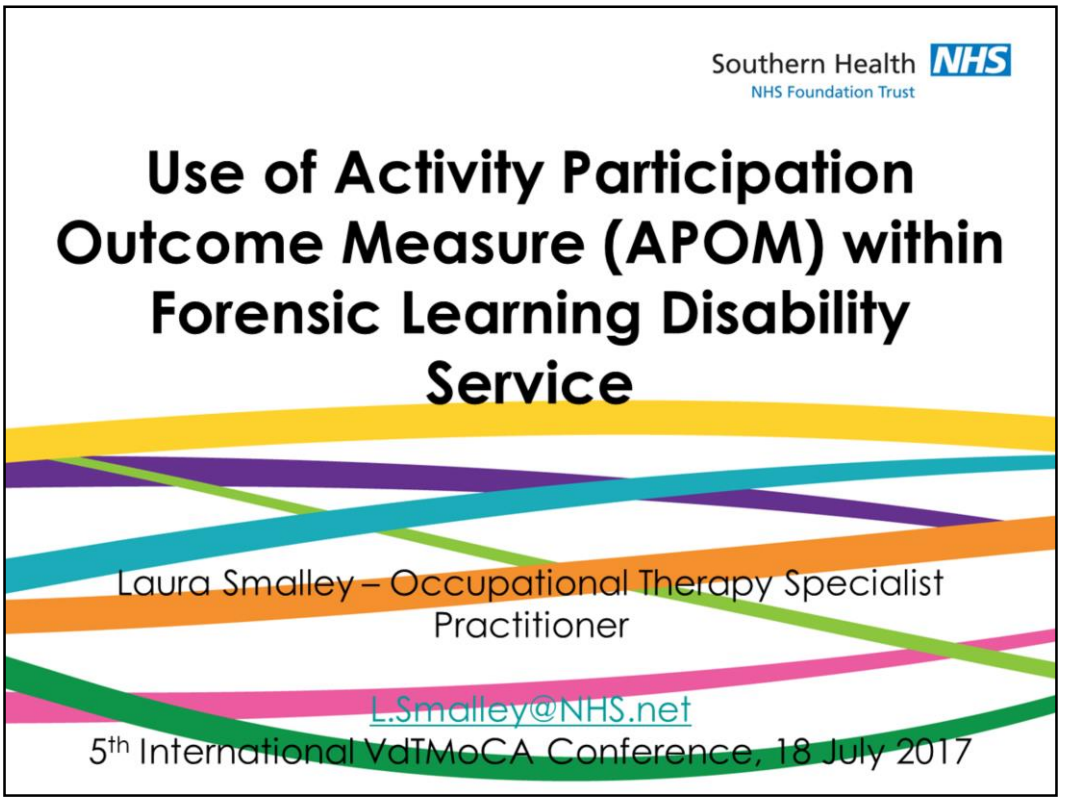
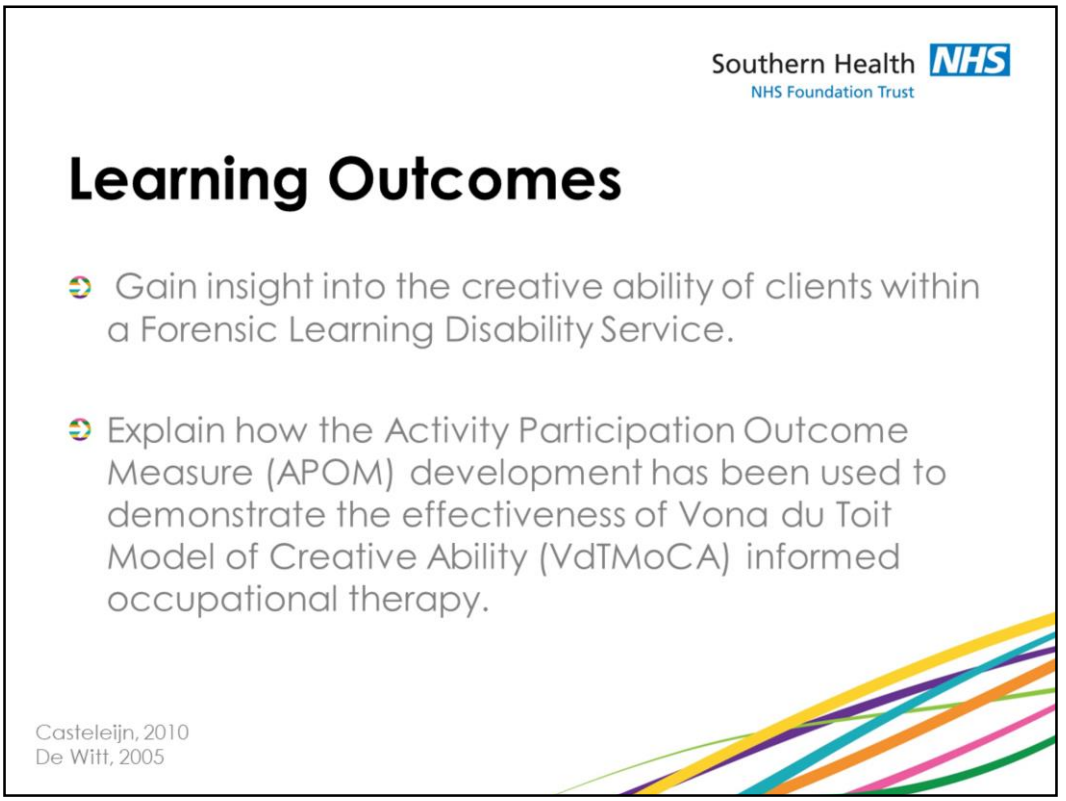


I'm Laura Smalley, Occupational Therapist within an Forensic Learning Disability Service. Since qualifying I have worked within forensic services, and for the majority of this time, been within services that use Vona Du Toit Model of Creative Ability (VdT MoCA) (De Witt, 2005) to support Occupational Therapy practice.

