Implementing The Model of Creative Ability in an Acute Mental Health Inpatient Setting.

Owen Chinembiri

(Senior Occupational Therapist)

Rochford Hospital

Content of Presentation

- Brief Overview of Department
- Pre Model of Creative Ability (MoCA)
- MoCA Theory and Literature
- Transformation
- New Programme
- Conclusion
- References

Rochford Hospital OT Department

2 Acute Admissions Wards, 22 beds each

Occupational Therapy (OT) Staff:

- Head Occupational Therapist (0.72 whole time equivalent (wte))
- Band 6 Occupational Therapist (1.0 wte)
- Band 5 Occupational Therapists (3.5 wte)
- Band 4 OT Technicians (0.5 wte)
- Band 3 OT Technicians (1.6 wte)
- Band 2 OT Assistant (0.5 wte)
- Pottery Specialist (0.1 wte)
- Dedicated Therapies Suite: Kitchen, Arts and Crafts Room, IT Room and a Multi Activity Room
- Therapy Rooms on the ward

Pre MoCA

- The department had a therapy program that consisted of the orthodox OT groups and activities, arts and crafts, cooking, which are synonymous with OT (Holder 2001)
- The groups were divided into “closed” department based groups and “open” ward based groups
- Clients who were acutely unwell were generally not engaged as they were deemed as difficult to engage - contact was made but they did not become involved in sessions run
- At the time, clients tended to stay in hospital for longer periods of time so we could afford not to engage clients initially and wait until they improved

MoCA Theory and Literature

- When the MoCA was being introduced in the Trust we read through available theory and scrutinised our current program to see if it fitted in with MoCA
- du Toit (1972) and (van der Reyden 2003) and (de Witt 2005)
- Findings
  - We had been trying to engage functioning at different creative ability levels in the same therapy groups
  - We also looked at the treatment we currently provided
  - Our client group range was mainly Self Differentiation to Self Presentation. With a few clients at Tone and Passive Participation
  - Any therapy activities that we were running at the time that did not meet the requirements of the identified levels were dropped
  - From the groups that met the activity requirement we looked at how they could be graded for the different functional levels
  - We also then looked for new groups and activities that would be appropriate for our client group

Transformation

- We then proceeded to develop a program with three Tiers
- Tier 1: Tone and Self Differentiation (Therapist and Client Directed Phases) Clients at this Tier are still acutely unwell and tend to be confined on the ward. These clients are only engaged individually or in small ward based therapy groups which tend to be short, repetitive with immediate gratification
- Tier 2: Self Differentiation (Transitional) and Self Presentation (Therapist/Client Directed Phases). Client's symptoms are starting to subside and can now be engaged outside the ward. Therapy aims to increase norm awareness and facilitate interactions and offer quick gratification
- Tier 3: Self Presentation (Client Directed/Transitional Phases and higher) At this Tier clients are now generally in control of their symptoms, and can manage longer therapy sessions. Therapy is in groups and the aims are to improve performance in tasks, compliance with social norms and activities must still be flop proof

New Program

- Examples of Changes

  Cooking was divided into 4 sessions

  – 1)Cooking on the ward (Tier 1): Fruit Salad

  – 2)Baking and Snack Group (Tier 2): Cheese Straws

  – 3) Lunch Cooking and Breakfast (Tier 3): Meals

  Arts and Crafts also split across the three Tiers.

  Computers was expanded to include Photography for Tier 3 clients

Conclusion

- We have now been using the program for about 2 years and are now reaping the benefits through higher attendances and better quality of engagement to our therapy groups
- We have been able to now work with clients who are unconstructive in their action levels and had previously been problematic to work with and sometimes omitted all together, similar to what was experienced by van der Reyden (2006)
- We are also now able to work with clients across the range of functional levels and provide therapy that is more appropriate to their functional level
- The model has helped in guiding technicians and therapists in use of handling principles appropriate for the level of functioning
- Our therapy programme continues to develop as our knowledge of the model increases and in line with changes in staff, working environment and policy changes

References

- De Witt PA (2005) Creative Ability – A Model of Psychiatric Occupational Therapy IN Crouch RB and Alers VM. *Occupational Therapy in Mental Health and Psychiatry* 4th edition 3 – 61
- Van der Reyden D (2003) Planning an occupational therapy programme for large numbers of institutionalised patients. Chapter 5, Part *2 Issues in Occupational Therapy* (2003) 3rd Edition pg 97-124. Atheneum Press Limited, Gates Head, Tyne and Wear, UK.
- Van der Reyden D (2006) The Model of Creative Participation (Model of Creative Ability) Unpublished Presentation at London South Bank University February 16 and 17 February 2006.
- Du Toit V (1970) Patient Volition and Action in Occupational therapy, A paper delivered to The South African Association of Occupational Therapists National Congress, CapeTown 1970. Published by The Vona and Marie Du Toit Foundation.
- Haiman S (1989) Occupational Therapy in Mental Health (A Journal of Psychosocial Practice and Research) Volume 9, No 4 1989. The Haworth Press. New York.
- Holder V (2001) The Use of Creative Activities within Occupational Therapy. *The British Journal of Occupational Therapy,* 64 (2)