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To cite this article: Sue Parkinson BA, DipCOT, Andrew Chester BSc, Sarah Cratchley BSc & Julie Rowbottom BHSc (hons) (2008) Application of the Model of Human Occupation Screening Tool (MOHOST Assessment) in an Acute Psychiatric Setting, Occupational Therapy In Health Care, 22:2-3, 63-75, DOI: 10.1080/07380570801989465

To link to this article: http://dx.doi.org/10.1080/07380570801989465

Published online: 10 Jul 2009.

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Application of the Model of Human Occupation Screening Tool (MOHOST Assessment) in an Acute Psychiatric Setting

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With thanks to Dr. Kirsty Forsyth, Director of UK CORE, Occupational Therapist Bryony Robinson who created the MOHOST self-assessment, and all who have reviewed this article.
ABSTRACT. The Model of Human Occupation Screening Tool (MOHOST) plays a key role in the occupational therapy assessment protocol at an acute psychiatric unit in Britain. This paper incorporates a case study and discussions with the occupational therapists to explore how the assessment influences practice from initial assessment to final outcome measure and how single observation forms and prototype self-assessment forms based on the MOHOST have contributed to the assessment process.

KEYWORDS. Assessment, mental health, model of practice

INTRODUCTION

The Model of Human Occupation Screening Tool (MOHOST) version 2.0 (Parkinson, Forsyth, & Kielhofner, 2006) originated in Britain (Parkinson, 2006), and allows occupational therapists to rate how 24 factors relating to a person’s volition, habituation, performance, and environment combine to influence occupational participation. The therapist rates each item as to whether the factor represented by the item facilitates (F), allows (A), inhibits (I), or restricts (R) the person’s occupational participation.

The MOHOST is designed so that the instrument can be scored based on a variety of data sources and approaches to collecting information. This paper highlights two specific methods of applying the MOHOST: (a) to provide a “shapshot” picture of the client following a single intervention and (b) to function as a comprehensive summary after a period of information gathering.

Many publications have described the MOHOST’s use (Abelenda, 2002; Colville, 2005; Duncan & Moody, 2003; Forsyth & Kielhofner, 2005; Hatton, 2005; Kielhofner, 2008; Kramer, Hinojosa, & Royeen, 2003; Larty & Lucas, 2004; Mitchell & Neish, 2007; Parkinson, 2002) and a study of its psychometric properties is forthcoming (Forsyth et al., in press). This paper adds to the discussion by describing how the assessment has been embedded into the occupational therapy process across a large mental health service in Britain where occupational therapists are based at more than 40 separate sites. We illustrate how the MOHOST influences practice from initial assessment to conceptualizing a client’s situation (Kielhofner, 2008), goal setting, and evaluation of treatment.
STRATEGIC PARTNERSHIP

The process of incorporating the MOHOST and other Model of Human Occupation (MOHO) assessments was undertaken as part of a course of action aimed at guarding against fragmentation of occupational therapy services (Craik, Chacksfield, & Richards, 1998), and meeting government calls for an integrated approach to service, organizational, and professional development (Department of Health, 1999). The process involved a partnership between academics and clinicians (Parkinson, 2006) in tune with the British College of Occupational Therapists call for the gap to be bridged between practice and theory (College of Occupational Therapists, 2002), and the call from the Health Professions Council for practitioners to utilize theoretical concepts and standardized assessments (Health Professions Council, 2007). Throughout the partnership, therapists’ perspectives on the MOHOST and other MOHO assessments have been systematically gathered and are used in this paper to provide anecdotal information regarding therapists’ experiences applying the MOHOST.

DECIDING TO USE THE MOHOST AS AN INITIAL ASSESSMENT

Deciding which assessments to use required that we first identify, select, and become familiar with relevant tools. Reviewing the available tools clarified not only what therapists needed to know about their clients but also how they defined their roles and expertise (Phillips & Renton, 1995). In addition, consideration was given to which assessments would support evidence-based practice through the routine collection of relevant client data (Lloyd, King, & Bassett, 2005; Melton, 2001; Parrott, 2001).

