Reflections on using the Model of Human Occupation Screening Tool in a joint learning disability team

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MOHOST,
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Increasing demands for evidence-based practice can cause dilemmas for practitioners, who are striving to identify assessments and outcome measures that are reliable in their practice setting, clinically useful and flexible. A 6-month preliminary study of the Model of Human Occupation Screening Tool (MOHOST) in a community learning disability service yielded positive results by satisfying all these requirements. The occupational therapists found that the MOHOST facilitated consistent and evidence-based practice, without compromising professional autonomy or a client-centred focus. It appeared straightforward, flexible to use and applicable in a wide range of learning disability settings.

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Context

In the current intellectual and financial climate in the National Health Service, it is imperative that services adopt the most up-to-date and evidence-based frameworks for assessment and treatment (Department of Health 2008). It is also important that, using pragmatic and other forms of clinical reasoning (Schell and Cervero 1993, Unsworth 2004), clinicians retain the freedom to practise flexibly. Services must also be responsive and inclusive (Department of Health 2001) and founded on a philosophy of respect and partnership with clients (Law 1998).

Contrasting demands can lead to a tension between standardisation and clinical flexibility in occupational therapy. A potential solution may be to adopt a model of practice that uses consistent and evidence-based occupational concepts to structure the way in which therapists think about their assessments, interventions and reports, while allowing clinical freedom to use the widest possible range of practical assessment and intervention methods. The Model of Human Occupation (MOHO) meets these requirements and has risen to prominence as the most commonly used occupation-focused model (Kielhofner 2008). At its core are three systems: volition (motivation), habituation (patterns) and performance (skills). In simple terms, for anyone to do anything, they must want to do it, they must get used to doing it and they must have, or learn, the skills to do it. As this all takes place in a real environment, an additional critical feature for MOHO is how the environment facilitates or restricts occupational performance.

A range of specific assessments have flowed from this model. The Model of Human Occupation Screening Tool (MOHOST) (Parkinson et al 2006) is potentially one of the simplest and most flexible to use. It was 'designed to capture the very broad construct of factors that influence occupational participation' (Kielhofner et al 2009, p131) 'irrespective of symptoms or diagnosis' (Parkinson et al 2006, p20). In addition, studies have suggested that therapists need only minimal training to score MOHOST consistently using the self-explanatory manual (Kramer et al 2009).

*Fig. 1. Model of Human Occupation Screening Tool (MOHOST) visual summary.**

Motivation for Occupation				Pattern of Occupation				Communication & Interaction Skills				Process Skills				Motor Skills				Environment:			
Appraisal of Ability	Expectation of Success	Interest	Choices	Routine	Adaptability	Roles	Responsibility	Non-verbal Skills	Conversation	Vocal Expression	Relationships	Knowledge	Timing	Organisation	Problem-solving	Posture & Mobility	Co-ordination	Strength & Effort	Energy	Physical Space	Physical Resources	Social Groups	Occupational Demands
F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I
R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R

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The MOHOST primarily uses open-ended observations. Information can be gleaned from multiple sources in the process of 'getting to know your client' (Parkinson et al 2006, p29). These include practical assessments, observations of the person engaging in an activity, verbal discussions and accounts from carers and staff (Parkinson et al 2006). Moreover, there is considerable flexibility concerning the precise kind of practical assessments and observations that can be used. For example, a weakness in motivation may manifest as poor enthusiasm for structured occupation and limited ability to make realistic personal choices: This phenomenon can be observed in a wide range of practical situations (for example, kitchen assessments, art groups, personal care sessions or employment programmes). All of these individual observations can inform the completion of the MOHOST, despite not being standardised processes in themselves.

The qualities discussed above made the MOHOST a good choice for a preliminary study by occupational therapists in a learning disability service, who were seeking to introduce an evidence base to their assessment process without compromising clinical flexibility.

Critical reflections

Over a period of 6 months, 11 members of the occupational therapy service, including support staff, contributed to using the MOHOST. Fifty MOHOSTs were completed. Three afternoon training and troubleshooting workshops were held, with staff having the opportunity to share good practice and discuss any problems or issues. Scoring issues were discussed and illustrative case studies employed. Staff were also encouraged to contribute to a critical analysis of the assessment tool during these workshops.