I first trained to use VdT MoCA in 2012, and trained to use the Activity Participation Outcome Measure (APOM) (Casteleijn, 2010) in 2015. Since then I have used APOM on a regular basis to outcome the effectiveness of Occupational Therapy, and the service users creative ability.

I moved from working in Child and Adolescent Mental Health Services to Learning Disability last year, and knew that embedding VdT Model of Creative Ability was a project prior to starting within the service. There are two parts of my role, one to develop OT provision within our Community Forensic Learning Disability Service, and the other to provide Occupational Therapy assessment and intervention within the inpatient service. The presentation today is going to be structured around how we use APOM within our inpatient forensic Learning Disability Service.



Our Learning Outcomes we would like to achieve by the end of this presentation:

- To gain insight into the creative ability of clients within Forensic Learning Disability Service.
- And to explain how the APOM has been used to demonstrate the effectiveness of VdT Model of Creative Ability informed Occupational Therapy.

I would like to achieve these by:

- Sharing information about our Forensic Learning Disability Service and sharing the journey of Occupational Therapy within our service, including before the use of VdT Model of Creative Ability, and how we are embedding VdT Model of Creative Ability in our service.
- Sharing information about the APOM and our reasoning behind why we decided to use it.
- Providing insight into the creative ability of our clients we work with as well as sharing reflections on using Model of Human Occupation Screening Tool (MoHOST) (Parkinson et al., 2004) and APOM through use of a case study.
- I will share my reflections on both these outcome measures
- I will finally summarize and conclude why APOM is demonstrating the effectiveness of our OT provision.

Move to next slide

We are a low secure service based just outside of Southampton. We have recently increased in size of our hospital from 6 beds to 10 beds.

These beds are for men who have a Learning disability and are detainable under the Mental Health Act (1983) and often have or are at significant risk to offending behaviour.

Our average length of stay varies significantly. We provide shorter admissions for people who are going through court process, these stays are often less than 6 months. On the other hand we do have longer admissions for those coming from higher security hospitals aiming to live in the community, these admissions range from 12 to 24 months.

As mentioned, we also provide input into a Community Forensic Learning Disability Team, so if a service user is going to be living in Hampshire we will see them within inpatient services and then through to living in the community. We often stay involved for a substantial period of time post discharge.

We have some resources which are adequate, but our environment is mostly challenging. Our therapy rooms are based upstairs and do not have the same physical

security resources as our ward environment. This makes it challenging to access and has an impact on our OT provision.

We have access to:

Gym

Larger kitchen upstairs

Outside Garden space

Community

Ward (lounge, quieter area, small kitchen based on the ward)

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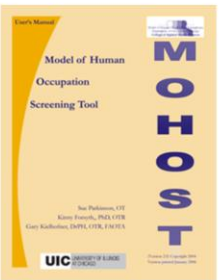
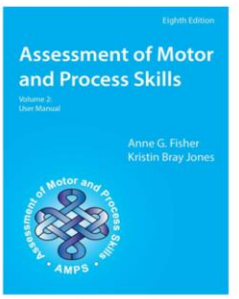
Outcome Measures before…



Model of Human Occupation Screen Tool (MoHOST)

Parkinson et al., 2004

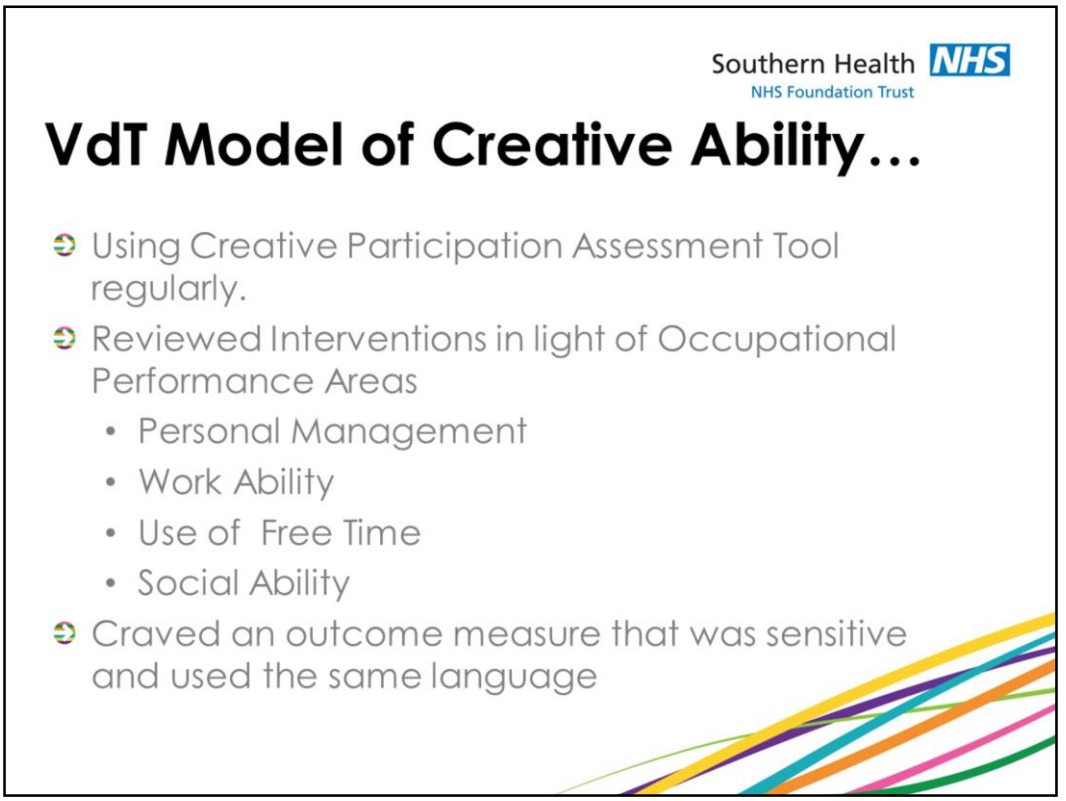


Assessment of Motor and Process Skills (AMPS)