Assessment protocols were established for each service area. Each protocol was depicted in flowchart form (see Figure 1, for an example) and supported by a clinical reasoning document (see excerpt in Figure 2). These described the assessments of choice for gaining a broad overview of a client’s occupational participation as well as more secondary assessments that could provide greater detail concerning a client’s strengths and challenges. The majority of assessments chosen were based on MOHO, reflecting the findings of practitioners that MOHO can provide them with a theoretical understanding of occupation and support an occupation-focused practice (Forsyth, 2001).
The protocols identified the MOHOST as being the most appropriate assessment to use in acute adult psychiatric settings in Britain where length of stay is often brief (in the majority of instances, less than 2 weeks). It was also chosen for use in learning disability and some rehabilitation settings where clients are less able to engage in verbal interview procedures.
Therapists found the MOHOST quick to administer and useful for summarizing what was learned about a client. Moreover, as one therapist noted, “It helps me to work with clients holistically, because it takes a broad look across all aspects of a person’s occupational participation.”

In the acute adult psychiatric settings, it was decided that the MOHOST would be used to gain a baseline assessment of a person’s occupational participation following engagement in four therapy sessions. This use of the MOHOST as a summary of the therapist’s accumulated knowledge of the client allows ample opportunity to collect necessary information. It allows the therapist to get to know the client and triangulate information gleaned through reading case notes, talking with clients, and by observing them in a range of situations along with discussing findings with team members and/or relatives (Parkinson, Forsyth, & Kielhofner, 2006). In the meantime, occupational therapists can use the single observation MOHOST form to capture information about their clients on a day-by-day basis. This use of the MOHOST provides a snapshot of occupational functioning. Each item on the single observation form corresponds with an item on the summary MOHOST and the information noted will contribute to the summary rating that is completed following 4 therapy sessions. For example, observing whether an individual “shows awareness of strengths and limitations” on the single observation form during a given session will contribute to the therapist’s understanding of the client’s overall “Appraisal of ability,” which is then rated on the summary MOHOST. As one therapist remarked, “I’ve found the single observation MOHOST form very helpful as a way of assessing and comparing clients’ responses to a variety of different environments and activities, as well as monitoring and recording change over time.”
Figures 3 and 4 show extracts from MOHOST assessments for Sandra, a 61-year-old inpatient who was admitted to hospital feeling depressed and who remained suicidal having attempted to cut her wrists. A member of occupational therapy support staff completed the single

**FIGURE 3. Sandra extract of a single observation MOHOST (4 items of 24).**

<table>
<thead>
<tr>
<th>Area to Evaluate</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shows awareness of strengths &amp; limitations</td>
<td>N/S F A I R</td>
</tr>
<tr>
<td>Demonstrated appropriate restraint due to injury</td>
<td></td>
</tr>
<tr>
<td>Shows pride/seeks challenges</td>
<td>N/S F A I R</td>
</tr>
<tr>
<td>Very competitive</td>
<td></td>
</tr>
<tr>
<td>Uses appropriate nonverbal expression</td>
<td>N/S F A I R</td>
</tr>
<tr>
<td>Eye contact not consistently made</td>
<td></td>
</tr>
<tr>
<td>Relates to and cooperates with others</td>
<td>N/S F A I R</td>
</tr>
<tr>
<td>Responded to requests but withdrew from social conversation</td>
<td></td>
</tr>
</tbody>
</table>

**FIGURE 4. Sandra first summary MOHOST—Report and ratings.**

*Sandra lacks motivation to engage in many previously held interests or to set occupational goals. She is generally negative in her appraisal of her abilities, pessimistic about her future and unable to sustain a productive routine other than managing her personal activities of daily living. She mostly avoids interacting with others but when she engages in activity her process and motor skills are good. Her needs appear to be reasonably well met in the hospital environment although family relationships are currently strained.*
observation MOHOST form (extract shown in Figure 3) after Sandra attended a multi-gym session 2 days into her admission. It was noted that she demonstrated a high level of process and motor skills and volition in this particular environment, although she withdrew from social interaction. The occupational therapist used the information along with reports from other sources (talking to Sandra, the nursing team, and other therapy staff) to complete the first summary MOHOST (ratings shown in Figure 4), giving a broader overview of Sandra’s occupational participation as a whole. The summary MOHOST highlighted the fact that Sandra was much less able to maintain her motivation for occupation and pattern of occupation in the hospital environment generally.

