi Nadine,

I'm Dr. Kielhofner's post-doc, Jenica Lee, nice to meet you! I've been following this email thread pretty closely, and it's both exciting and interesting to learn how practitioners all over the world are using and supporting MOHO and its related tools in their practice.

I think you brought up an interesting comment surrounding the issues of availability "strong evidence" in our practice- esp. about how you alluded to the fact that RCTs appears to be the standard for providing the strongest evidence- RCTs are great, but do not and cannot address every practice issue. The reality is not every client we see is status post knee or hip replacement, but rather most clients we provide services to have very

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complex co-morbid, medical, psychosocial issues that an RCT not only impossible to conduct, but just can't simply answer. The right evidence really depends on the practice decision that is being informed, (e.g. the needs of the client), so we must embrace all forms of evidence that will accurately inform our practice decisions.

Another issue surrounding evidence-based practice is low uptake of evidence by practitioners. Lack of time, heavy caseload, lack of skills to finding and interpreting evidence were major barriers to accessing and using literature. Dr. Kielhofner and I actually just did a workshop at the AOTA conference to help address some of these issues.

The MOHO Clearinghouse has made efforts to organize evidence and have developed a wide range of resources to make evidence more accessibly to practitioners, including:

1. Evidence based search engine available on the MOHO website. This allows you to access all forms of evidence including case examples and illustrations in book chapters or documented programs of list-serv discussions related to that topic.
2. Evidence Briefs available on the MOHO website. Summary of studies noting the research questions, population, methods, findings, and practice implications.
3. Clinical question papers: Review papers that synthesize all the current evidence related to clinical questions relevant to a specific area of practice. For example, I did a paper that synthesizes all the existing MOHO evidence that addresses current work-related practice issues including what MOHO assessments would be best to use in a work-related program? What factors contribute to successful work-related interventions? And What kind of outcomes can be achieved with MOHO-based work-related services?

I have attached the pdf of our AOTA presentation that discusses this topic more in detail. It's a lot of slides, but the 1st third of the presentation is on the evidence currently available on some of the occupation-based practice models that are used in our field including MOHO. I did a literature review on these models and did a side by side comparison looking at the theory, technology for application, and its research based. the 2nd part of the presentation illustrates how we generate evidence (ESD and EO study), and the last third of the presentation talks about the types of resources developed to disseminate evidence and instructions on how to access these resources on the MOHO website.

I hope you find this information helpful.

Best,  
Jenica

**April 21, 2008**

Gail-

Thank you for raising this issue. I spent the majority of my 13 year clinical career working in mental health. That wonderful time of my career took me into the juvenile correction system and a chemical dependency treatment center in addition to two psychiatric hospitals. For the last 13 years I have taught mental health content in our

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curriculum here at VCU. I consider the students' background in mental health as one of the strengths of our program because we still have two excellent mental health courses in our curriculum. I have wonderful relationships with 6 community agencies where the students engage in 25 hours of service learning during their last semester before starting fieldwork II. Only one of the facilities, (which include a residential adolescent program, an adult day care, a mental health clubhouse, a TBI clubhouse, an adult MH residential transition program and a day program for adults with intellectual disabilities), has an OT and she has worked there for many years and is very close to retirement. The students finish up their experiences with new found confidence and efficacy as OT leaders. And they witness the benefits of our expertise and services with these clients! They see the impact of their work because the entire team of 5 or 6 students participates in the final session. Even though they have wonderful things to say about these experiences it is hard to get new therapists to enter these now "nontraditional" settings. They have no role modeling. The turnover in staff is such that in most cases there is no institutional memory of the contributions that OTs may have had in those settings at one time. I have remained friends with former co-workers in therapeutic recreation and social work. We still meet for dinner several times a year. It saddens me that it is rare to find any OTs left in the mental health systems where they all work currently. At least in our area we still have a few "die hards" who are working in inpatient psychiatric services so the opportunity for new therapists to get experience in mental health before venturing out in the community is at least possible. But young therapists wanting to enter community mental health OT practice would have to be visionary, very competent and capable of articulating the unique perspective of OT in settings that don't understand or fully appreciate our professional knowledge. We can be wonderful team players and still bring a unique perspective to any team that we are on! That is why a strong grounding in theory is so essential. MOHO has always given me that grounding and I do my best to pass that on to all of my students. It is wonderful to read about therapists working in mental health in the UK, Canada, and Australia using MOHO theory and assessments. I pass some of the inspiring postings on to my students regularly. This summer I will be taking 6 of our OTD students to Canada to study client-centered practice and the Canadian health care system from the Canadian perspective. We will learn about their health care system and contrast it with our own. We will be visiting mental health therapists amongst others. I will be sure to ask them about the opportunities to work in mental health that are available to new therapists. If compensation was identical between mental health and physical rehab in the US there might still be fewer therapists choosing to work in mental health, but there would certainly be more than are choosing this option now! With school loans and rising cost of living, our new grads often go to the highest bidder and no one in mental health is even present at the auction!