Fisher and Bray Jones, 2014

Before we started embedding VdT Model of Creative Ability in the service. It was mainly using Model of Human Occupation (Taylor, 2017) as framework, and outcome measures were not frequently used. At times a Model of Human Occupation Screening Tool (MoHOST) was completed prior to a Care Planning Approach meeting (often held every 3 months). Other outcome measures used included Assessment of Motor and Process Skills (AMPS) (Fisher and Bray Jones, 2014). However, this wasn't routine and time between re-assessment varied significantly.

There wasn't any documentation of how this information was shared with service users or professionals.

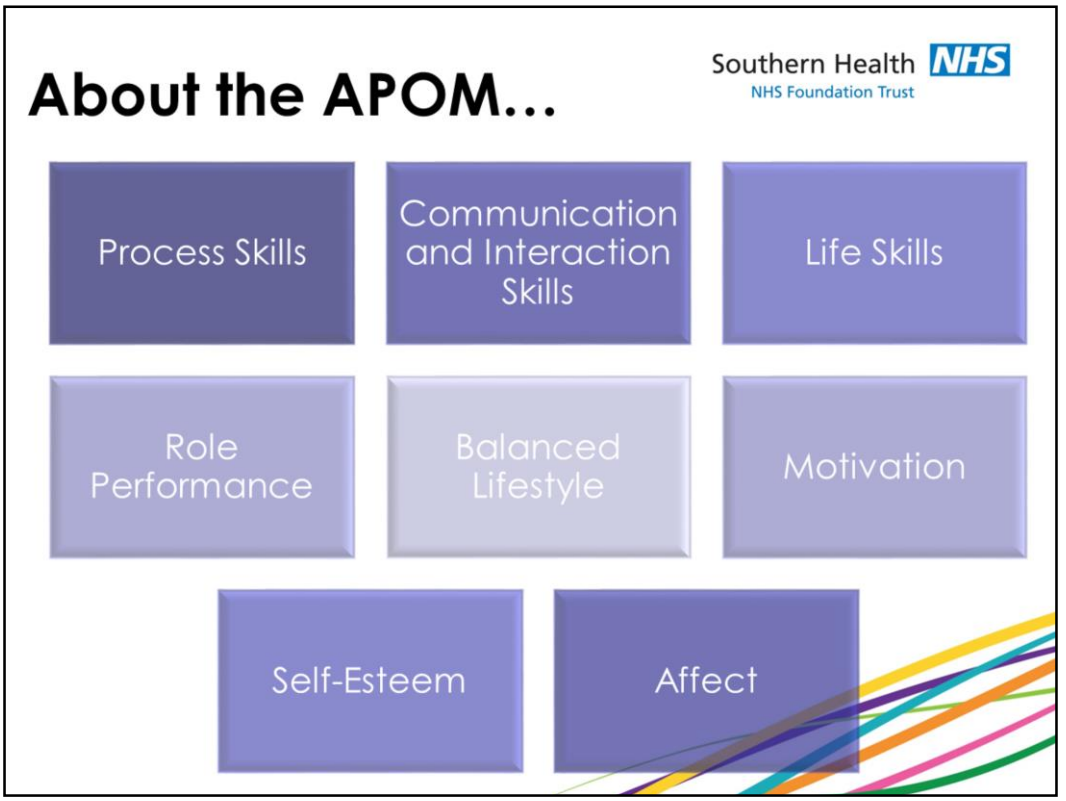


As mentioned, I knew before starting my role that developing VdT Model of Creative Ability was a priority. Other members of the OT Team had recently attended training on the VdT Model of Creative Ability, and also saw the potential benefits the model could have for the service.

We started to review our interventions and thinking about Occupational Performance areas of personal management, work ability, use of free time and social ability.

We used Creative Participation Assessment Tool regularly with our service users to monitor creative ability, however, we was missing something. We was still using MoHOST mainly because of it's familiarity to other Occupational Therapists. However, it wasn't supporting the use of VdT Model of Creative Ability, and it wasn't really capturing the smaller changes to our service users ability.

We needed to find an outcome measure which shared the same language as VdT Model of Creative Ability, and that was sensitive enough to measure the small, but still significant changes to our service users.



I was trained to use the APOM within 2015. The APOM had advantages as it shared the same language as the VdT Model of Creative Ability, and it was standardized outcome measure.

The APOM was intriguing, as we felt it could capture the sensitiveness of changes to creative ability, as well as other advantages.

The APOM was developed by Daleen Casteleijn in 2010. It was developed with mental health settings participating in the research study, and therefore evidence is aimed more at mental health population than Learning Disability (Casteleijn, 2010).