**UTILIZING MOHOST ASSESSMENTS AS THE BASIS FOR CONCEPTUALIZING A PERSON’S OCCUPATIONAL NEEDS (CASE FORMULATION) AND SETTING GOALS**

Assessments provide little benefit if they do not inform the treatment process (Thorner, 1991) and lead to the setting of collaborative treatment goals (Lloyd, King, & Bassett, 2002). The findings of the MOHOST should therefore be converted into goals, helping to define the key occupational changes that a client agrees to work towards. One therapist noted\(^1\) in this regard,

Some clients find it helpful to see the assessment form itself, particularly the report of their strengths and limitations and the visual profile provided by the ratings scale. This can be a good focus for talking about occupational needs and goal setting. With other clients, it’s more helpful to share the findings orally, translating the language of the assessment into a form which meets the client’s needs.

The results of the MOHOST are made more relevant when they contribute to a comprehensive case formulation explaining the client’s circumstances, rather than simply giving a list of performance strengths and limitations (Kielhofner, 2008). Accordingly, we organize the information gained from the MOHOST into an ordered and cohesive formulation that conveys an acute respect for the person’s unique circumstances and highlights key issues (Chesworth, Duffy, Hodnett, & Knight, 2002). MOHO theory sup-

\(^1\)The quotes in this paper come from therapists who were involved in a program development project and were included as authors in this manuscript.
ports this process by providing therapists with concepts for understanding the elements of a client’s occupational situation and how they are interrelated. Moreover, the emphasis of MOHO on volition and the unique interaction of personal characteristics with the environment (Kielhofner, 2008) supports client-centered practice. It encourages therapists to view the strengths and limitations outlined in the MOHOST in the context of:

- The client’s occupational identity, which includes awareness of abilities, expectation of success, their sense of self and belonging in current and past roles, plus life turning points and direction as revealed in their occupational narrative
- Occupational competence, especially the extent to which occupational abilities and participation match identity
- Key issues that prevent and support occupational adaptation in relation to self-care, productivity, leisure, performance of activities, and skills development (including contributing volitional, organizational, and environmental factors, strengths and supports, and limitations and challenges)

The aforementioned considerations are then encapsulated in a statement that summarizes the “nature, balance, pattern, and context of occupations and activities” (Creek, 2003, p. 8) in the individual’s life and clearly identifies the focus for occupational therapy.

Communicating this conceptualization to the client in order to negotiate treatment goals is the next step (Kielhofner, 2008). The case formulations are shared with and validated by clients enabling all involved to “understand the rich complexity of occupational behavior,” (Hagedorn, 2000, p. 63). Based on the summary MOHOST shown in Figure 4, Figure 5 illustrates the case formulation for Sandra. Presenting the case formulation to Sandra helped her to understand why she felt so depressed and angry and she could appreciate that the occupational therapist was able to identify the issues facing her. Having previously been skeptical about the benefits of occupational therapy and reluctant to engage in interview procedures, Sandra agreed to negotiate measurable goals and explore possible solutions.

**REVIEWING PROGRESS USING THE MOHOST AS AN OUTCOME MEASURE**

It is a challenge to discover “appropriate tools to measure the quality of our work” (Clarke, Sealey-Lapes, & Kotsch, 2001, p. 1). The MOHOST is well placed to evaluate the effectiveness of occupational therapy inter-
Occupational identity. Sandra has always identified herself as a busy, active worker with strong interests in maintaining her personal fitness and a concern to support her family. Her son moved to live abroad 2 years ago and her parents, for whom she was the main caretaker, died last year, just after Sandra retired from her job as a receptionist at a health club. She has found it difficult to establish new interests or routines and compares herself unfavorably with her husband who has maintained a full social life since he retired 6 months ago.