Participants aimed to demonstrate that their interventions could be evidence based, and clinically effective without compromising professional autonomy. They were most interested in the following aspects of the MOHOST:

1. Ease and flexibility of use
2. Application in learning disability settings
3. Value as a framework for report writing.

Ease and flexibility of use

The MOHOST is laid out clearly and economically (see Fig. 1). The front sheet of the assessment contains a visual summary of strengths and weaknesses in the three main subsystems (motivation, patterns and skills) together with the environment. Skills are further subdivided into motor, process and communication skills, giving a total of six areas. Each of these contains four separately scored items, all scored on a four-point rating scale – FAIR – according to whether the item Facilitates, Allows, Inhibits or Restricts occupational participation. This makes the MOHOST easy to use because clinicians only have to circle 24 ratings and write a few lines of accompanying text.

Accompanying sheets give one-line descriptor statements for scoring each of the 24 elements and space for comments (see Fig. 2). In order to become familiar with these items, participants found that it was useful to complete MOHOSTs for well-known clients collaboratively, debating scoring issues and consulting the manual to learn terminology and simple rules (for example, when undecided between two ratings, circle the lower one). It also became apparent that filling in the 'comments' line, however briefly, was important to aid later recall and justification of the rationale for assigning a particular item rating.

Once the ratings have been completed, a small space is provided for the occupational therapist to summarise the person's strengths and weaknesses. This summary should reflect the central MOHO categories of motivation, patterns, skills and environment and how these are dynamically and systemically interlinked. Consequently, treatment plans can address anomalous scores, use strengths to address weaknesses and take account of ways in which changes in one subsystem can affect the others. For example, an improvement in habits can have an effect on skills or a deterioration in the social environment can affect habits and motivation adversely.

*Fig. 2. Examples of descriptor statements for a Model of Human Occupation Screening Tool (MOHOST) item.**

Appraisal of ability	**F**	Accurately assesses own capacity, recognises strengths, aware of limitations
understanding of current strengths & limitations	**A**	Reasonable tendency to over/under estimate own abilities, recognises some limitations
accurate belief in skill	**I**	Difficulty understanding strengths and limitations without support
accurate view of competence	**R**	Does not reflect on skills, fails to realistically estimate own abilities
awareness of capacity		*Comments:* .....

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No participant concluded that the MOHOST constrained his or her practice. All felt free to conduct whichever practical assessments and interventions they deemed appropriate. Moreover, they reported that the intellectual effort needed to complete the MOHOST encouraged a focus on occupational performance and participation instead of impairment (Kramer et al 2009).

Application in learning disability settings

The MOHOST rating system is ordinal rather than normative (Fife-Schaw 1995): a rating of F requires an objectively unhindered performance similar to that of a non-disabled individual and *not* simply a good performance taking disability into account. Participants therefore found it straightforward to use the rating system with people who had mild to moderate disabilities, where the results were useful in highlighting contrasting strengths and limitations. This then informed the treatment approach: for one client, poor motivation for occupation and good motor skills led to a plan to attend the gym; for another, the negative impact of poor family dynamics was exposed and could be addressed; and in a third case, good skills but poor self-care patterns suggested that a rehabilitation approach would be likely to work well. The MOHOST was also used to score the members of an art group, with the result that previously unidentified strengths and weaknesses were highlighted and could be addressed within the group. One participant commented: 'It gives you a useful tool for forward planning appropriate to people's needs and abilities.'

When using the MOHOST with profoundly learning disabled people, one of the key advantages is that a verbal response is not required. However, ratings do tend to be very low for most items and some staff expressed concern with this, wondering if the MOHOST had the required clinical sensitivity for this client group (Blount 2008). There is an important ideological dimension to this concern; for perfectly sound historical and human reasons, learning disabilities services prefer to focus on what people can do rather than what they cannot, yet the MOHOST, as an ordinal and objective measure of occupational performance, necessarily highlights deficits. There was considerable debate between the participants over this issue and further work and guidance on using the MOHOST with this client group would be most welcome.

