THE VdTMoCA IN JAPAN – A SUMMARY OF KEY ASPECTS FOR FUTURE RESEARCH AND CONSIDERATION

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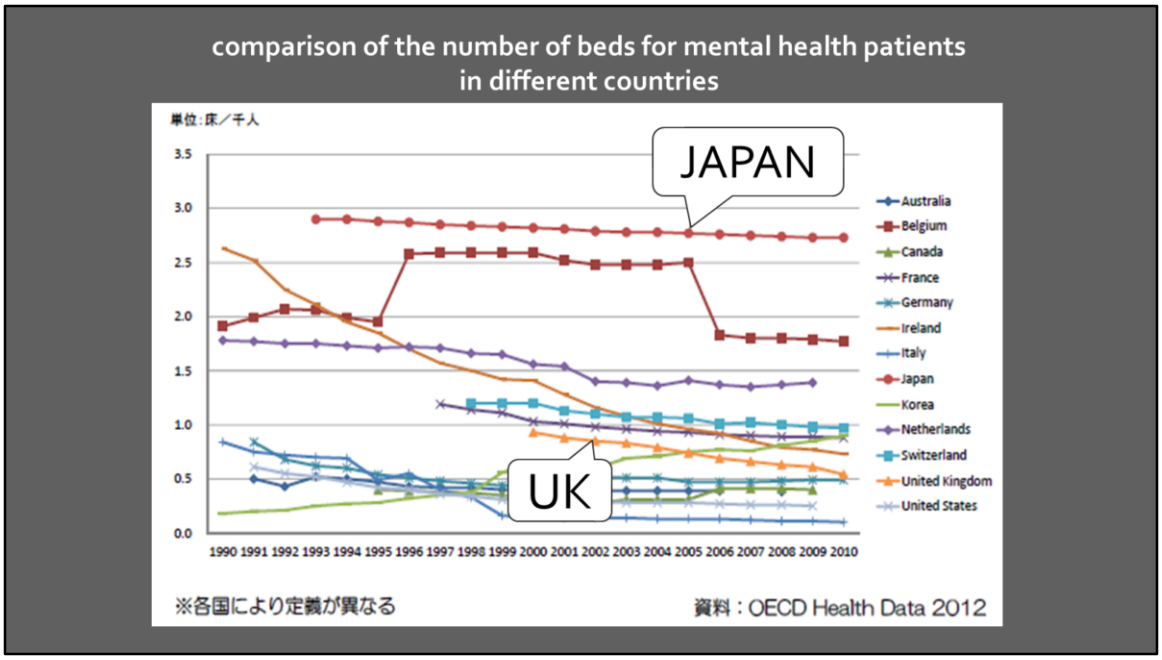
I am presenting on behalf of the VdTMoCA study group OTs in Nagasaki.

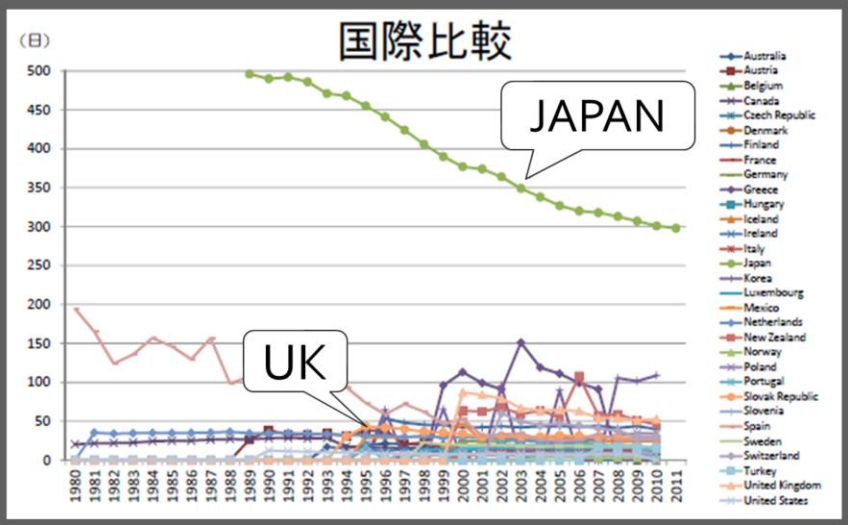
We wish to share some of the benefits and challenges of learning and using the VdTMoCA from our perspective, as a contribution towards considerations for research and further developing the model.
First of all, to set the context of our experiences in mental health services.