Dianne

**April 21, 2008**

Hi Gail,

In New Zealand we have just had some restructuring of Allied Health paycales for those therapists working in health. Every new graduate

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starts on the same amount and receives automatic increments up until the start of their sixth year of practice, The increments are reasonable totally \$16000 (New Zealand). After this it's a bit more complicated but to get pay increases you must go through merit progression proving competency in your practice through performance reviews and its unlikely that you will receive pay rises as often as yearly. There are two merit pathways: Management or advanced practitioner. I'm not sure how it works for those OT's in private practice or education but that's how it is for us in health.

Thanks

Rosie Brown

**April 21, 2008**

Hi Gail,

I confess I've always wanted to know a little bit more about how OTs work in the US health service! Like, David, I wouldn't pretend to be a spokesperson on the UK system but the majority of OTs in the UK work in physical health settings either in the National Health Services (Health) or Local Authority Social Services (Social Care) where pay and conditions are not exactly the same but will generally be fairly equivalent. And although our national voice is sometimes less heard than some of the bigger professions, (doctors and nurses), government support for the role of OT is not unforthcoming, particularly with the current emphasis on social inclusion and vocational rehabilitation where OTs have very clear roles to play.

There has been a general increase of public attention on mental health services and new community services have been created in recent years (Early Interventions services, Crisis Services, Assertive Outreach services) sometimes with newly created OT posts. However, in the current economic climate, there have been job losses and there are currently more OTs qualifying than there are jobs available so more OTs than ever are working in alternative settings, with charities, job support agencies, private institutions etc where pay is more variable. Even in these settings, OTs will usually regard themselves as autonomous practitioners/specialists who are able to influence their role development and advise e.g., re which assessments would be most beneficial, whereas I have come across practitioners in the US who have told me that they would need to convince their employers as to the evidence base of any assessment before they would be given permission to trial its use.

Within the NHS, there is an agreed payment structure that was reviewed just over 3 years ago to ensure that most of the people employed, (including OTs,

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other Allied Health Professionals, Nurses, Domestic staff , Managers etc) are subject to the same payscales and conditions. The idea was to ensure parity, and although there has been some notable variations in how the structure has been interpreted in different services throughout the country, on the whole, OTs will start off on band 5 (with support staff including OT assistants, secretaries, and most Technical Assistants on bands below this), moving to band 6 posts with greater responsibilities. The number of band 7 posts (often Heads of OT services) appear to be declining as services move towards general management as do the number of band 8 posts (Lead OTs and consultant OTs).

As to the difference between community and hospital settings, the general trend within the UK for the past 20 years or so has been to move from institutional settings to community services where there is often (though not exclusively) a sole OT in any one team. These posts therefore tend to be banded at band 6, with more band 5 posts existing in hospital services where greater levels of supervision are sometimes available. Another difference is that OTs are more likely to work wholly as OTs in hospital settings whereas they might be employed as generic mental health workers in the community or have significant generic care-co-ordination responsibilities.

Anyway, I'd better stop now and let the listserv concentrate on MOHO again!

