



# The Vona du Toit Model of Creative Ability

A practical guide for  
acute mental health  
occupational therapy  
practice



VdT MoCA  
FOUNDATION (UK)



# **The Vona du Toit Model of Creative Ability**

## **A practical guide for acute mental health occupational therapy practice**

FIRST EDITION

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# Dedication

This book is dedicated to Vona du Toit whose major contribution to occupational therapy is yet to be fully acknowledged in the profession.

The Foundation is indebted to Dain van der Reyden for her endless generosity with knowledge, support and kindness.

Thank you also to Associate Professor Daleen Casteleijn for seeing the potential for the VdTMoCA to thrive in the UK and supporting us in making this happen.



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# Contributors

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**Wendy Sherwood** MSc, DipCOT qualified as an occupational therapist in 1991 and has worked in a broad range of mental health services, including with people with long term chronic conditions, rehabilitation, acute, day services for people with personality disorders, community mental health team, adolescent and medium secure forensic services. Wendy has 13 years' experience as a lecturer in occupational therapy. As a private practitioner, she has trained occupational therapists and support workers in the model nationally and internationally. In 2006 Wendy founded what is now the VdT Model of Creative Ability Foundation (UK) of which she is the Lead Director. Current projects include a PhD on the model and co-editing the first dedicated text on the model, for which she has also co-authored a chapter. In relation to the model, Wendy is particularly passionate about international collaboration and establishing a research evidence base.

**Beth White** BSc (Hons) is a clinical lead occupational therapist who has worked in mental health services since qualifying in 2001. Beth is currently the clinical lead of the adult occupational therapy mental health inpatient service at Berrywood Hospital in Northampton. Beth was introduced to the VdTMoCA in 2009. In 2010, supported by Sarah Wilson, she led a full occupational therapy service redesign in the adult acute mental health inpatient service at Berrywood Hospital in Northampton, which received an Innovative Practice Award. Beth's enthusiasm for the model continues to grow with seeing the developing confidence of occupational therapists in their professional identity and effectiveness through use of the model. Beth is one of the founding Directors of the VdT Model of Creative Ability Foundation (UK) and is an accredited trainer in the Activity Participation Outcome Measure. Beth has strong links with experts in the model in South Africa and is committed to developing the use of the model in the UK.

**Sarah Wilson** MSc, DipCOT is an occupational therapist with experience of working in mental health settings, predominantly in acute inpatient mental health since she qualified in 1991. Sarah is the manager of the mental health inpatient Occupational Therapy and Physiotherapy services for adults and older adults in Northamptonshire Healthcare NHS Foundation Trust and the lead for Occupational Therapy. In 2010 Sarah led a full service delivery change to underpin practice with the VdTMoCA. These services became the first Centre of Excellence in the use of the VdTMoCA in the UK. Sarah is driven by quality and the desire to improve service user outcomes and to this end has assisted many services to implement the model. Sarah has presented on the model nationally and internationally and is co-author of a chapter in a forthcoming text on the model. Sarah is a founding Director of the VdTMoCA Foundation (UK) as a natural progression of her commitment and enthusiasm for developing the use of the VdTMoCA throughout the UK.

# Preface

As the lead editor, editing this book has been a challenging but exciting venture. Upmost in my mind has been the desire to address the continuing professional development needs of colleagues in practice, aware of their need for support and guidance in using the Vona du Toit Model of Creative Ability (VdTMoCA) (de Witt 2005, 2014). With attempts to do so comes responsibility - to provide relevant and useful information that correctly represents the theoretical assumptions of the model applied to practice. I am grateful therefore, that this undertaking has been a collaborative one with colleagues that have a wealth of clinical and managerial experience in relation to acute mental health occupational therapy that is informed by the VdTMoCA.