These figures were presented by my colleague, Satomi at your 2015 conference.

This graph illustrates a comparison of the number of beds for mental health patients among different countries. Japan is at the top of the red line and England is the orange line. In Japan, in 2014 there were 1071 hospitals for people with mental health problems. Currently, there are approximately 32,000 people hospitalised.

comparison of the average number of days that mental health patients spend in hospital



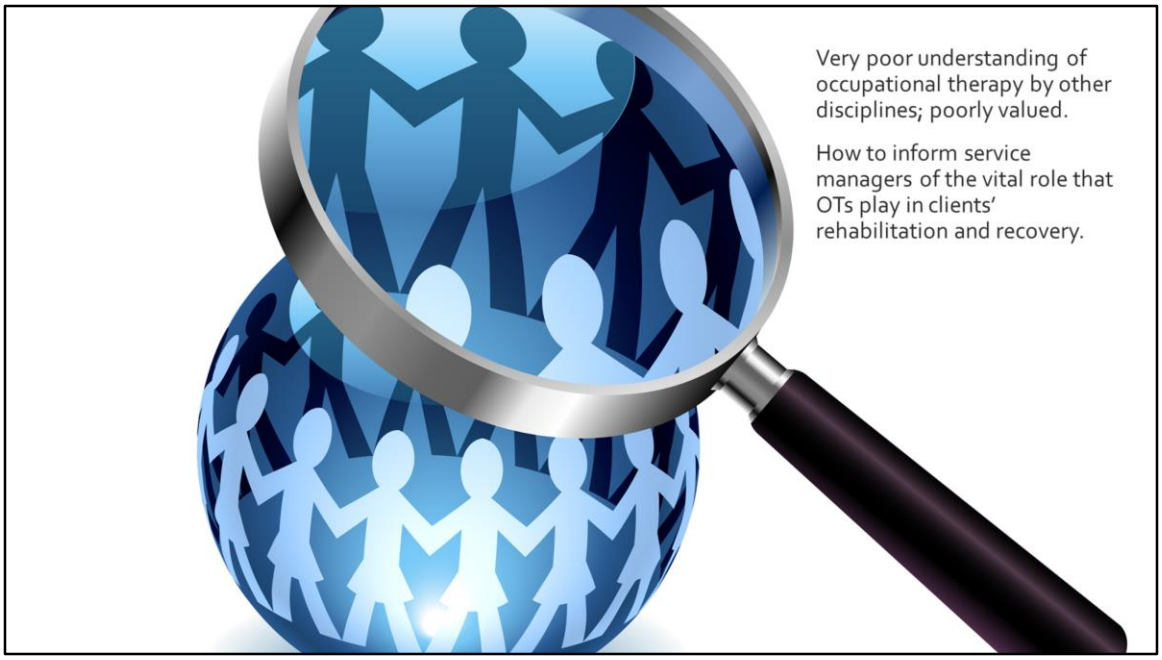
This is a comparison of the number of days on average that mental health patients spend in hospital. The vertical line stands for the number of days, and the horizontal line stands for the number of years. In 1989, the average length of stay was 500 days, and even though it has steadily declined, it is still 5 to 6 times longer than many other countries. Hence, it can be said that admission of mentally ill patients in Japan is for the long-term.

In 2004 the Japanese government aimed to reduce the number of hospital beds to 70,000 in ten years. However, they have only managed to reduce them by 10,000. The reason is that Most mental health hospitals in Japan are privatised and run for profit. The more treatments that are carried out, the more profit hospitals make. Hence, reducing the number of beds automatically reduces their revenue source.

The following figures correspond to the revenue to Himi Central Hospital derived from OT treatments. Between the 5 OTs they provide a service for 1600 to 1800 cases on a monthly basis, which amounts to

→£18,053.10～£20,309.73

Even when we make this much money, the hospital constantly pushes the OTs to see more and more patients and generate more and more income. This, is our context of occupational therapy practice in Japan.

