Defining the role of the occupational therapist in mental health following MOHO

Date: Wed, February 1, 2006 7:23 am

I work in a team of occupational therapists in older adult mental health, both functional and organic. We often find it difficult in defining our role to other professionals and clients in a clear concise way. We follow MOHO closely but would like to be able to explain our role linking in with the MOHO way of working.

Is anyone else in this situation or has had experience or overcome this in any way?

Your feedback would be greatly appreciated.

Thank you

Rachel Collins - OT Older Adult Mental Health, Coventry PCT

From: Catherine Hadrill

Hi Rachel,

I have dug out a couple of leaflets that I have used before. One was for the team and is quite verbose,(deliberately to humour the style of certain tem members!), the other was sent to clients with a pre assessment questionnaire. Regarding within the MDT I have found case studies good. I now am bolshy and will not present my role unless all other members do it also (some regularly don't), or I suggest a case study and different professions present what they think another's role will involve and you go from there.

Hope they are of some use

Catherine Hadrill
OT Montgomery shire Learning Difficulties Team, Powys
I am an OT team leader in an adult CMHT. We are about to develop our day services side more to become one team and focus on social exclusion and community activities. At the moment we are key members of the CMHT. We use MOHO assessments on a regular basis to look at occupational performance and set treatment goals. We will do this for all referrals that come to us. Over the last 3 years we have developed and defined our roles so that the majority of our case loads are now OT specific. We are care coordinators for our case load but will still do assessments for the rest of the team as needed. For these we tend to use the OSA. We will do the assessment and have 2-3 sessions with the service user and then pass the goals etc back to the care coordinator for them to implement them with the service user. I think it is an OT specialism though and not an MDT tool.

As a trust we have just taken on board that all mental health OT's will use MOHO assessments and we are setting up protocols for use of the assessments for each area. For CMHT we will be using the OCAIRS and the OSA. Both of these can be used as outcome measures. It takes some setting up and some working with the team but is worth it in the end.

Hope this is of some help. Good luck.

Helen Green
Head Occupational Therapist
Weymouth & Portland CMHT

From: Jacqui Conway

I work as an OT and team leader in England in a service for adults with severe and enduring mental health problems. We are part of day services and we work to enable people to participate and integrate back in to mainstream communities and to execute therapeutic programmes with individuals to help them do so. My line manager who is a nurse would like to pursue an MDT type of assessment tool to gauge functioning, formulate problem areas and set goals. It is wonderful that he is so enthusiastic but I am worried that by letting him utilize OT assessments that he may be a little misguided. We are keen to be able to demonstrate our specialism in working with occupational functioning, but as an MDT with OT's fully integrated in the teams, we do not have an OT structure or department and we do not wish to alienate our OT friendly manager (they are quite hard to come by!)

Any help re views on this matter and also for assessment and outcome tool ideas that may help us would be greatly appreciated.

Kind regards

Jacqui Conway
From: Carolyn Prange

Greetings,

I too am in the same position as Rachel. I find it difficult to convey to my peers what the role of OT is on our behavioral health units. Many are still stuck in the mind frame that we are here to "keep the patients busy or occupied". I am the only OT working between our two units. We have a unit designed for Geriatric acute psychiatric inpatient care and one for adult acute psychiatric inpatient care. I would welcome any information others are using to educate staff and clients.

Thank you,
Carolyn Prange, OTR

Date: Mon, March 6, 2006 2:18 pm

Dear Helen and others-

I would like to announce that just last week we officially released the newest version of the OSA, v2.2, which includes the OSA keyforms. The paper keyforms are developed from a sort of "standardized" sample, and allow you to generate an interval level client measure and error based on the OSA responses. This can be done even if a few items are not rated if they are not applicable. This makes the OSA an even better tool for measuring client centered outcomes after OT intervention. The OSA keyforms are similar to the keys developed for the OPHI-II, and an citation that talks about the development of the OPHI-II keyforms is:


An article is currently being completed that describes the development of the OSA keyforms. A study that used time 1 and 2 data from clients demonstrated that the OSA could capture change in occupational competence and values for occupations.

I hope this information is helpful to your services!
Best-
Jessica Keller, MS, OTR/L
Head Research Assistant, MOHO Clearinghouse
PhD Student, Disability Studies
From: Lisa Mahaffey

I read this with interest. I think it is because of using MOHO that I am able to not only explain what I do as an OT in mental health but justify my position and why they want me on staff when they could cover groups with someone who costs less. (Sorry, this has become my soap box). For the patients, I start out by saying that while others work with them regarding their feelings, medications and issues, I want to focus on the things that "occupy" their time. I wrap my explanation around the construct of roles. I have been doing a teaching group for several years where I ask the group to name the things in their life that are most meaningful. Almost without exception, they name the exact roles that are on Fran Oakley's role checklist. I then explain that roles come with a set of responsibilities that when met, lead to beneficial outcomes (and that sense of meaning). I will have them go through this process using specific roles.

We then talk about how having a mood disorder or mental illness that is not being managed well, leads to a set of behaviors that do not allow them to engage in the responsibilities of their roles and of course, they aren't able to reap the benefits. I also use this construct to explain my expertise to the staff. With the staff, (when given the opportunity), I will explain how the other constructs of the MOHO impact the ability to engage in role responsibilities. Of course that includes the patients cognitive skills and lately I am more interested in the sensory processing difficulties of patients with mental illness. I also believe that we as OT's have the ability to help patients recognize the direct connection between their actions and the volitional aspects of the model (with the patients I use the term self-esteem). Basic CBT teaches that we think, then feel, then react. I think of my program as looking at it from the bottom up. You can change your reaction (what you do) which will impact how you think and feel. Start by developing a set of clinical questions based on the MOHO constructs, that you ask about every patient when they become part of your caseload. Use the model language such as "Does this person identify roles? Are they able to identify the responsibilities of their roles?" etc. After completing the assessment, answer the questions using the same language. Obviously treatment is based on the answers that indicate behavior that doesn't support function in daily life roles (whether that is volition, habituation or mind/body performance).

Hope this is helpful.

Lisa Mahaffey M.S. OTR/L