Occupational abilities. Sandra has good process and motor skills and previously had excellent communication skills, but doubts her ability to cope and sees problems as being insurmountable. Her role within the family has diminished partly due to her relinquishing household tasks and partly because her husband has taken on various duties. Sandra describes having a lot of anger that she finds hard to express.

Key occupational issues. (1) Interaction. Sandra used to have multiple roles as a mother, as the carer for her parents and as a worker in a sociable job. Her alienation from previous roles reinforces her negative image of herself. She engages in a few solitary pursuits such as reading, watching television and doing crosswords but perceives herself as not having a meaningful routine. (2) Productivity. Sandra maintains a daily routine of getting dressed and eating hospital meals but currently has difficulty planning and making decisions. She is passive when offered choices, but angry and frustrated with herself when others make decisions for her. (3) Physical exercise. Sandra values physical activity and although she describes no longer feeling any enjoyment, she feels that she ought to maintain her fitness.

Summary. Sandra has experienced multiple role losses and despite her many skills she currently has difficulty engaging in social situations, pursuing a productive routine and maintaining interest in her physical fitness.

In those cases where occupational therapy services extend over time, the MOHOST can be used to document progress. In Sandra’s case, she was discharged from hospital after 18 days but continued to receive occupational
therapy as an outpatient. The focus of her goals therefore changed from performing activities in the hospital setting to reengaging in previously held occupations in the community. She became more able to evaluate her own progress, and Figure 6 shows an extract from a newly developed self-assessment form based on the single observation MOHOST that she completed after attending a badminton session. The form was originally designed in collaboration with service users to evaluate their participation in a group program. It allowed Sandra to be more actively involved in the assessment process by drawing on the MOHO concepts which were now familiar to her.

**UTILITY OF THE MOHOST FOR COMMUNICATION**

Figure 7 gives details from a summary MOHOST completed as a final outcome measure prior to Sandra’s discharge. Like all the other MOHOST assessments, this would have been discussed with Sandra and filed in care notes accessed by the whole care team. The ability of the MOHOST to provide a useful format for report writing and to structure the verbal feedback given to multidisciplinary teams (MDTs) is clearly appreciated by occupational therapists, as evidenced by the following comments:

Sharing MOHOST assessments with other members of the MDT has raised the profile of occupational therapy—people understand our role much more fully and as a result, referrals are more appropriate.

Other MDT members have welcomed our use of MOHOST. They say it helps them to understand the role of Occupational Therapy more fully. They like the concepts and language used and have begun to
FIGURE 7. Sandra final summary MOHOST—Report and Ratings.

Sandra currently has a much improved sense of her abilities though still requires support to maintain hope for the future and sustain interest levels. She has begun to reengage with some of her household roles and is exploring ways of extending her social network with a view to contributing to the running of a local badminton league. She is now more able to interact with confidence and although she still has occasions when she lacks energy, she appears much more at ease in her home environment and believes that her husband is more understanding of the difficulties she has faced.

<table>
<thead>
<tr>
<th>Motivation for Occupation</th>
<th>Pattern of Occupation</th>
<th>Communication &amp; Interaction</th>
<th>Process skills</th>
<th>Motor skills</th>
<th>Environment: Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
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</table>

use these themselves when talking about client’s strengths and needs. This helps with referrals and collaborative working.

Using MOHOST can help therapists maintain a clear sense of identity and role within their MDT, countering the pressures which sometimes push OTs towards generic working in mental health teams. It helps the therapist maintain a truly occupational focus in their assessment and clinical reasoning and it helps to communicate this to the rest of the MDT.

**CONCLUSION**

Our annual audits of the assessment process in occupational therapy services continue to demonstrate that the MOHOST is the most commonly used, standardized, occupation-focused assessment in our acute mental health settings. Routine use of the MOHOST in these settings has allowed
occupational therapists to embed theory into practice and to define their role within the team and to their clients by articulating their unique contribution to the treatment process (Forsyth et al., in press). In the future, we will be considering how to draw on the wealth of data generated through the use of MOHO assessments to research the effectiveness of the occupational therapy services. We have no doubt that the MOHOST will play its part in contributing to this much-needed evidence base.

REFERENCES


Received: 08/17/07

Revised: 11/01/07

Accepted: 11/01/07