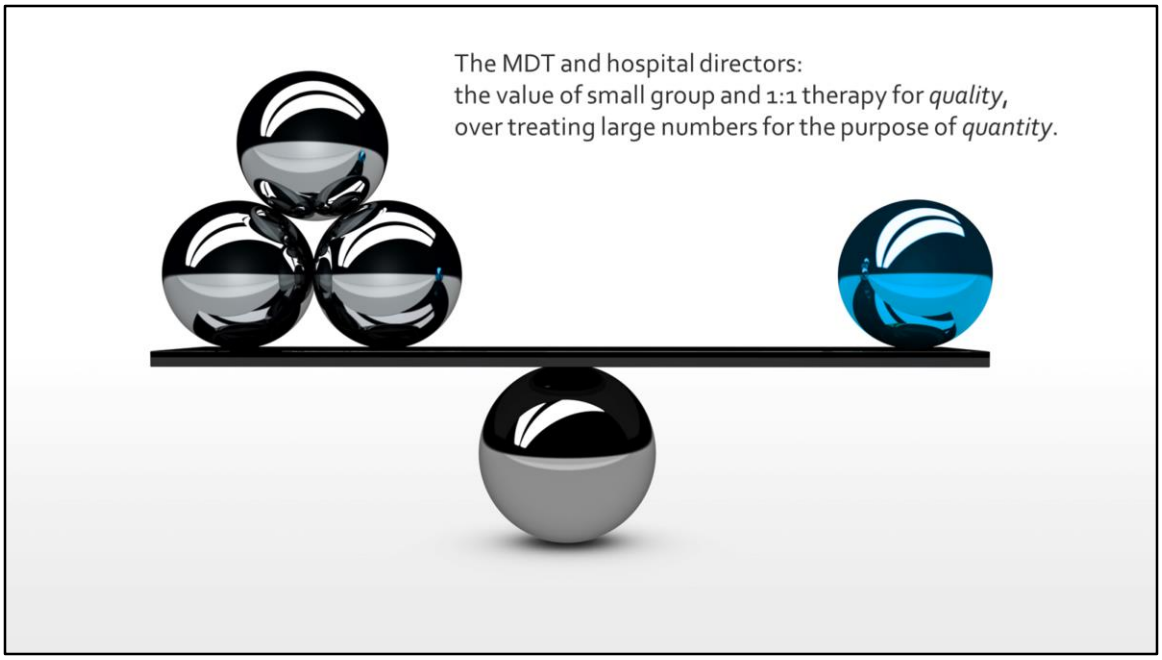

Very poor understanding of occupational therapy by other disciplines; poorly valued.
How to inform service managers of the vital role that OTs play in clients' rehabilitation and recovery.

Due to their potential to generate income, occupational therapists are under significant pressure to treat people in large groups – there is a focus on quantity before quality.

Previously, doing this was problematic due to therapists attempting to facilitate large group activity sessions without knowing how to recognise the differing levels of ability of patients. Through using the VdTMoCA, we are able to deliver quantity without compromising quality. Through the model, therapists are able to identify which levels of creative ability patients are functioning on, and subsequently plan, structure and present sessions in a way that allows for and thus better enables participation at different levels, whilst still catering for large numbers of people. This has been possible for sessions that are exercise, game, or simple task-based, and for between 30-60 patients within the same session.

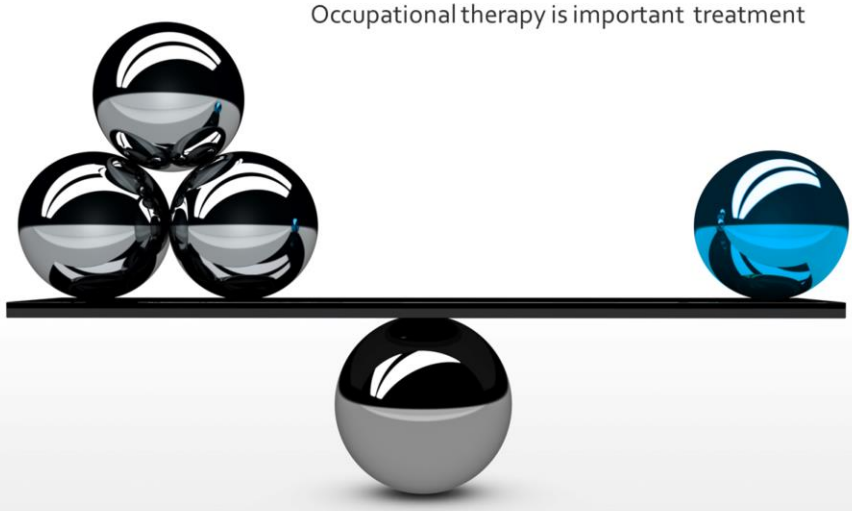
As illustrated in Mr Motmura's presentation, Occupational therapy has had a significant positive impact on patients who exhibit complex and highly challenging behaviours.
Previously, these people would have been deemed too challenging to work with effectively – not suitable for OT. However, the VdTMoCA helps Ots realise that no