APOM has eight domains and these consist of several items that represent the domain. The domains are:

Process Skills

Communication/Interaction Skills

Life Skills

Role Performance

Balanced Lifestyle

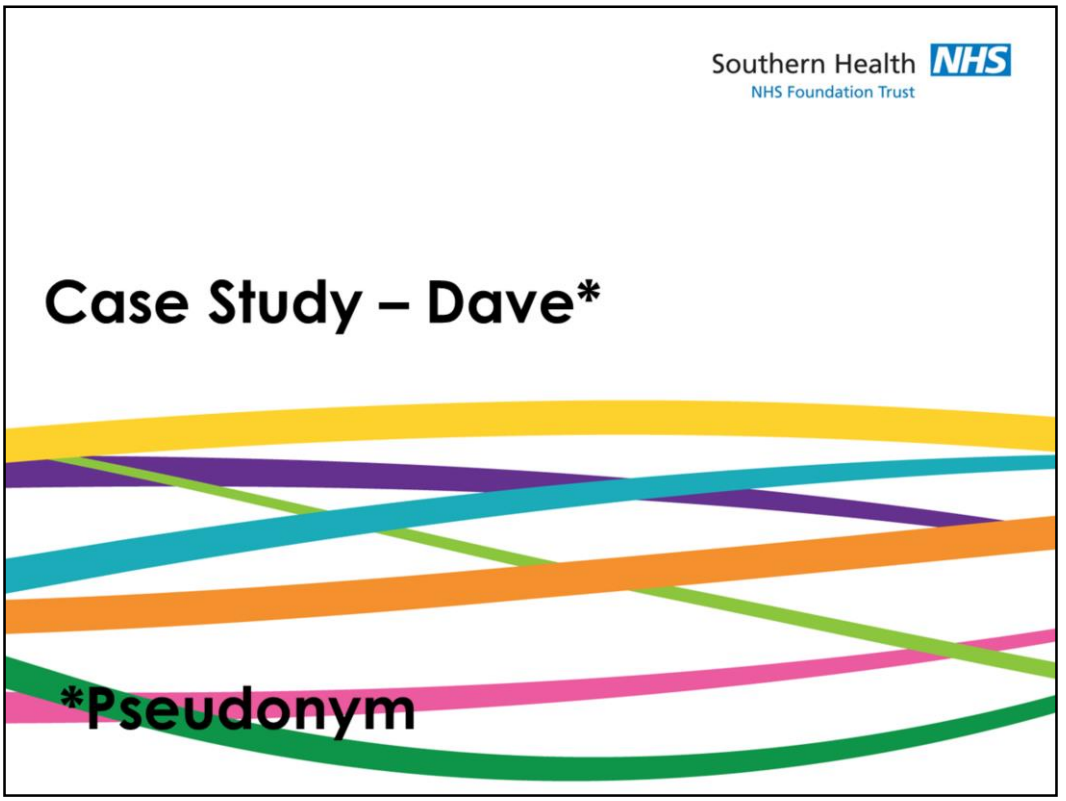
Motivation

Self-Esteem

Affect

When you score someone between 1-18 on each item within each domain, and this is then averaged across each of the eight domains, then a final average is also provided. Dependent on the number scored, this can be converted into a specific phase and level within the VdT Model of Creative Ability.

Although the APOM manual states that the APOM is to be used as an outcome measure for entire client groups, thus measuring the effectiveness and efficiency of an Occupational Therapy progammes (Casteleijn, 2015). Through my clinical experience of using the measure, I have not only found it useful to monitor broader Occupational Therapy progammes, but also to measure one persons individual change. Furthermore, due to the variability of both forensic (Royal College of Occupational Therapists, 2012) and learning disability (Lillywhite and Haines, 2010) populations in ability, it's challenging to provide an accurate service average, which would be rich in information to analyze further. With this in mind, I will demonstrate the use of APOM within a case study which is representative of our typical creative ability levels for our patients observed within our service.



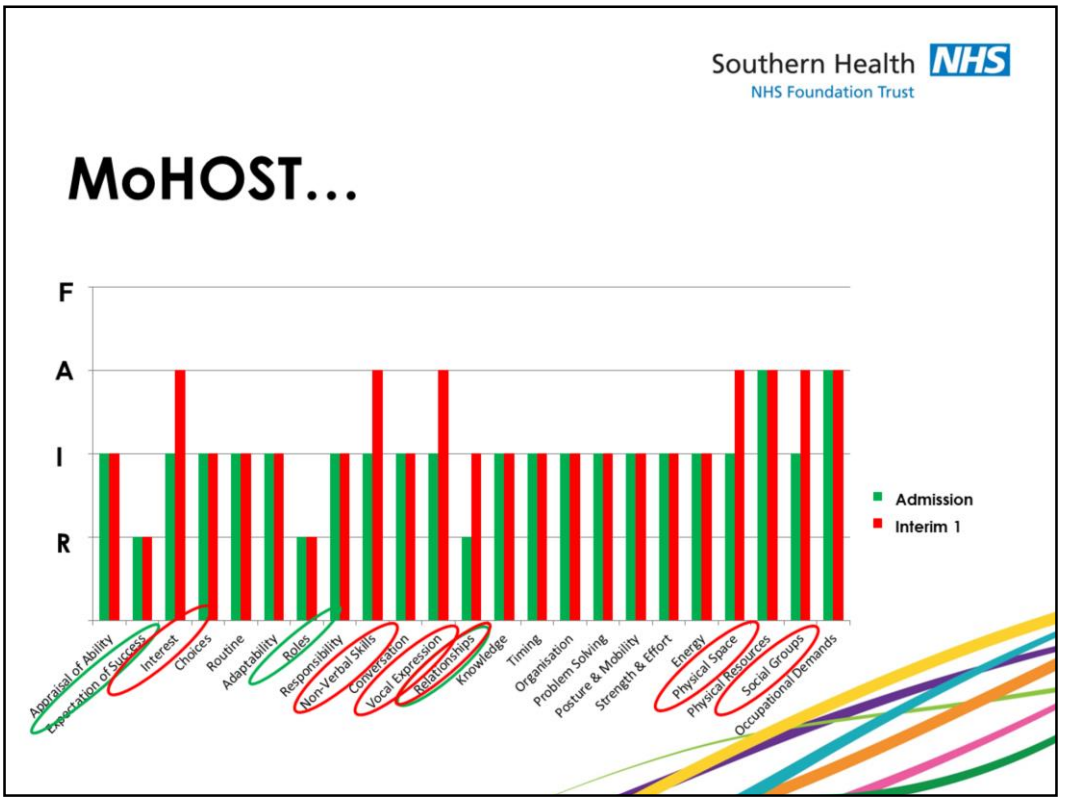
To ensure confidentiality, a pseudonym has been used. I would like to introduce Dave to you.