The participants were able to use MOHOST results to justify comprehensive care packages or to highlight the positive impact of environmental changes, such as rehousing, hoisting or bathing provision. In addition, there proved to be surprising islands of good functioning (for example, expression of interest or grip skills) in an otherwise poor picture. This enabled the therapist to focus on factors that could 'facilitate … an individual's participation in daily life' (Kramer et al 2009, p181), which might otherwise go unnoticed. One participant commented: 'It helps you realise that not everyone can do everything – but everyone can do something.' It also led seamlessly to the use of other MOHO assessments offering a more finely grained focus; for example, the Assessment of Communication and Interaction Skills (Forsyth et al 1998) or the Volitional Questionnaire (De las Heras et al 2007).

Occasionally, it was difficult to assign ratings. It is possible simply to leave an item unrated, but usually the issue was resolved by seeking more information or going through the manual in detail. Sometimes, however, the descriptors, being necessarily general in nature, did not easily capture the complexity of the individual picture. In these situations, the participants needed to base scores on a more general consideration of whether the item facilitates, allows, inhibits or restricts occupational participation. Consideration of the support that a person needs was found to be useful. This is made explicit in the manual, which suggests that 'F' means that no outside support is needed, 'A' means that the person may benefit from occasional support, 'I' means that the person requires support and/or encouragement and 'R' means that the person is unable to manage despite support. The participants found that other factors might be usefully considered, such as how a person may score on a four-point risk assessment (for example, minimal risk, manageable risk, unacceptable risk or catastrophic risk). Familiarity with the four-point rating scales used in other MOHO-based assessments also led to greater confidence when assigning ratings for the MOHOST.

Value as a framework for report writing

Kramer et al (2009) encouraged occupational therapists to use the MOHOST flexibly in order to allow the instrument to be integrated more fully into the service setting. A

method of writing reports was therefore devised, containing a brief introduction/background section, followed by a single paragraph for each of the six areas addressed by the MOHOST. Practical occupations (for example, kitchen activities) were woven into the six areas as examples, rather than treated separately. Finally, a summary was included to outline recommendations and treatment plans.

These reports typically covered two sides of A4 paper and proved helpful in explaining the unique contribution that occupational therapy offers within the multidisciplinary team. Using professional language that is easily understood by colleagues (Mitchell and Neish 2007), they have aided communication with other health disciplines to ensure that clients receive the appropriate treatment and assisted social care colleagues in making robust cases for scarce services and funding. The formulation of MOHOST reports also helped the participants to prioritise competing demands and decide whether continued intervention was necessary or whether it was sufficient to make recommendations to others. The report format served as a record and justification of such decisions, useful in complex and potentially contentious cases where disagreements over assessment outcomes and recommendations could lead to complaints or even litigation.

Writing these reports was a challenge at first. One participant commented: 'Using the framework to write the report will take some getting used to. It's about letting go of old ways of doing things.' However, the participants felt that the effort was worthwhile. They believed that it contributed to the maintenance of their occupational therapy skills within a multidisciplinary community setting, which evidence suggests can be difficult (Parkinson et al 2009).

Summary

Conducting this preliminary study using the MOHOST has been a success, demonstrating that it provides an evidence-based model that is simple, logical and appropriate for use with most people who have learning disabilities. The MOHOST offers a sound basis for the construction of concise and professional reports and its use does not limit professional autonomy. Resources, training and time requirements are very reasonable and realistic, and the MOHOST has the potential to improve outcomes for clients by ensuring that their potential for occupational participation is fully considered. The participants in the preliminary study have therefore agreed that the MOHOST will continue to be used in their service.

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Key messages

- MOHOST enables consistent, evidence-based assessment without constraining professional autonomy.
- MOHOST is straightforward and cost-effective and can be used with a broad range of learning disabilities in various settings.
- MOHOST-based reports are an effective way coherently to summarise occupational therapy assessments, interventions and recommendations.

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