Pre-post outcome evaluation with clients with impaired appraisal of abilities

July 8, 2011

Hi all

As many of you will be aware there are increasing pressures to demonstrate the added value of occupational therapy to commissioners of health services. We are exploring a range of options on how best to report on the effectiveness of OT interventions including pre-post use of MOHO assessments.

I've had a few interesting discussions recently with some of our OTs working with client groups who have impaired appraisal of abilities eg eating disorders.

In our eating disorders unit the intention is to use the MOHOST in a pre-post way as a way of reporting on occupational changes. However a common scenario seems to be that clients newly admitted to the unit can present as reasonably capable during the assessment period, but then as the OT gets to know the client better and the clients awareness of their condition improves, many problem areas come to light.

This clearly presents a challenge when it comes to reporting on the efficacy of OT since many scores will actually go down at re-assessment in the above scenario (though appraisal of abilities may well go up).

One option could be to delay the initial assessment to allow more time to build up an accurate picture but ther are two challenges with this

1) the longer one leaves it to assess, the less 'baseline' it becomes ie the more liklihood there is of a treatment effect kicking in
2) there are pressures from the MDT to produce an assessment early on

So any thoughts gratefully received
from a very windy and gloomy London

regards

David

July 8, 2011

Hi David

We have seen a similar presentation in clients with personality issues, possibly for different reasons, though I suspect they are very similar presentations(?) - Not just in the MOHOst assessment, also on things like The Borderline Personality Disorder (BPD) section of the Structured Clinical Interview for Diagnosis (SCID II), Millon (MCMI-III), The CORE, The Inventory of Interpersonal Problems (IIP-32) Quality of Life (QOL) and the Adolescent/Adult Sensory Profile also.

Is some maybe under reporting difficulties, to get of receiving services/avoid hospital etc, especially the stigma of being a MH client. Also what about 'apparent competence' (Linehan 1999) when 'triggered' by past events, then when responding with more reflexive primitive brain, have less 'apprently competent' adaptive responses, using old well used often developmentally 'immature' coping patterns/behaviour in the absence of opportunities to learn or have learning of more complex and adaptive behaviours validated by parents/carers etc..... (Using less 'cortical' brain for novel ideation, planning, thinking, logical and therefore less situation specific, so typically less adaptive).

Clinically we have also often like you seen increased disclosure of difficulties later on and have hypothesized it as possibly being due the building of trusting relationships - also ? increased awareness of own difficulties, especially when starting to be more curious, having more volition, taking risks now feeling safer to try new things usually avoided, therefore sometimes discovering new things can't do, showing greater difficulties.

It would be good to hear how others thoughts and how to accommodate for this......as time goes on and clients make more progress, it seems to sort out, but perhaps we need to find a way to account for this initially......some ongoing longitudinal studies???
Kathryn Smith
Consultant Occupational Therapist

July 11, 2011

Hiya David

Yes interestingly I have just discussed this very issue with an OT student who is with me for the day. I work in adult rehabilitation (mental health) and we sometimes find that scores, particularly process skills, can rate down on the second assessment. This is because we work intensively with people, and we will have had more opportunity to observe any skills deficits. Luckily this trend does not continue, and with rehabilitation scores improve. As the MOHOST is a screening tool, I feel it is appropriate that it is completed early despite therapists having less client knowledge. If scores change later this is something that can be discussed at the time. I don’t think other professions would be too concerned as the changes should be fairly minimal e.g. A to and I. If someone goes from an F to an R it is more likely to be due to decline in condition rather than an inaccurate baseline assessment.

I have completed a LOT of repeat mohosts in my service, as clients stay up to two years and I do one for each CPA. It is really interesting to look at the progress over time - Particularly with volition and habituation.

thanks

Vicki Aiken
Occupational Therapist

July 11, 2011

Hi All

Very interesting discussion.

In our service we are asked to complete functional assessments to aid diagnosis for clients with dementia and other mental health or mild learning challenges. This can cause a mixed presentation of functioning and perceived difficulties either over whelming the client or not being acknowleged at all.
We screen the occupational functioning using the MOHOST and complete an AMPS Ax where the process skill deficits are not "clear cut" (for want of a better phrase!). We find this gives us a good baseline Ax of overall functioning and allows for test/retest over time.

maybe the AMPS would be worth considering.

regards
Laura

**July 11, 2011**

Hi David, Kath, Vicki

I've always thought that this situation might occur but despite using the MOHOST for many years, I never experienced it myself. When people have asked me what they should do if it happens, my response has always been that documenting their findings using the MOHOST would be no different from writing in the day-to-day notes which we date and sign as an accurate reflection of our current knowledge. I also presume that the OT would clarify the reduced ratings in the analysis section, attributing the changes to increased awareness on their part.

I'd be interested to hear more about the situations when the ratings decline. For instance, when do you and/or your colleagues complete the first MOHOST? The MOHOST is based on 'getting to know your client' and as such it is rarely filled in after the initial assessment unless this is very rigorous. Rather, it is filled in after an assessment period, (my colleagues in inpatient settings consider whether they have gathered enough information after 4 sessions/contacts).