Dave is 27 Years old, and has a diagnosis of Learning Disability and Schizoaffective Disorder. Other hospitals have questioned if Dave has autism as well, however, this has never been a formal diagnosis.

Dave has been a patient within our service for 6 months, the reason for admission to our service was to support transition from secure services to the community within his local area. Dave had been within a non-NHS bed out of his local area before our hospital. Dave had been a patient within various secure hospitals since being a teenager. He also has previous convictions including GBH. Dave has been sentenced to prison and also been placed on section under Mental Health Act. Dave is currently on a section 37/41, which is a hospital order from a judge (used instead of going to prison). The 41 part is restrictions from Ministry of Justice.

Since being at our hospital, Dave has participated in a range of assessments and interventions by all disciplines, which is something he hasn't really done before. Dave's medication has reduced significantly which has also supported participation.

I wanted to show you our outcome measure using both MoHOST and APOM. We will start with MoHOST first.



The 'admission' data was collected about a month into Dave's admission, we had seen Dave participate in numerous one to one sessions and groups facilitated on the ward. We had been out in the community and also participated in sessions within the building. Activities also ranged from ones Dave was familiar with, to activities he reported he hadn't done before.

The green lines are the first MoHOST assessment completed. Just in case people are not familiar with MoHOST scores; a 'F' suggests that this domain facilitates occupational participation. 'A' allows occupational participation. 'I' inhibits occupational participation and an 'R' restricts occupational participation.

As you can see, Dave scored mostly 'I's on the MoHOST for all areas, which suggests for that domain his ability inhibits occupational participation. It's hard to see purely from the assessment what Dave's strengths are. Mainly as most of the outcomes are within the same rating scale which is 'I'. We can explain with written context what Dave's strengths are, but this isn't captured fully in my opinion by the assessment.

Click again within first paragraph.

You can see some areas which could be opportunities for development, these could be: Expectation of success, Roles, and Relationships. To make it easier, I've highlighted

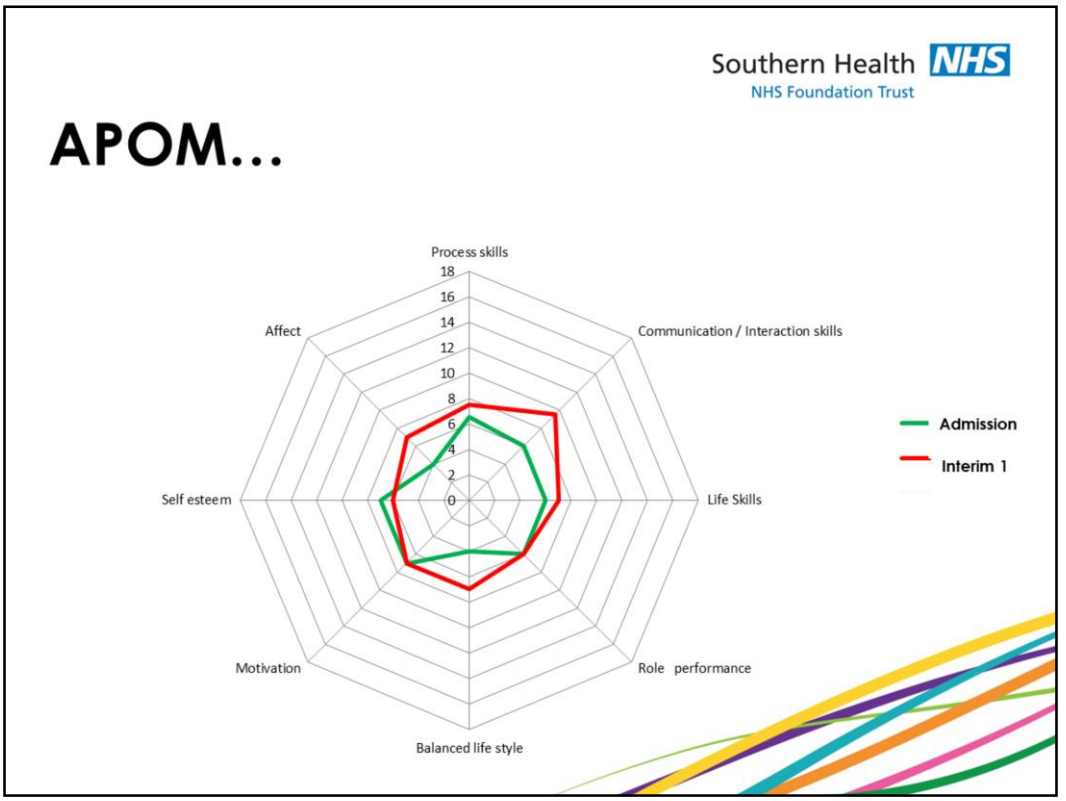
with the green circles the areas that could be used to support development of skills.

Click again within 2nd Paragraph

'Interim 1' was collected 3 months after admission data (4 months into admission). This is shown in red. You can see there have been improvements made, particularly in interests, communication skills and some changes to the environment including social groups. Dave had worked on his communication and interaction skills in various interventions by OT. He had expanded on his interests and this had an impact on his balance of routine. These have been highlighted using the red circles.