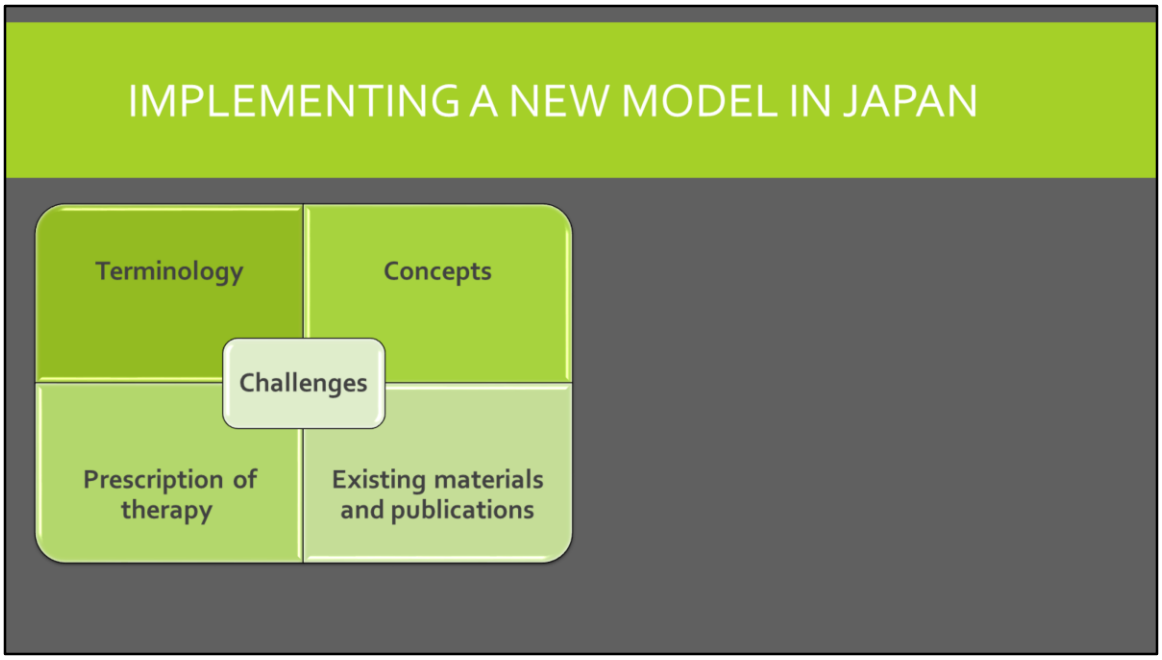
one is unsuitable for OT. It is not that the person is unsuitable for OT, but that the OT that we traditionally have known how to provide, is not suitable for the person. That has all changed. We can provide OT to all, and most importantly, we can clinically reason, justify and explain it.
To summarise the key benefits of the VdTMoCA ..