To be able to embark on this book, just 12 years post the model's introduction to UK practice, is a milestone that was unimaginable when I was introduced to the VdTMoCA in 2003. I was lecturing in occupational therapy at the then named Essex School of Occupational Therapy when a South African occupational therapist called Carla van Heerden introduced me to the VdTMoCA. Carla was a Consultant Occupational Therapist in what was then known as South Essex NHS Foundation Trust (SEPT). Carla spoke of how much she had valued the model during her career for enabling her to work effectively and efficiently in mental health services with people of any diagnosis and degree of severity. I had a lot of experience as a mental health occupational therapist and I was aware of not always being successful in effectively engaging the most unwell service users in therapy. The assertion that the model could enable me to provide effective therapy to every person had a significant impact upon me. I decided to leave education and explore this model in forensic practice.

At that time, resources on the model were limited to a chapter in a South African occupational therapy text. There was no assessment form or clear explanation of how to undertake the assessment. I found much of what was written on the model difficult to understand, thus I was grateful for the occasional long arm supervision session from Carla. Those sessions enabled me to better understand the levels of creative ability as they manifested in the service users that I described to her from my practice. The insights and understanding that I gained encouraged me to continue and I gradually became a far more effective occupational therapist than I had in the previous nine years of clinical practice. Service users developed and recovered ability that I had not before been able to facilitate; they realised positive change that I knew to be the result of the occupational therapy that I had provided. What an exciting and satisfying experience.

Having commenced an MSc study on the assessment, I returned to education in order to share the VdTMoCA with undergraduate occupational therapy students. At the same time, the model was being implemented into practice in SEPT and I subsequently developed training for an increasing number of clinicians that had heard of its benefits to practice. I did not anticipate that the model's positive impact on practice would be as far reaching as it has been. Occupational therapists in mental health, forensic and learning disability services in particular have responded enthusiastically to the model. They have reported on how it enables them to more competently

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## CHAPTER ONE

# DEFINING PARAMETERS

WENDY SHERWOOD

### KEY LEARNING POINTS

- The meaning of creative ability and its relationship to the occupational therapy domain of concern
- The VdTMoCA as both a practice theory and model of practice
- How the VdTMoCA relates to the recovery model, client-centredness and personalisation

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### INTRODUCTION

The VdTMoCA is at an interesting stage of its development. As a model that was developed in South Africa and which received very little attention elsewhere for most of the last 50 years, it has remained a model that predominantly reflects the South African context. However, over the last 10 years, the VdTMoCA has been intensely explored in the very different socio-cultural contexts of the UK and Japan. The model has been scrutinised, questioned and discussed in ways never before experienced by our South African colleagues. A continuation of this process, supported by research will inevitably result in changes to the model and/or how it is expressed. In the main, the key concepts and theory in the model appear to be applicable in these very different cultures. However, it has also been a challenge to explain and relate aspects of the model to occupational therapists and other disciplines in these countries. This is partly due to the fact that there is not a comprehensive text on the VdTMoCA; the contemporary literature is one chapter by de Witt (2005, 2014) within a South African occupational therapy text. The size restrictions of a chapter of course prohibit in-depth explanation and discussion of the model. Journal publications, although still limited, are on the increase as is research at Masters and PhD level. Much knowledge is embedded in clinical experience within South Africa, this is not however readily available to the occupational therapy population at large. A textbook that is currently being written on the VdTMoCA will hopefully address many outstanding needs.

This chapter explains and discusses some of the parameters of the VdTMoCA as it relates to contemporary occupational therapy practice in the UK. This chapter may help you better understand the key concepts of the model and the position of the model in relation to key concepts in today's occupational therapy practice. It may also help you to explain key concepts to colleagues in the workplace, as needed for collaborative practice.

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## CHAPTER TWO

# THE VDTMOCA IN ADULT ACUTE MENTAL HEALTH

SARAH WILSON

### KEY LEARNING POINTS

- Contextual influences on the decision to implement the VdTMoCA in NHFT
- How the VdTMoCA has influenced the provision of occupational therapy in NHFT

### THE NEED FOR A NEW APPROACH TO PRACTICE

In the last 12 years, the VdTMoCA has become increasingly used in mental health, forensic, learning disabilities and older people mental health services (VdTMoCAF (UK) 2013, 2015a, 2015b). Data from a survey of 100 occupational therapists conducted in 2014-2015 by the VdTMoCA Foundation (UK), identified that fields of practice in which the VdTMoCA is mostly used or is of most interest are acute mental health and forensic mental health (Table 2). In these contexts, the model was identified as being highly valuable for enabling occupational therapists to effectively engage service users that present the most significant challenges to occupational therapists and service delivery.