Although the two sets of data now demonstrate some clearer strengths for Dave, and areas which he has worked and developed on since admission, it's difficult to highlight further areas of development or priorities in regards to Occupational Therapy treatment, as many of the lower scores are now the same domain, under 'I'.

We also completed APOM assessments on the same time points as the documented MoHOST assessments.



The further towards the outside of the graph, the higher the level of creative ability is at that moment in time. As you can see from the green line (admission data), Dave's strengths were his motivation, his process ability, and self-esteem. Areas which we set goals around particularly was his lifestyle and the variety of occupations he was participating in, we developed goals around establishing routine and structure which he could still keep when he left hospital.

At the time of admission Dave's average score within the APOM was 6, suggesting this was at Self-Differentation at a transitional stage.

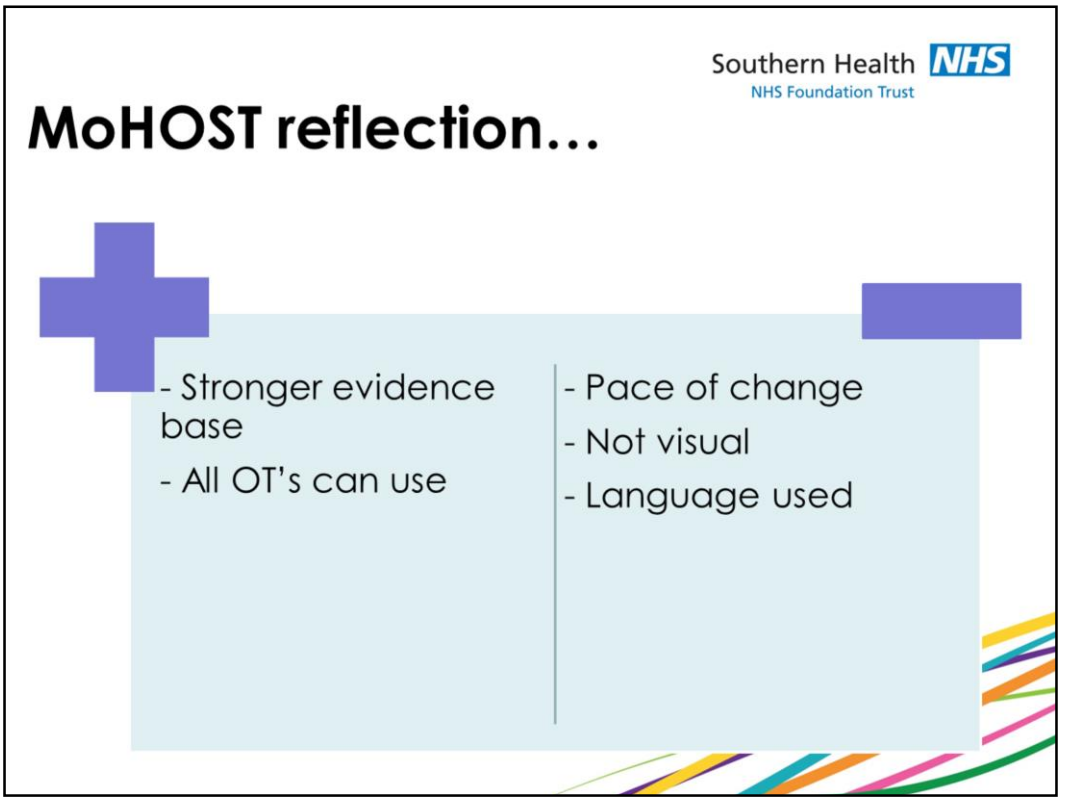
Interim 1 (4months into admission) is the red line on the graph. This shows maintenance in ability within areas of role performance, and motivation. Other areas except self-esteem demonstrated improvements, particularly in balance lifestyle, communication and interaction skills and affect.

Within this time Dave continued to participate in Occupational Therapy, including with one to one support attending our smaller groups aimed at improving social skills, and to provide routine to the day. Dave started going out with recommendations on how to structure his community leave by OT and this was more frequently than before, and not just for leisure based occupations but a range including personal management (like getting his hair cut).

Within Interim 1, Dave's average score was 7, suggesting that Dave was now at Self-

Presentation at a Therapist directed level.

Dave's next goal is regarding work roles, and wanting to attend a day service within the community aimed at improving work skills by improving knowledge and skill relating to car maintenance. Dave wants to work with cars in the future and can see how this would support his bigger goals when living in the community.



I thought the best way to capture my reflections on both assessments was to highlight the benefits and positives and the negatives and concerns of using both outcome measures. So my reflections on MoHOST.