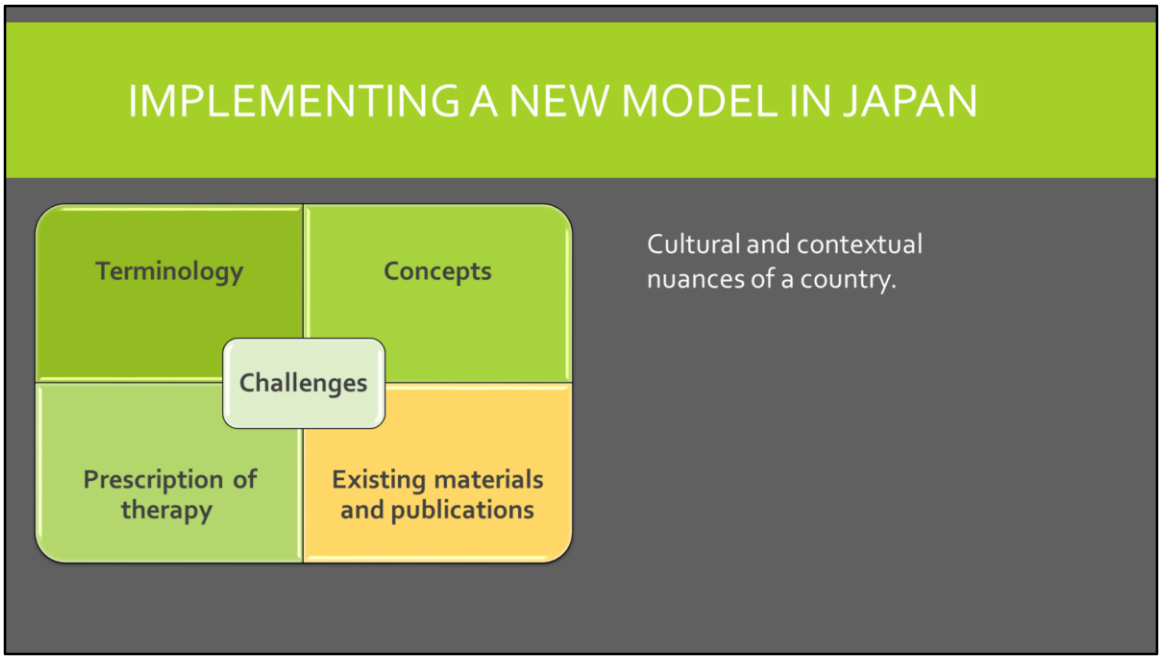
As Mr Motomura has demonstrated, for some people individual therapy is essential. As you can appreciate, it is highly irregular for Ots to spend their time with just one patient, for economic reasons. However, the outcomes achieved are enabling

Occupational therapy is important treatment

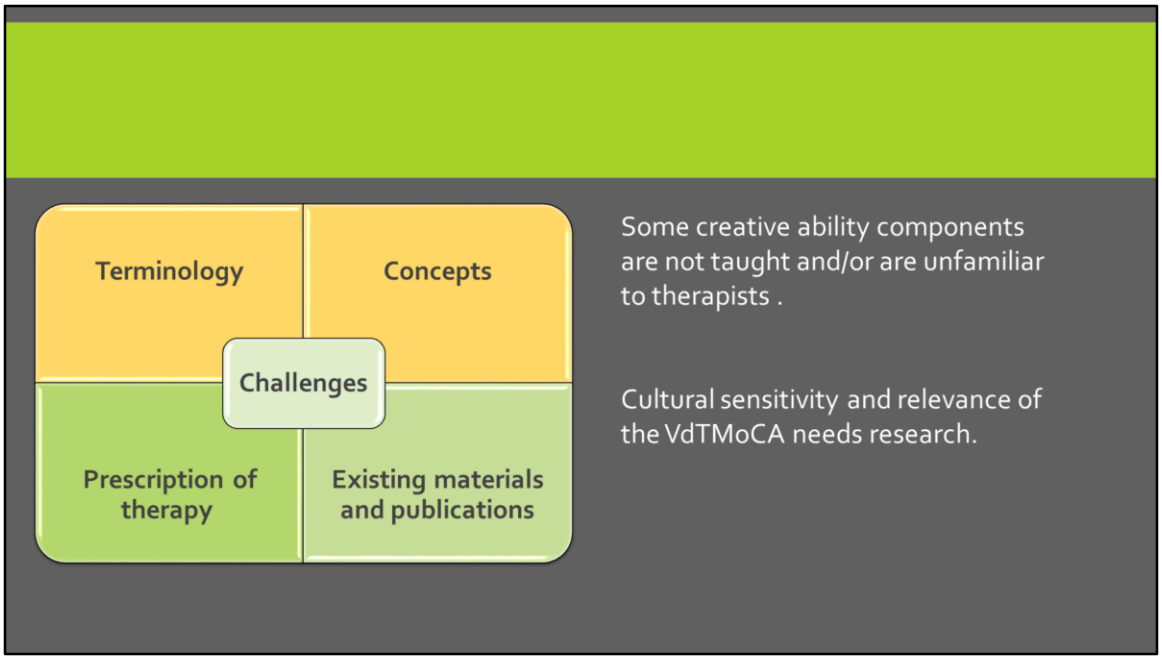




To date, the main challenges in using the VdTMoCA have been to do with terminology, concepts, prescription of therapy, and existing materials and publications.