Also, do you and/or your colleagues observe people engaging in activity during the assessment period? It's interesting to note that a person's process skills is sometimes rated lower after a period of getting to know a person. Process skills need to be observed (by an occupational therapist) in order to make accurate ratings, rather than relying on interview-based assessment methods.

As for the issue of needing to speed up assessment to capture the baseline, the experiences described in your emails seem to suggest that this tactic actually fails to
capture the baseline - in those cases where the second assessment results in reduced ratings as more information comes to light, then this is the true baseline.

Finally, I was wondering whether the pressures from the MDT for an early assessment sometimes need to be questioned. A thorough assessment can often speed up subsequent treatment so saving time overall. Another option would be to consider other assessments that can be completed in a single session, such as the Occupational Self Assessment or the Occupational Circumstances Assessment Interview and rating Scales.

Looking forward to discussing this issue further.

Sue Parkinson

July 12, 2011

Hi All:

First comment is related to the MOHOST and changes in clients between time points (the decreased MOHOST "process skills" domain scores once you know a client better and see his deficits):

We approach this dilemma in psychology in much the same way - documentation of the change. We assume that there will be change and not necessarily in a positive direction. Provided that you note that the deficits became more apparent over time, or in a new situation, or once the client settled into a more natural habit pattern and was no longer pushing so hard, or whatever the case might have been, the approach to that is to note it. I believe there would be room to do this in the comments section of the MOHOST, or in general within the client's chart, etc. I think it would depend a lot on setting demands and documentation norms in the setting.

Second comment related to the AMPS:

The AMPS has been deemed by some to be the "gold standard" in terms of measuring motor and process skills. However, you probably know that the AMPS requires a special certification/training course and calibration as an AMPS rater to be able to use it. Plus, the AMPS measures a "chunk" of the person - motor and process skills... If that is your central focus, it may be the best measure for you.
The MOHOST is more integrative and inclusive - but easier to use and more flexible to apply. The MOHOST has the potential to capture enough practical and necessary clinical detail about motor and process skills if the clinician has a well-seasoned eye and enough time to make a careful and variegated assessment.

In psychology, assessment is often about seeing and about knowing what to look for. I think some of the similar concepts might apply with the MOHOST.

Renee Taylor

July 12, 2011

Dear all:

In my experience and evidence based practice it has been common that the scores vary from the initial assessment not necessarily to better ratings. I agree with Renée on her comments regarding the flow people go through. It is a life in progress. If we do good therapy we should integrate the dynamic view of an occupational life (MOHO principles) in which we bring opportunities in different degree of challenge according to the environment/contexts people live in or perform their occupations, and according to that, people will then need more support/training on exploring these new challenges in all areas. This is totally normal. Many people when they get to be aware of themselves and know themselves better, and the possibilities (opportunities and constrains) of their environments they get to see better the challenges..This is the beauty of MOHO, giving us the theory and the flexibility of looking at occupational change. We cannot forget this. Just think of our own lifes.

Using MOHOST as an initial occupational profile is very useful in many situations, as it is after applying it, to choose thoughtfully more specific assessments according to areas that need further assessment.

Is because of the flow and dynamics of occupational participation and its continuum in real life that we need to contextualize the moment, conditions and specific contexts where the assessment is applied. MOHOST provides this opportunity as well as other MOHO assessments.

The other aspect is to really use our therapeutic reasoning on seeing which aspects are crucial to beging to work with, and stablish measurable goals for each phase of
intervention. Using tools integrating their results in different areas and get to the "why of occupational participation and performance".

Best to all
Warm hug
Carmen Gloria de las Heras
Chile

July 29, 2011

Hi all
Many thanks to all who have replied to this thread and its off shoot 'MOHOST Discussion, AMPS, and General Thoughts'. The responses have been most helpful. Just a few responses to some of the suggestions:

1. Using qualitative descriptors to explain reduce scores
Whilst I totally agree with this when producing reports on individual service users, when collating data on multiple clients for managers / commissioners I fear that the qualitative comments could easily get lost / ignored.

2. Delaying initial ratings to get true baseline & endeavouing to ensure that OTs get to observe clients in task performance before making ratings
Both ideas make alot of sense, though as I mentioned before the longer one leaves it to enter the ratings the more likelihood there is of a treatment effect kicking in. So assessing too quickly and too late could both result in an inaccurate 'baseline'.

3. Using an assessment that can be completed in a single session eg OSA & OCAIRS
Definitely worth considering though for the client group that triggered this discussion (Eating Disorders) the reason we have opted for the MOHOST is that clients usually have impaired appraisal of abilities and so interviews and self reports are not going to give a complete picture.

thanks again
David

August 4, 2011

Dear David:
You might want to consider using MOHOST and the VQ. You get to complement well the evaluation of their sense of efficacy in multiple contexts through observation. It is very useful. When people improve in ratings of the Volitional Questionnaire to the level of competence in progress you can decide the use of self assessments and/or formal interviewing, not before. Following the remotivation process guidance helps to integrate and prioritize decisions on evaluation methods to use when appropriate with this group of persons.

I hope it helps some. I am sorry for the delay of my response.

Love to all
Carmen Gloria de las Heras, MS, OTR
Chile