Dear colleagues.

I have been reading a lot of messages here about adaptation of assessments and I am a bit confused/intrigued. It may be the barrier language and surely I am missing something. I would appreciate if we could discuss his theme.

My understanding about standardised assessments is that they are reliable and they measure accurately all the aspects they were built for. There are studies that assure us of that. Non standardised assessments may be great, but, if there are no studies to ensure its reliability, there is no guarantee that the assessment gives us the information we need. Without proper studies to support it, most likely we may be getting more than we need from the assessment, or less than we need, or something totally different or even getting duplicate information. (I believe this assumption is not that wrong). Without a reliability study, there is no reliability... we will have just a fancy checklist at best.

There has been a great flux of messages lately to this ListServ talking about adaptations of the MOHO assessments and I am curious to learn more about these adaptations (and I am thinking of no one in specific).

When adapting an assessment, all it's reliability goes down the drain. All the studies that that assessment may have only support the assessment as it was originally built. There is no way that the evidence that might exist for the original assessment will support the adaptation of that assessment. Unless there are studies written after the adaptation to prove it's reliability.

So here goes the questions that are puzzling me:

What level of adaptation have we been discussing here?
Why there is so much need to adapt a standardised assessment?
If that need exists, why not develop studies to prove its reliability?
Or why not choose another standardised assessment to use that may be more adequate ro our needs, instead of the one we are trying to adapt?
On an Evidence Based culture, where does the use of an adaptation of an assessment fits?
Is there any procedure to ensure an adaptation does not compromise the reliability of an assessment?
I know that there is out there many "home grown" tools developed by colleagues that are good. But in this case, why not develop a study to verify its reliability?

I strongly believe that we should provide the best support to our service users and that comes from the use of reliable assessment tools. That is why I do not understand fully the concept of adapting an assessment without proving its reliability before using with service users. And I am not talking about the use of addenda or "companions".

Thank you for reading this. Looking forward for your answers.

Rodrigo Frade
Community Mental Health Occupational Therapist

December 8, 2011

Hi Sarah,
I'm glad to hear that I'm not the only person out there who has thought of using the ACLS within this kind of setting while concurrently (and predominantly) working within the framework of MOHO. I certainly find the cognitive disabilities model challenging to use and some of the assumptions that the model makes around the limited potential for change in cognitive status (and more broadly, recovery) I find bothersome but I think it might be useful for making short term decisions about how and which occupations I attempt to engage consumers in when they present with cognitive impairment in the context of experiencing acute psychosis.

In regards to using the MOHOST, I started using it as my boss (the unit nursing manager) requested that I complete a screening tool with all consumers admitted to the unit. I'm not sure that was necessarily an expectation that screening outcomes would inform the treatment that consumers receive as much of the intervention I carry out is group based. I think that I maybe need to consciously think about the screening outcome when planning how I engage with consumers and which occupations I engage to the extent that is possible in group based contexts. Would I possibly be able to get a copy of your adapted version of the MOHOST?

Cheers,
Moses

December 10, 2011

Dear Rodrigo and Members:

Rodrigo you raise a pivotal point about recent discussions on the listserv.

I can speak from two perspectives - that of listserv moderator and that of Director of the MOHO Clearinghouse. They are different perspectives.

As listserv moderator, I believe that it is important to have open dialogue on this listserv about how each and every person in the MOHO community is using the MOHO model and its assessments. I believe that clinicians should have as equal a voice as researchers in terms of sharing clinically relevant information regarding the Model and in discussing
facilitators as well as barriers to its application in practice.

As Director of the MOHO Clearinghouse, I want to be clear that the MOHO Clearinghouse does not and will not support the dissemination of any assessment (or companion/addendum) for which: 1. There is not clear evidence of a gap or need for its use within the MOHO Conceptual Practice model, and 2. It is not undergoing intensive psychometric analysis to ensure its dependability (e.g., validity and reliability).

The stance of the Clearinghouse is that if an issue is raised about the need for a new assessment, a workgroup will be formed to examine and discuss the need more carefully. The formation of this workgroup will be announced publicly to the listserv, so that every member has an opportunity to be involved. New developments will then be communicated back to the listserv by the workgroup. This will also limit the chances of simultaneous replication of new assessments under development. Without open communication, the MOHO community will not achieve efficiency.