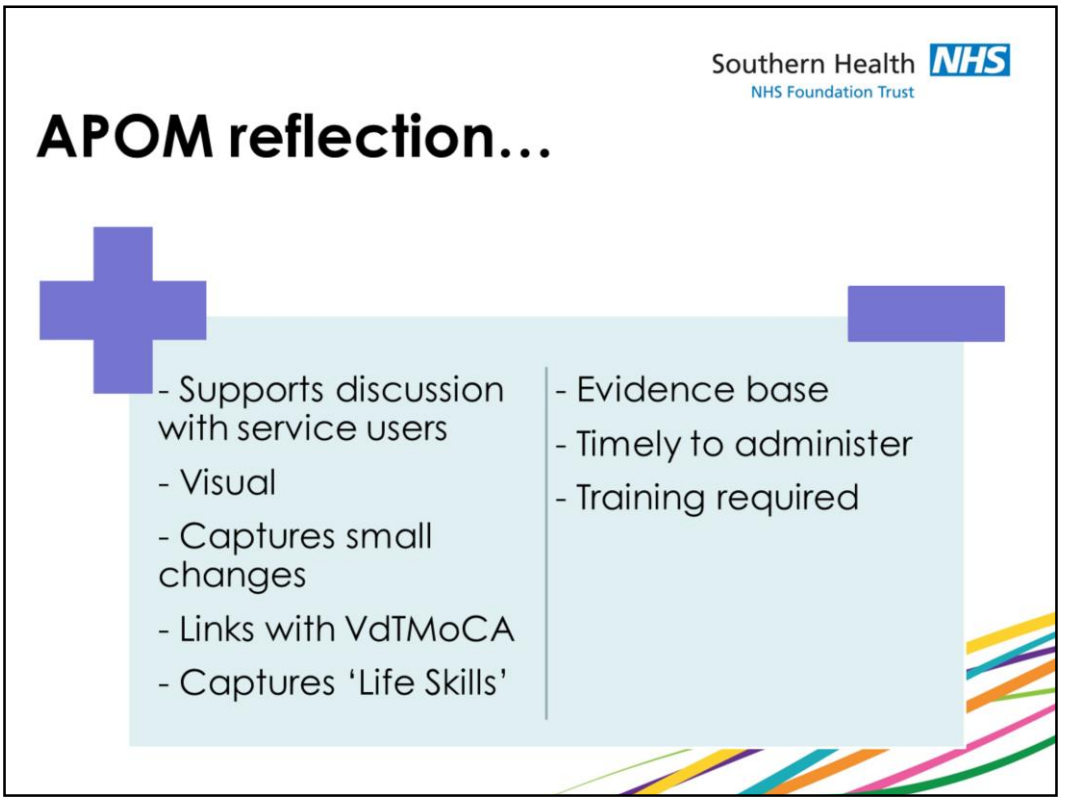
All OT's can use MoHOST without additional training, there is additional training available around the use of Model of Human Occupation if wanted. Many OT's are familiar with MoHO and use of MoHOST as it is taught commonly on training and observed in practice on clinical placements.

There is a stronger evidence base from a variety of different clinical settings, which is also a strength compared to APOM.

However, personally within practice I find MoHOST difficult to share with service users and other professionals, I find myself wanting to change the language which then shys away from our unique perspective on functional ability. As I have done within this presentation, you can make the MoHOST visual, however, with the number of different scoring criteria, it often looks very overwhelming.

As seen within the case study, the pace of change often isn't documented as clearly as APOM for our service users development. When discussing the implementation of VdT Model of Creative Ability, we was noticing that MoHOST wasn't as sensitive as we

needed for our service and service users. Although the outcome measure was picking up changes, it often took Occupational Therapists to fill in more context around the scores.



Again, I wanted to share my personal experience of using APOM. So my reflections on using the APOM in practice.

Within our service we find the APOM provides us further framework to guide discussions and set further treatment goals with our service users. We can do this because of the simple, visual data that is provided. APOM outcomes and documents the small changes to participation, which we often discuss within our Multi-Disaplinary Team meetings. It captures within a valid and reliable format, rather than saying our clinical opinion (Casteleijn, 2015).

Of course, the APOM also links to VdT Model of Creative Ability, which we use to structure our interventions. The model in itself is supported by our senior clinicians and service managers who like the guidance we can provide to support participation in occupations.

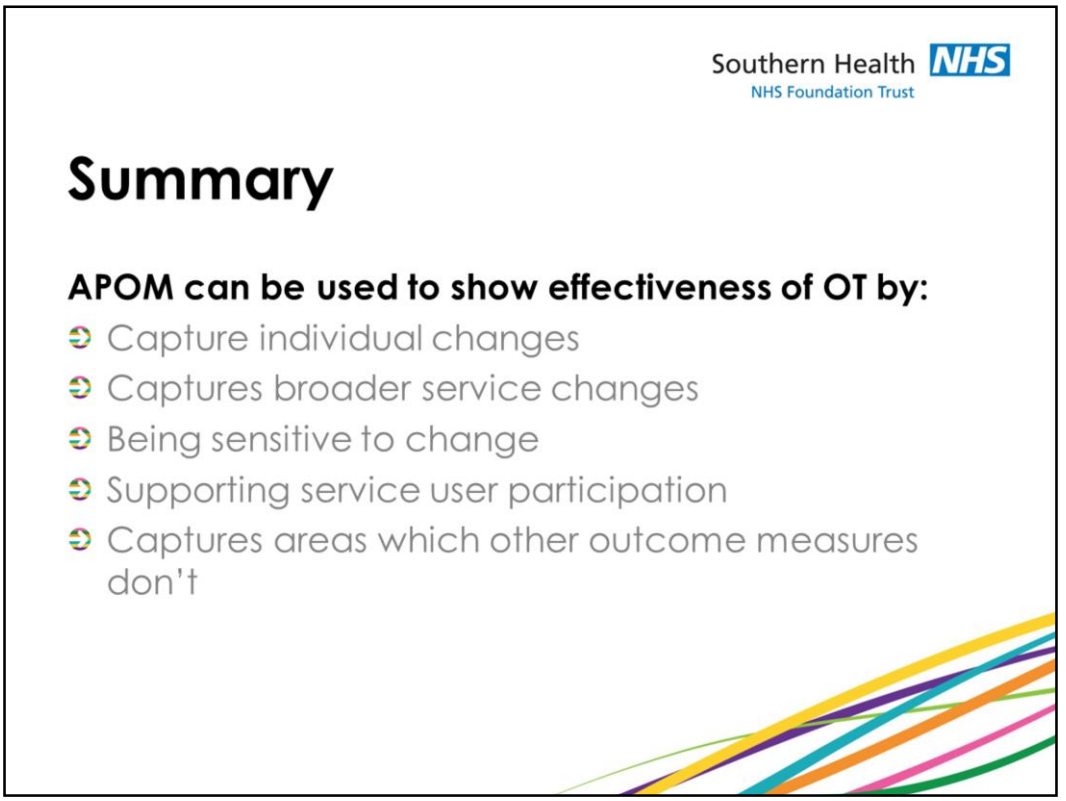
Personally, I appreciate the life skills performance domain. Within our clinical setting it is really useful to have an OT outcome measure which not only addresses other areas such as process skills, motivation, roles and balance of life style, but also addresses areas such as personal care, safety, use of transport and money management.