Prior to learning about the VdTMoCA, our adult acute inpatient services in Northamptonshire Healthcare NHS Foundation Trust (NHFT) were struggling with a range of challenges that are common in this field e.g. short length of stay, broad range of diagnoses, and difficulties with engaging people that are very unwell or behaviourally challenging. In order to ascertain a way forward, a questionnaire was completed by all occupational therapists and support staff in our service, asking for their comments on all aspects of the occupational therapy pathway. The findings identified a variety of issues:

- On admission many of the service users were too unwell to engage with occupational therapy, yet with the reductions in length of stay was the pressure to work faster and smarter with our service users. Our response had been to provide a multitude of group sessions to elicit engagement and interest, but these were poorly attended by the majority of service users.
- The occupational therapists felt very busy and overloaded with the group programme. This was compounded by doing generic tasks such as taking service users to the local cash machine or to the shops to get cigarettes. In part, they did this in order to feel valued by the wider team. As a result, therapists felt frustrated that they were not meeting their potential as professionals.
- The occupational therapy team was unsure about its role in the acute mental health setting and they had lost confidence. This was due to us measuring our effectiveness by the amount of interventions we provided. This was supported by the multidisciplinary

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## CHAPTER THREE

# HOW AND WHERE TO START: 7 STEPS TO IMPLEMENTATION

SARAH WILSON

### KEY LEARNING POINTS

- Stepwise implementation of the VdTMoCA in practice
- Models guiding change
- Transfer of knowledge to own clinical setting

### A STARTING POINT

Individual or groups of occupational therapists that are considering using the VdTMoCA, frequently face the dilemma: "it's a good idea, but how do we start to make changes while still providing our existing service?"

This chapter aims to assist occupational therapists in starting the process of implementing the VdTMoCA by guiding consideration of steps that could be taken. Of course there is no 'one size fits all' approach, no recipe for success and no right or wrong approach. It is important to acknowledge that each occupational therapist will have differing drivers for change and face different challenges that will influence implementation. Occupational therapists will possess varying skills and knowledge, have different expectations of the value and potential impact of the VdTMoCA, and face diverse levels of support or challenge from surrounding people. Therefore it is important that the following content is considered and adapted according to one's own distinct setting and variables. For the purpose of this book it is assumed, however, that acute mental health services are likely to have the following commonalities:

- Service users will be cared for in the setting 24 hours a day
- Predominant staffing of inpatient units will be nurses and occupational therapists in a multidisciplinary team but numbers, skill mix and line management structures will be different to each organisation
- Occupational therapists will provide assessment and treatment predominantly in a ward environment (may be locked in the case of a psychiatric intensive care unit)
- Off ward therapy areas may be available to some occupational therapists, as well as varying use of community based assessment and intervention depending on resources and service based expectations
- Service users will have differing leave restrictions that may impact on access to occupational therapy
- Length of stay will be time limited; there is a focus on minimal length of stay and eliciting improvement for safe discharge. A pressure on bed occupancy may dictate the timing of discharges and admissions

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## CHAPTER FOUR

# CASE EXAMPLES

BETH WHITE, WENDY SHERWOOD

### KEY LEARNING POINTS

- How the VdTMoCA can inform the occupational therapy process in acute mental health practice
- How the occupational performance grid is used to identify the overall level of creative ability
- Applying the treatment principles for levels of creative ability

## INTRODUCTION

Learning to effectively apply the VdTMoCA takes many years - it is a model that grows with you as you develop as an occupational therapist (Sherwood 2005). Through practice, experiences of service users create 'pictures' of service users at particular levels and phases of creative ability, and of assessment and treatment interventions that have been effective. That is, knowledge evolves through practice-based learning. Ideally, learning occurs through practicing alongside colleagues with greater knowledge and experience than oneself i.e., through apprenticeship. In the UK, most VdTMoCA occupational therapists do not have an apprenticeship opportunity. Thus, written case examples are frequently requested from the Foundation.