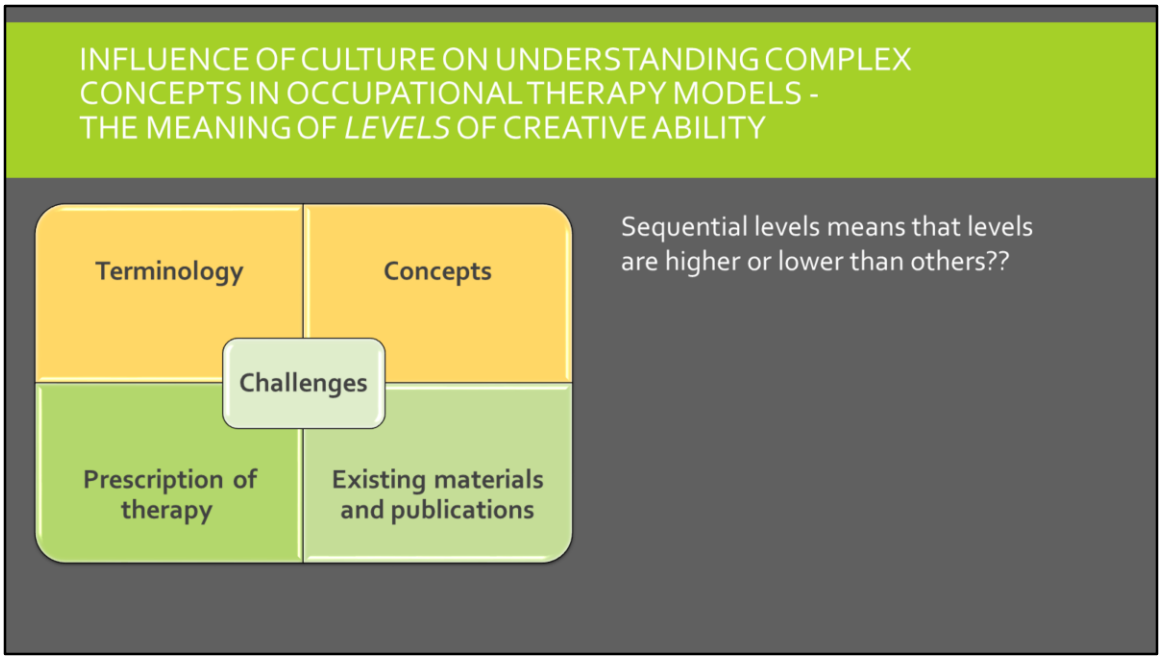
Regarding Materials, A full text on the model is significantly overdue, but we understand this is in progress in South Africa. The different cultural perspectives of South Africa, the UK and Japan indicate a need to explore how the model is perceived, understood and explained with sensitivity to the cultural and contextual nuances of different countries. We are making our mark in this respect, by working on a 4 year project with Wendy Sherwood to create the first text book on the model in Japanese.



Regarding terminology and concepts, some creative ability components are not taught and/or are unfamiliar to therapists outside of South Africa. This, together with the fact that understanding of some terms is assumed and others have not been explained or defined in detail in previous publications, has made understanding them problematic. Examples are: concept formation, effort and the notion of quality.