Best regards,

Sue

**April 24, 2008**

Sue -

What you and others have described is a fair system that attempts to "spread the OTs around" with attention to parity of wages. In the U.S., it is another story. Since our system is profit driven, and since there isn't much money to be made on providing services to people with chronic mental illness, there aren't a lot of private providers, it is mostly government agencies and community organizations. They can't afford to pay too much as they are usually short on funds and don't particularly value the OT's role in most settings. Plus, some people here are uninsured, meaning they don't have good ongoing contact with any health care provider as the provide won't get paid.

On the other hand, the nursing homes, outpatient clinics and to some extent hospitals can pay as much as they want, it is a free market. So, their pay rate rises and they add sign on bonuses and loan payback programs, and the other government and community sites serving veterans,

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people with mental illness, intellectual disabilities (called learning disabilities in the UK), or community dwelling older adults can't compete with that pay scale. When there is a shortage of therapists, like there is right now, it is very hard for those community sites to hire therapists, especially new graduates who have a lot of student loans to pay off and who want the higher salary.

It sounds like mental health practice, including use of MOHO, is doing much better outside the U.S. Less than 5% of OTs work in mental health in the U.S., although they are a vocal and strong group. It seems that the way the workforce is distributed in the UK, Australia and other locations facilitates this strong mental health role and that is a good thing. We are constrained here by our own lack of imagination and the system and a society that doesn't support good services for mental health. However, OTs are very strong in the public schools, working with children of all ages that need therapy or teacher consultation services. About one third of therapists work in that setting, and others work with children in an outpatient clinics and home based programs. That is why some of the more recent MOHO assessments have focused on children, there are a lot of needs in that area and a lot of OTs practicing in those settings in the U.S.

Hope that helps to give a glimpse into practice in the U.S. and how it influences the use and development of MOHO. We have a long way to go in many areas.

Gail

**April 21, 2008**

Hi Gail,

Just to inform you briefly about the wage structure in South Australia...

OTs and other allied health professionals come under what is known as the Professional officer (PO) classification system. Your level under that system is then determined by your roles and responsibilities. For instance a new graduate most likely starts as a PO1, a senior OT or sole clinician (PO2), a discipline senior OT (PO3). For each level there is a salary range, i.e. PO1 is approximately \$42,000-55,000 per annum. Whether you are on the base salary for that level or the highest wage is determined by your experience, or the number of years spent in the role. For instance, I am paid at PO2 increment 2 (sole OT in rural SA and in my second year). Each level has a limit on the number of increments. I think Level 2 has a maximum of 4 increments, i.e. PO2-4. The rest of Australia works to a very similar system, however the pay varies, depending mostly on cost of living in that state.

Hope this provides you with some insight

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Regards  
Lucas Milne

**April 22, 2008**

Hello Jess,

Attached is a powerpoint that you and others may find useful. It was created by an occupational therapy student, Jennie Josefson, while taking Dr. Kielhofner's Advanced MOHO course at the University of Illinois at Chicago. She created this presentation specifically for CLIENTS; to educate them on MOHO and why an OT may use MOHO with them in therapy. The PowerPoint was designed for clients receiving services due to substance abuse.

If anyone has trouble with the document, you can email me directly.

Good luck,  
Annie Ploszaj

**April 17, 2008**

Dear Lucas I am 1 of 3 OTs working in a large primary care mental health team in the UK .

We carry many hats in our team as highlighted below I thought it might be useful to share this although does not directly answer your questions. I think we have a good standing and the role of OT is valued. My predecessors did a lot to promote our role and we have recently developed the more specific vocational role in line with our national agendas. I want to introduce more MOHO assessments to assist us in demonstrating our work through use of a professional language and framework more clearly.

1. Generic case coordination

2. Vocational leads this involves providing specific vocational input to our clients-  
MOHO assessments I am looking to use to develop this are the WRI and WEIS

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3. Groups we run anger anxiety management and self esteem groups

4. Individual OT assessments for clients that we 'share' with other care coordinators- at times I have asked Amps' trained colleagues to assess, but have also found it is useful to use the OSA with clients. Again I am hoping to further develop this with either the OCAIRS or OPHI but it is early days.

I hope this helps

Lindsey Mosley