For example, our Workgroup, which began as an examination of the issue of money management in MOHO, has evolved into a discussion of the need for an addendum to the OSA that covers a broader number of items and then allows for certain items (money management being only one) to be explored in more depth, according to the client's level of interest. As a Workgroup, we continue to discuss the need for such an addendum, since we realize that initiating something like this would involve at least a year or two of intensive psychometric research before it is formally introduced to the MOHO community at the most nascent stage.

Additionally, Dr. Patricia Scott recently posted a published addendum to the OSA that is bound to be of some help in our decision making and is likely to be helpful to many members seeking something that extends the OSA. (You may find Dr. Scott's published measure on the Clearinghouse website - for free access.)

In terms of there being a time at which there is an endpoint to the need for the development of new standardized assessments in MOHO, - I am not really sure if there should be or needs to be an endpoint. It could feel arbitrary or artificially imposed onto the Model. Given Dr. Kielhofner's rapid death, it is challenging to steer the ship without his explicit opinion and instructions on this matter. However, I believe that to put a moratorium on new innovation could run the risk of future growth and development of the Model.

Although I am a researcher and value the importance of rigor in assessment development, there is a difference between how assessments are used and applied in research versus clinical settings. As listserv moderator, I wear a different "hat" than that of the "pure scientist". I feel strongly that, as moderator, I need to not only allow but to facilitate people in the MOHO community to be in touch with one another, to share, and to communicate with one another about how they have found it most helpful to use MOHO in their own clinical "backyards".
As a practicing clinician and community psychologist for many many years, I feel that would be a violation of the need for inductive, participatory, communication. It would be a violation of the need for clinicians to be empowered about combining clinical interpretation and evidence-based practice in their actual practice settings.

Thank you for raising this issue, and I look forward to reading the responses that it generates.

Renee Taylor

December 10, 2011

Dear Renée:

You have just embraced what MOHO and its instruments developed are all about. Also you have pointed out the rigurosity with which we should act upon.

I just send another message to the listserve...I do not want to say it again...

It is crucial to respect the hard work done by many of MOHO community on developing assessment tools and protocols for intervention tant are well used and proved by many...

We should be conscious that MOHO has never replicated other assessments that are useful in our profession.

As a serious clinician and expert on MOHO theory and practice for many years now, I can say that MOHO instruments are unique...That there are other instruments to evaluate instrumental activities of Dayly Living that can be combined togueter with MOHO assessments...The way in which we apply them is what it matters...

So, we need to think about integration of knowledge...It is in Conceptual Fundations of OT, it is in MOHO perspective (2008)... What we can´t do is to reivent the wheel, the same thing other people in OT try to do. Let´s study what we have in OT and do "Occupational Therapy".

If I sound strong is because my passion for O.T. and MOHO model are huge. And I believe MOHO has given direction to OT practice.

Your explanation is very clear Renée...I invite those of you who haven´t seen previous discussions to look in the Clearinghouse web site those explanations that Renée gave befoire. They represent exactty what Gary has tought and written. You have texts that can be reviewed about conceptual models of practice....what they are....what they should accomplish ...

Keep enthusiastic!!

Big hug for all
Love
Carmen Gloria de las Heras, MS, OTR
Chile

December 12, 2011

Rodrigo, Renee and Members,
I am concerned when I see therapists posting adaptations that are used in clinical sites. It is pivotal to the stability of the MOHO instruments that they are used in their standardized form.

That said, I do believe we need to identify, as a community of professionals and scholars what adaptations need to be made to these carefully developed, standardized and validated instruments, and work to make them in a responsible manner.

I have offered the addendum to the OSA that we have developed during our research as we needed specific information on ADL’s and IADL’s, to others, yet I would never represent this as an instrument until reliability and validity has been conducted. Which it has not. We are reporting the results as change in each item over time and have not yet developed scales. This needs to be done before it is a legitimate instrument.

Gary Kielhofner was a true scholar and any of his colleagues who worked with him on the reliability and validity of these instruments, can tell you that he held them to high standards. To be true to His legacy and to MOHO I feel we need to do the same.

Gary also believed, as was evident in his controversial Stockholm address that practice should drive research, not the other way around. I think the proliferation of ideas about adaptations and needs for adaptations should send the message to those of us in academia, committed to extend Gary's work, to look at the needs expressed on this listserv, and work together as researchers and clinicians to meet these needs.

Patricia Scott, PhD, MPH, OT, FAOTA,