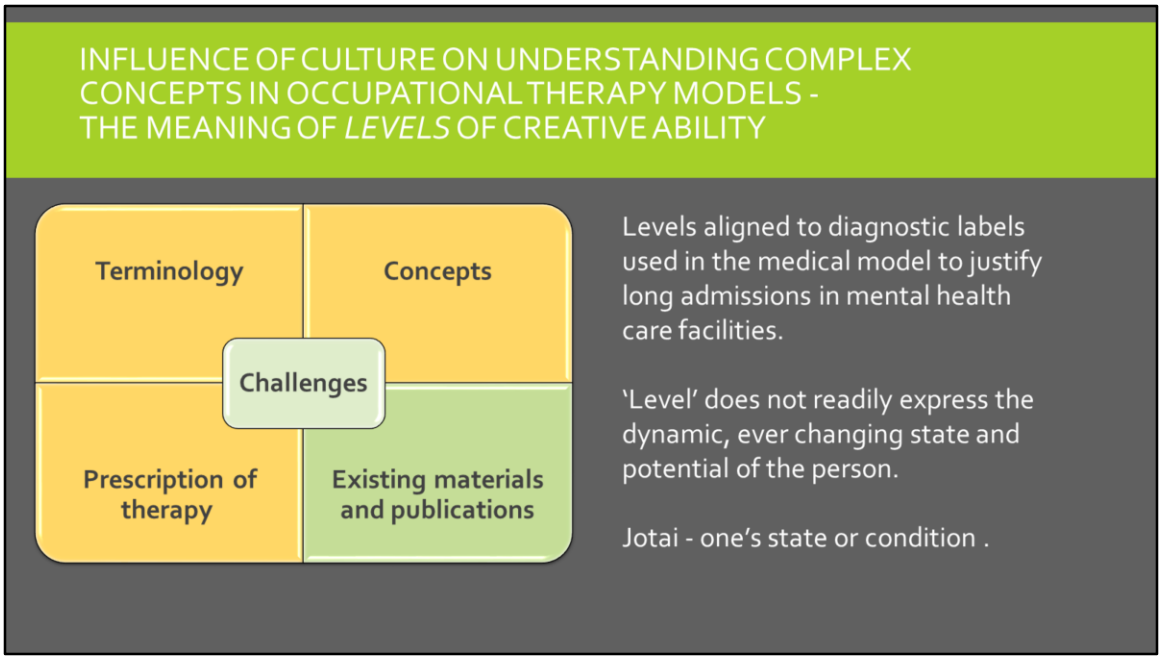
Japanese occupational therapists can be cautious about Western theories, because they often fail to be adapted to the Japanese culture and values (Y Nakano 2009, personal communication, 2 September). It is widely acknowledged that during the course of the profession's development, a Western culture or world-view has significantly influenced its values and beliefs about occupation (Black, 2002). For example, the occupational therapy profession has traditionally focused on the importance of independence (Russell, Fitzgerald, Williamson, Manor, & Whybrow, 2002), although in some cultures the collective, and inter-dependence is more desirable. The Kawa Model and the Three Dimensional Model of Self for Understanding Activities and Roles by Miyamae et al 1998), have developed in Japan to provide an Asian cultural perspective on occupation and related personal experiences. Nevertheless, some therapists in Japan report a preference for the VdTMoCA, which they find to be culturally relevant and sensitive. This is important to

explore through research.



Inter-related with issues of terminology, is the challenge of having a cross-cultural understanding of concept of *levels* of creative ability.

The sequential levels, commonly referred to as higher levels and lower levels, may be perceived as suggesting that people on the higher levels are better than people on the lower levels. Although this isn't what is meant, there is great potential for misunderstanding, and many OTs in Japan are hesitant about the model for this reason.



Historically in Japan, levels have been aligned with diagnostic labels that were used in the medical model to justify long admissions in mental health care facilities, from which people could not be discharged until they had progressed through set stages. The use of levels reminds therapists of this outmoded practice and carries negative connotations. There is anxiety amongst some occupational therapists that using creative ability levels negates to pay attention to the uniqueness of the person. Although this isn't the case, grouping people into levels and the prescription of therapy according to levels. raises anxiety that the individual person may be lost.

some therapists are of the view that the term level also does not readily express the dynamic, ever changing state and potential of the person. Again, although this is not the theoretical premise of the model, cultural meanings of 'levels' pose challenges to a shared understanding. It has been suggested that as an alternative to the term level, the Japanese word jotai is used, which means one's state or condition. This distances the levels of creative ability from the medical model use of the term levels, and is also more suggestive of the dynamic between person and the world, and the potential for change.

In summary, the VdTMoCA is highly valued by a small, but growing group of OTs in Japan, for enabling us to better understand people we serve as patients, provide better quality therapy, and in so doing, changing MDT and hospital dirctors perspectives of the value and contribution of OT. There is much more to learn, explore and consider together with our colleagues in South Africa and the UK.

We look forward to growing more through learning from the presentations and discussions today.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