Implementing the VdTMoCA on an Older Adult Low Secure Forensic Ward

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Key Focuses

- What are the range of presentations displayed by the cohort?
- How was the model implemented in this setting?
- How valid is this model for the assessment and treatment of this cohort?

Introduction

This service review is based on a low-secure older adult forensic ward in Birmingham. The physical environment was originally designed for working age adults. Three years ago the ward was reallocated as an older adult ward, and it was acknowledged that both environmental design and theoretical framework to inform occupational therapy provision needs to be reviewed. Approximately two years ago the occupational therapy provision started the transition from using MOHO to using the Vona du Toit Model of Creative Ability (VdTMoCA).

Patient Profiles

Patients	Age	Diagnoses	
		Mental	Physical
16 men with at least one primary diagnosis of a mental health condition	>55 years*	Paranoid schizophrenia	Chronic: COPD, historical strokes
		Mood disorders	
		Personality disorders	Recurrent acute: chest infections, UTIs and cellulitis
		Several types of dementia	Mobility and transfer issues

*Exceptions are made to the age limit, if particular physical health problems require specialist care alongside mental health care.

Aims and Objectives

- To provide evidence based and effective occupational therapy provision
- To build new occupational therapy structure on the ward
- To review treatment plans for individual patients to include physical and mental health difficulties, and environmental limitations.
- To inform and give recommendations for environmental design.

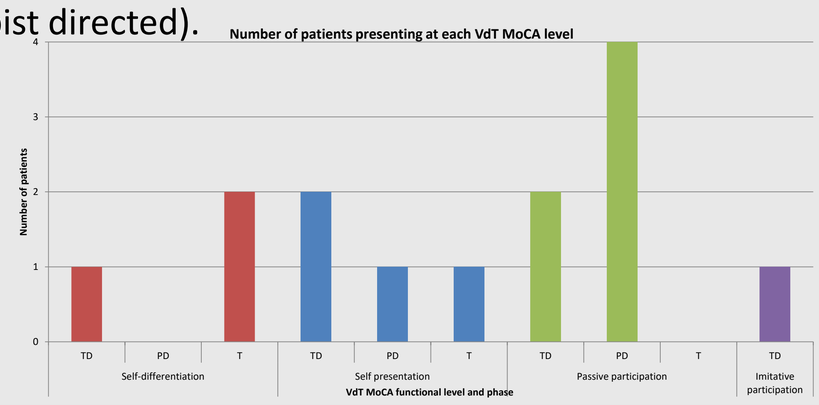
Method

- **Baseline assessments** were completed on all patients including creative participation assessments of familiar and unfamiliar tasks.
- **Biannual** outcome assessments were conducted using the Activity Participation Outcome Measure further evaluating patients' performance and service outcomes.
- **Weekly** OT reviews of therapeutic engagement were conducted with individual patients with feedback informing service development and improvement.
- **Analysis** of findings were conducted in the context of environment, resources and client group to establish the most effective way of implementing the occupational therapy service on this ward.

Results and Discussion

VdTMoCA scoring range of the cohort

Self-differentiation (therapist directed phase) to imitative participation (therapist directed).



Factors enhancing presentation score	Factors diminishing presentation score
High level of engagement with professionals	Complexity of physical and mental co-morbidity
Positive structure	Institutionalisation (obstructing unfamiliar task management and new skill development)

Benefits

- Supported occupational therapy staff to engage patients who present with low occupational functioning and challenging behaviours.
- Allowed the occupational therapy staff to gain insight into the complex needs of long-stay mental health patients, many of whom have developed coping strategies to 'mask' their actual creative ability and occupational performance.
- Supported occupational therapist to identify what assistive equipment would be suitable to support patient's physical health needs while also considering their cognitive limitations as a result of their mental health diagnosis.

Limitations and Challenges

- Reluctance to attempt unfamiliar tasks – despite otherwise good engagement. Creative ability was therefore challenging to assess, leading to a potential bias towards higher scoring in the cohort.
- Treatment of mental and physical co-morbidity often requires the therapist to draw upon multiple models rather than relying solely on the VdTMoCA.
- Introducing specialist VdTMoCA focussed language into care plans and clinical feedback has been challenging.
- An important balance needs to be struck between identifying occupational therapy as an individual and evidence-based profession and making sure assessments and feedback are clearly understood by both patients and members of the MDT.

Implications for Practice

- Supports therapy staff to meaningfully engage patients who have a history of poor engagement with professionals and services
- Supports therapy staff to appropriately grade and select assistive equipment in conjunction with other theoretical frameworks
- Can potentially be challenging for use with highly institutionalised patient group

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