This chapter provides cases to illustrate how the theory of the Vona du Toit Model of Creative Ability may be applied in practice. Prior to the cases, there is information to orientate you to the case examples in terms of the occupational therapy process as it is guided by the VdTMoCA in Berrywood Hospital and the Welland Centre in Northamptonshire Healthcare NHS Foundation Trust, hereafter referred to as NHFT. These process would have been considered and/or applied in the cases. In this section, there is also content that expands upon information already available in the literature on the application of the model. There then follows five case examples.

It is recommended that you read the cases alongside the de Witt (2005, 2014) and du Toit (2009) literature, in order to review the levels of creative ability and associated treatment principles as illustrated in the cases.

## ORIENTATION TO CASE EXAMPLES

The following information complements and is in addition to the guidance on VdTMoCA assessment and treatment provided by de Witt (2005, 2014) and du Toit (2009).

**Introduction to occupational therapy:** In NHFT, the role and purpose of occupational therapy is explained to each service user. One of the ways that this is done is through providing service

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## CASES

What follows is a series of case studies that illustrate the application of the VdTMoCA in adult acute mental health practice. The cases describe a range of assessment methods, aims and treatment sessions in relation to people on the levels of Self-differentiation to Passive participation. Although other acute mental health services may also see people at the Tone and Imitative participation levels, in NHFT it is unusual to work with people on these levels. Therefore, we have not included examples of people on these levels of creative ability. Confidentiality in the cases has been maintained through the use of pseudonyms and exclusion of specific details that could identify individuals.

The full complexity of practice and the richness of contextual situations cannot be adequately relayed through case examples, but the following cases serve to illustrate the occupational therapy process informed by the VdTMoCA. These cases cannot detail all of the information that was gained or all of the processes and clinical reasoning that occupational therapists and teams undertook, or could undertake in practice. Some of the cases contain more assessment information than others, reflecting the reality of acute mental health practice in that therapists do not always have an abundance of opportunities to undertake assessments. However, the cases illustrate that it is possible to gain adequate information relatively quickly in the acute setting to be able to commence treatment.

---

### **BEN: SELF-PRESENTATION, PATIENT DIRECTED PHASE**

Ben was 27 years old and admitted to hospital under section 2 of the Mental Health Act (1983, 2007) following a relapse of a schizoaffective disorder with which he was diagnosed five years ago. Ben had been experiencing symptoms of elation, paranoia, pressured speech, and flight of ideas. He lived with his father and grandmother; his mother died two years ago. His older brother lived locally.

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## ASSESSMENT

### **Observation and interview**

In addition to routine observations outlined on pp. 44-45, therapists observed Ben as he participated in a 30 minute, organised basketball session with a sports technician and five other service users. The sports technician was trained in the VdTMoCA as part of the occupational therapy team. The activity was familiar to Ben and it was carefully structured by the technician with clear rules. In assessing his level of creative ability it was important to remember that the session was completely directed and was an adapted game of basketball rather than a game with standard rules and team demands. It did not require the executive functioning and normal compliant social behavior that the usual game of basketball would demand. Rather, the sports technician used a variety of short, graded activities to retain focus and to limit social demands.

For the other service users, the session was a treatment session that was utilised as an assessment opportunity with Ben. In the session Ben was observed to be at the level of Passive participation, therapist directed phase. It is noted, however, that the session was structured and facilitated for Passive participation level of performance.

Due to the symptoms that Ben was experiencing, a discursive informal interview was used to gain insight into Ben's life and experiences rather than a formal interview. Ben explained that he had been working as a graphic designer prior to admission, but had found this increasingly problematic due to increasing psychotic symptoms. Ben said that he had an interest in music and named some of the artists that he liked to listen to. He also said that he enjoyed dancing to music, cooking, physical activity and art, but he was unable to provide more detail due to thought disturbance, which affected his ability to focus attention. During conversation he appeared irritable and lacking tolerance for interaction and the company of others.