However, there are areas I need to consider with using the APOM within the service. APOM was developed to be used with a Mental Health setting and therefore the

evidence base is aimed at mental health. However, I would argue that a lack of an evidence base shouldn't be a deterrent not to use it, but an opportunity to develop the evidence base further.

The APOM takes longer to administer than other outcomes, I have to often find a quiet space to go through the spreadsheet.

There is also a lot of training required before you can use the outcome measure, it is recommended that Occupational Therapists should have time between attending the VdT Model of Creative Ability training, before attending APOM training. This means that if we recruited someone who wasn't familiar or trained to use the model, we would have a gap of how to measure participation within the service (Vonda Du Toit Model of Creative Ability Foundation, 2017). This would not only cost our service time, there would also be a financial cost of attended the training.



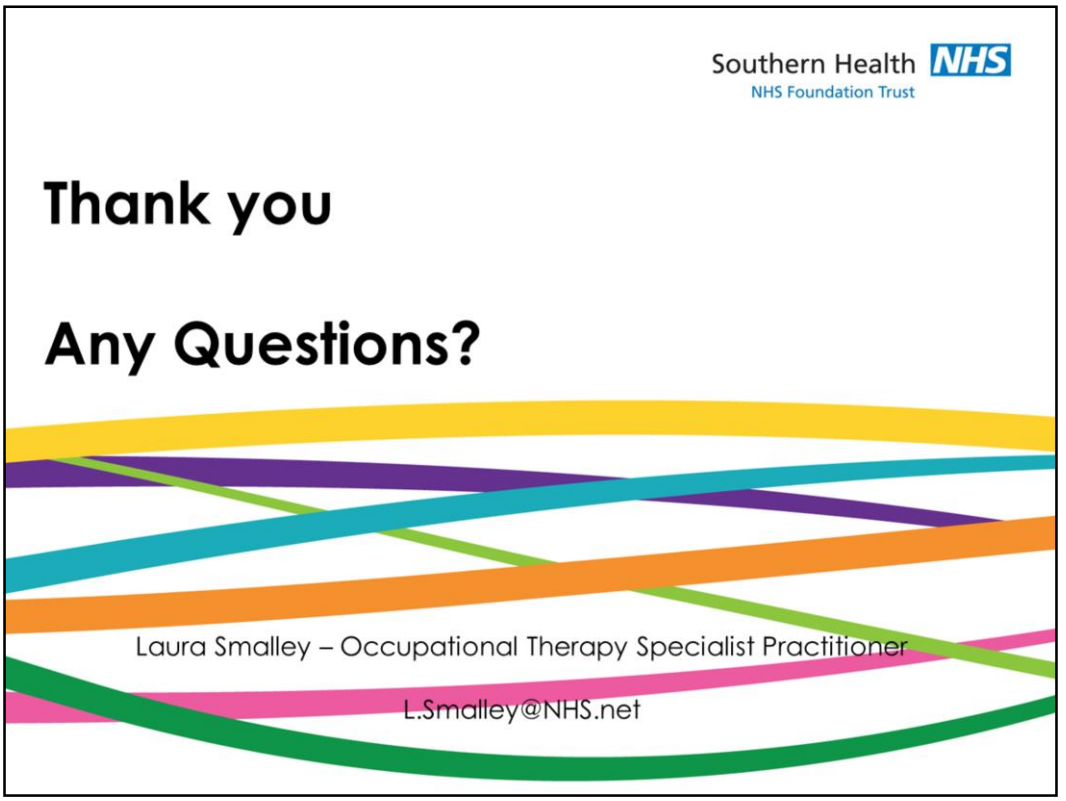
As I have just discussed, although the APOM manual states that the APOM is to be used as an outcome measure for entire client groups, through my clinical experience of using the measure, I have not only found it useful to monitor broader Occupational Therapy progammes, but also to measure one persons individual change.

Occupational Therapy within Forensic Services is invaluable (Royal College of Occupational Therapists, 2012)it is also difficult to capture the effectiveness of purely Occupational Therapy. This can also be considered for Learning Disability services (Lillywhite and Haines, 2010). Individuals ability can vary greatly, and therefore providing an average for a service might not be the most valid way of suggesting the effectiveness of Occupational Therapy input (Royal College of Occupational Therapists, 2012).

I also feel that the APOM brings something that other outcome measures haven't bought, it brings an opportunity for service user involvement and feedback. I find the APOM is useful in sharing with service users, our service users can understand and see their strengths clearly, as well as highlighting areas of development. This is very crucial within my practice area to demonstrate the effectiveness of Occupational Therapy. We can gain clear service user feedback using the APOM individual outcomes, which can then be shared with our commissioners and senior managers.

In conclusion from looking at both these outcome measures, I would argue that it's

not an either/or approach. But actually, both measures have captured different things and have very different functions. They can complement each other. Although I found APOM more useful to support service user discussions and personally find it beneficial to OT service delivery. I find myself continuing to use MoHOST's to support transition to other services and to support communication with Occupational Therapist within the local area. As the evidence base for APOM continues to grow, it will be interesting to see whether my opinion would change in the future.



On this note I wanted to say Thank you for listening, and I hope you found this useful. Mention references listed at the back of the presentation.

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