## OCCUPATIONAL PERFORMANCE AREAS

### Personal management

With several prompts, Ben was able to wash and shower without assistance. His room was untidy. Although he was shown where to do his laundry and he said that he knew how to use the washing machine, Ben did not organise getting his laundry done. He ran out of clean clothes and he wore dirty clothes for several days before doing laundry with supervision from a nurse. With a lot of structure and support he began to carry out a personal management routine. Prior to admission, grooming had been important to him such as flossing his teeth, having a close shave and styling his hair. This became evident during discussion of the personal care items that were brought into hospital by his family when he was admitted. However, he did not carry out these grooming activities, appearing to have lost interest in them.

Assessed level of creative ability: Self-presentation, transitional phase

### Social ability

Ben's communication was superficial in that he could comment about what was immediately apparent to him and that which was fairly concrete e.g. the weather or a football match he had watched on the television. He was able to start conversations but had difficulty maintaining this: he rapidly changed the subject or became distracted by something else that came to his attention. He also struggled to consider others, finding it difficult to tolerate interaction with them. Ben often made inappropriate comments about others' appearance, appearing rude and insensitive. He also interrupted conversations, apparently unaware of the impact that this had on others.

Assessed level of creative ability: Self-presentation, therapist directed phase

### Use of free time

Ben had a number of leisure interests, but he was unable to organise himself to participate in them in a constructive manner. He enjoyed dancing and would take up other interests, but due to a limited attention span and chaotic behaviour, he was unable to participate in them without structure and support.

Assessed level of creative ability: Self-presentation, patient directed phase.

### Work ability

**Task assessment:** Cognitive Games – this activity was unfamiliar to Ben. It was a puzzle game (Rush Hour) that took place in a small group on the ward. Ben was appropriately dressed for the day although his grooming in terms of shaving, cleanliness of his nails and hair was poor. He showed interest in the game, but he required prompts and reassurance in order to participate. Observations suggested that Ben had partial task concept because he understood the task and the principle of it, but engagement in the activity showed problems with task execution, completion and evaluation. Doing the activity required supervision in order for him to understand rules, understand the process of the activity and to follow simple instructions. Regular support had to be provided in order for him to sustain effort because he was easily distracted. At times his actions were erratic and not thought through. He had limited frustration tolerance when the game was not going the way that he thought it would. He struggled to reflect on his performance and to evaluate it.

Ben did not adhere to the social norms of turn taking and he made inappropriate comments to other service users. Symptoms of his illness were evident i.e. laughing inappropriately, suspiciousness of others and pressured speech. He was explorative in his actions; trying different ways to complete the puzzle in a 'trial and error / find out' way rather than with a focus on doing the puzzle correctly or well.

Ben had norm awareness for appearance i.e., he had acceptable personal hygiene and dress for situations. However, the way that he presented himself socially was sometimes unacceptable e.g. dancing inappropriately and interacting inappropriately with others. Regarding his daily activities and routine, Ben was disorganised, unable to initiate tasks and activities, plan ahead, set realistic goals or carry out a daily routine effectively independently. There were frequent incidences when Ben's behaviour was socially unacceptable and he was unable to demonstrate occupational performance according to basic, generally socially acceptable norms.

Assessed level of creative ability: Self-presentation, therapist directed phase.

## IDENTIFYING LEVELS OF CREATIVE ABILITY IN THE OCCUPATIONAL PERFORMANCE AREAS AND OVERALL LEVEL OF CREATIVE ABILITY

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Ben's level of creative ability was Self-presentation in all four occupational performance areas (OPAs) (Table 4). For personal management he was in the transitional phase; for social ability and work ability he was in the therapist directed phase, and for use free time he was in the patient directed phase.

Out of the four OPAs, two were in the patient directed phase. Social ability and work ability are highly influential on occupational performance (de Witt 2014). For both of these OPAs, the phase is therapist directed therefore, the overall phase is patient directed.

Table 4												
Recording levels and phase of creative ability in each OPA: Ben												
Level of Action	Personal Management			Social Ability			Work Ability			Use of Free Time		
	TDP	PDP	TP	TDP	PDP	TP	TDP	PDP	TP	TDP	PDP	TP
Unconstructive												
Incidentally constructive												
Constructive, constructive explorative			X	X			X				X	
Norm awareness experimental												

Key: TDP= therapist directed phase; PDP = patient directed phase; TP=transitional phase

## ANALYSIS – PROBLEM FORMULATION

Ben was motivated to participate in activity and gained satisfaction from the process of doing activities rather than from doing activities well. Norm compliance for behaviour and task performance was not evident; this appeared to be due to lack of awareness and attention caused by disturbed cognitive processes and mood rather than a lack of understanding or value of social norms.

Whilst Ben appeared to have the drive for activity participation with others, the schizoaffective disorder was interfering with occupational performance. He was unable to control mood and thought disturbance, which affected the quality of his performance and the duration of effort that he could exert. In particular, flight of ideas and limited focus of attention appeared to have a significant impact on his ability to execute tasks and activities. A number of executive functions were not apparent. Executive functions are essential for work ability e.g. planning, organisation, problem solving, self-evaluation and judgment. All of these functions were problematic for Ben due to problems with functions such as attention and awareness. He also had poor control over his emotions for example, he had limited frustration tolerance and there was impulsivity. These significantly affected his day-to-day performance of a broad range of activities across the occupational performance areas.

Ben had limited insight into his behaviour and the effect that it had on other people. Without insight and good emotional and social judgment, it was difficult for him to control and adjust his behaviour to that which was socially acceptable. The poor quality of his interactions and the socially unacceptable behaviour that he exhibited had a negative impact on his ability to form relations with others. Due to the problems with occupational performance, Ben required constant support and supervision from others to enable him to successfully participate in activity and carry out a routine. The amount of supervision required was due to problems with function rather than motivation.

Occupational therapists understand that when one is motivated to do something, but is unable to do it effectively/successfully, this can be a negative experience that affects one's self-esteem and subsequently motivation. At that time the occupational therapists did not need to prompt,



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encourage and support Ben to decide to do activity as he already had the motivation for activity... ..THE REMAINING CONTENT OF THIS CHAPTER IS NOT AVAILABLE AS A PREVIEW.

THE CONTENT INCLUDES: AIMS, GOALS AND TREATMENT PLANNING; TREATMENT PLAN INCLUDING EXAMPLES OF OCCUPATIONAL THERAPY SESSIONS AND HOW THEY WERE GRADED; SERVICE USER EVALUATION AND FEEDBACK.

THERE ARE 5 CASE EXAMPLES.

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## CHAPTER FIVE

# OCCUPATIONAL THERAPY TREATMENT PLANNING AND EVALUATION

MIRIAM LORKINS, BETH WHITE, SARAH WILSON

### KEY LEARNING POINTS

- Relate treatment planning and delivery to the current health and social care agenda
- Targeted treatment
- Inform service delivery, funding and commissioning

This chapter describes several initiatives developed at NHFT to enable the occupational therapy team and the multidisciplinary team to provide effective service delivery and discharge planning. The demands for effectiveness in the current health and social care arena are outlined to set the initiatives in context. This is followed by an explanation of occupational therapy treatment pathway templates that have been developed. These are set out in this chapter as a resource that you may consider in your practice. This chapter also illustrates how the VdTMoCA can be shared with a multidisciplinary team and how occupational therapy treatment provision can be evaluated and audited.

### THE CONTEXT FOR TREATMENT AND DISCHARGE PLANNING

All health and social care staff in the UK continue to face significant financial challenges in order to maintain the fundamental principles of equitable, personalised, effective and safe healthcare for all (Department of Health 2011). The many government driven reviews of health and social care in the UK over the past 20 years have built upon common themes, such as driving cost efficiency, focusing on evidence based effectiveness and the ability to demonstrate quality of care provision. The Health and Social Care Act (2012) has changed the way services receive funding through development of clinical commissioning structures. In this structure clinical commissioning groups hold healthcare budgets for their local geographic area, in order to allocate funding to services to meet the local healthcare needs of their community. Development of 'currencies' of payment for clinical pathways (such as stroke, coronary care, mental health) with the introduction of a National Tariff payment system, was to ensure funds were allocated based on the numbers, complexity of patient needs and clinical outcomes. The Mental Health Payment by Results Guidance 2013-14 (Department of Health 2013) identified the tariffs and clustering system for mental health was designed to ensure service users were "offered the right package of care, based on best practice, but personalised to meet their individual needs, and focused on supporting service users to move towards recovery" (p. 4). The healthcare arena at the time of writing this book will change, creating new structures for the

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occupational therapist to navigate. However, what will remain constant is the requirement for us  
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## TEMPLATES

### Non-Psychotic Disorders (Very Severe)

Key characteristics of service user group to consider prior to treatment:

**Individuals present with very severe depression or anxiety.** Focus of treatment for depressed service users will likely be around sensory stimulation to elicit responses for engagement and for anxiety service users, lowering arousal and anxiety levels.

**Limited functioning within all occupational performance areas.**

**Limited connection to daily life.** Will have limited awareness of the environment and those around them, will have difficulty connecting to normal routines and may have random biological patterns (e.g. sleeping during the day and poor nutrition and hydration)

**Impacted affect.** Is likely to express either agitation or apathy, although will be unable to reason why. Demonstrates responses such as; withdrawing to quiet small spaces, wrapping self in blanket, and pacing.

**ASSESSMENT PURPOSE** (additional to rationale on template): To determine likely level of recovery, to plan for realistic and timely discharge. Previous mental health history important in understanding probable long term impact of illness.

Specific assessment methods: (additional to methods on template):

- Individual assessments to be used. Social ability to be assessed through interactions with therapist and through observations in communal spaces and communal activities (i.e. meal times / when with visitors).
- Assessment Tool: Creative Participation Assessment
- Outcome measure: Creative Participation Assessment & Activity Participation Outcome Measure

### TREATMENT

**Stage One:** Likely level of creative ability is Self-differentiation; if the person is assessed as having some features of the Self-presentation level the therapist may apply some of stage two treatments.

**Expected outcomes:** Duration of stage is one week – the focus within this period is for therapist to elicit a sense of safety through use of self and the environment. Self-differentiation treatment principles are used to prevent withdrawal and increase awareness of self and environment. Careful handling is applied to develop a therapeutic relationship in preparation for stage two treatments.

**Treatments:** based on Self-differentiation treatment principles

- Therapists use their understanding of the person to optimise therapeutic opportunities e.g. a therapist who knows that the service user pre-morbidly enjoyed gardening, will walk alongside them in the garden and where appropriate encourage smelling a flower, touching soil or listening to birds.

**Stage Two:** Likely level of creative ability is Self-presentation (if a person is at Self-differentiation level they will continue with treatment at stage one).

Expected outcomes:

- This stage is separated into two, the anxiety pathway and the depression pathway.
- Self-presentation treatment principles have been applied to both pathways.
- This stage continues until discharge from hospital. Anticipated admission length does not exceed eight weeks (this is important in calculating cost of treatment provision). If

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THE TEMPLATE FOR THIS DIAGNOSTIC GROUP IS AVAILABLE AS A SEPARATE PDF.  
THIS BOOK CONTAINS A FURTHER 11 DIAGNOSTIC GROUPS AND TEMPLATES.

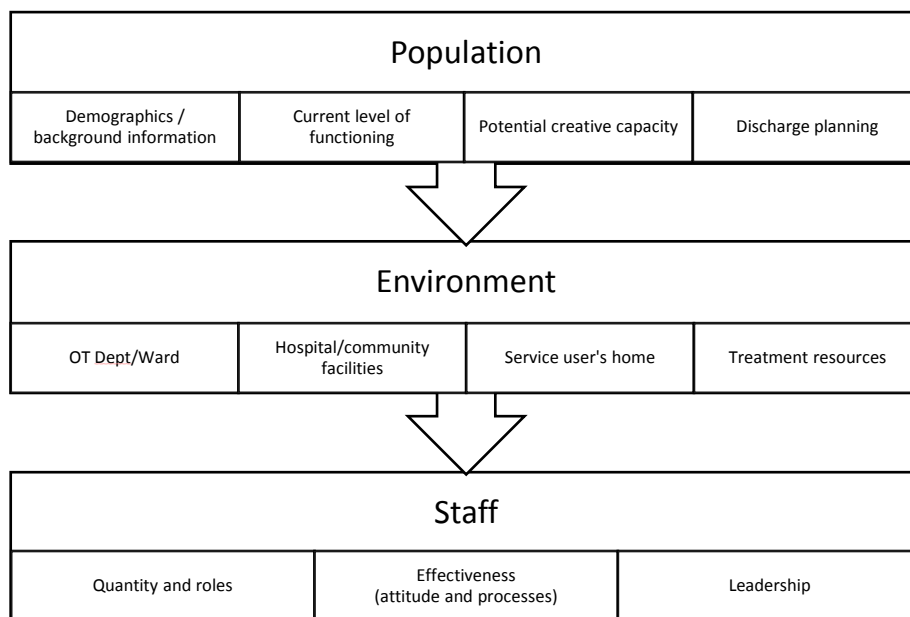
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## DESIGNING A TREATMENT PROGRAMME FOR A POPULATION

An important aspect of the occupational therapy role in the acute inpatient environment is the design of a treatment programme that effectively and efficiently addresses the identified needs of the population. The benefit of an occupational therapy programme is that it enables a number of individuals' needs to be met at the same time in the format of groups, thus making optimum use of staff time whilst maximising the number of treatments individuals can receive. The treatment principles of the VdTMoCA assist occupational therapists in how to best provide treatment for optimum outcomes i.e. service users at the Self-presentation level of creative ability usually need social opportunities to increase awareness of others and develop social skills. In the development of a programme when guided by these principles, occupational therapists will understand the format and environment within which treatment should be provided.

For the purpose of illustrating the process of planning a treatment programme for a population, such as a ward or collection of wards, a fictitious group of fifteen service users is referred to in this chapter. Occupational therapists undertaking programme planning will need to draw upon the following information about the population, the environment and staffing (Figure 4):

- A full baseline assessment of all service users functioning
- Service users' treatment plans
- Current and historical risk assessment, which may impact on the structure and delivery of treatment (e.g. consideration of tools, interactions with others)
- An understanding of the multidisciplinary team discharge plan, including the potential discharge timeframe, environment and required level of support
- An understanding of resources available (staffing, environment, equipment) and limitations to enable realistic programme planning



**Figure 4. Considerations for programme planning**

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END OF PREVIEW

THE REMAINDER OF THE BOOK CONTAINS:

## **CHAPTER SIX: Moving forward**

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### **Glossary**

### **Appendices**

- 1 **Treatment protocol examples:**
  - General treatment protocol - Self-differentiation
  - Marbling - Self-presentation
- 2 **Occupational therapy leaflets**
  - Self-presentation
  - Passive participation
- 3 **VdTMoCA action planning template**
- 4 **VdT Model of Creative Ability ward information pack**
  - How to approach a recovery focused daily routine based on the VdTMoCA
- 5 **Laminated service user levels sheet**
- 6 **Task assessments:**
  - Dot paint art
  - Cheese scone recipe
  - Smoothie making
  - Clay coil pot
  - Making a frog with clay
- 7 **Occupational therapy assessment one page summary**
- 8 **OPA grid guidance**
- 9 **Occupational therapy treatment delivery team evaluation forms:**
  - Self-differentiation treatment
  - Self-presentation treatment
  - Passive participation treatment
  - Imitative participation treatment
- 10 **Drumming group protocol**