Perspectives of the VdT Model of Creative Ability

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Originating from South Africa, the Vona du Toit Model of Creative Ability (VdTMoCA) was introduced in practice in 2003 into undergraduate OT education at London South Bank University in 2005, and is now taught at four universities.
The VdTMoCA is purported to be a valuable model for identifying a person's level of ability (functional ability and motivation), and for guiding the selection and use of activity for therapeutic benefit and change (de Witt 2005; Walters et al., 2014). There have been OT News articles and a large number of conference presentations reporting on the value of the model, but only one small, unpublished study of OT perspectives of the model has been carried out to date by Chinembiri (2011).

In order to gain up-to-date and comprehensive data on the use of the model in the UK, in 2013 a survey was undertaken of OTs, OT support workers, managers and educators (n=71). The survey aimed to: identify in which fields of practice the model is used, gain insight into perspectives on the utility and value of the model, identify needs for model development and professional development, and identify areas for research. The findings indicate that the model is highly valued for enabling effective practice, particularly with clients that OTs find challenging to effectively engage, and also for enabling justification and promotion of OT. However, there are also limitations that need addressing.
A summary of the findings are presented, including percentages of sample agreement with statements, where available. Quotes are provided that represent well the qualitative data. This is followed by findings of a survey undertaken at the request of a forensic OT in a MOHO driven service to compare the VdTMoCA with MOHO. Combined, these surveys present up-to-date data on OT perspectives in the UK.

Assessment

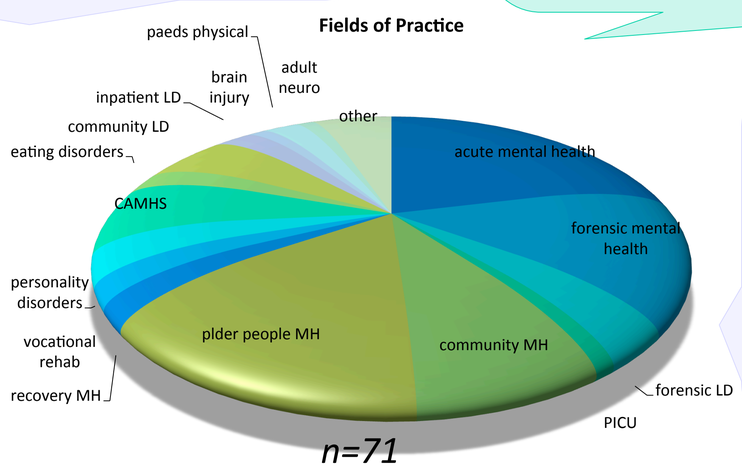
Assessment form is easy to understand (80%) and complete (88%). Self explanatory, clear and covers all the areas of observation needed to assess a client's function and motivation, making intervention much easier to identify. Holistic.
Assessment methods have good utility (99%).
You must be competent in terms of knowledge of the model's concepts and theory; training is required in order to develop a good understanding. A manual for use of the assessment tool is needed to ensure accurate understanding and reduce inconsistencies in its use

Intervention / treatment

The principles of treatment provided by the model for each level of ability greatly assist in activity selection and grading the "just right challenge" for therapeutic benefit (99%). The model promotes use of all of the OT tools of practice, making it an *occupational* therapy service (97%)
There has been an increase in engagement of clients with the lowest levels of ability/previously difficult to engage or provide a service for. Intervention is more specific with clearer clinical reasoning (87%)

Promotion of OT

Enables the articulation and promotion of role of OT (100%)
"It provides us with a language which is all our own and allows the purpose of an OT assessment and treatment to shine through, especially with regard to discharge planning and identifying packages of care".
"It has the potential to make what we offer as OTs unique in a climate where roles tend to get blurred".
Use of the model has enabled practitioners to feel more valued professionally by other disciplines (71%)



Communication

Use of the model can be explained to clients (70%) and to explain clients' improvement or regression to non-OTs (94%). Model is easy to explain to colleagues if time is dedicated to it. The names of the levels can be difficult for others to grasp and the theory base is not obvious which may make the model appear too simple when it is in fact very sophisticated. The model informs MDT decision-making when work practices allow OT to contribute in this way (72%)

OT delivery

Model has enabled OTs and OT support workers to feel more competent (88%), improved the quality of the service (70%), is useful for guiding support workers' understanding of clients (88%) and enables them to provide more effective intervention than without the model (97%)

Measuring change

Enables measurement of change (100%). "I'm able to identify subtle changes in various performance areas and use this information with the MDT to reflect on effectiveness of intervention and need for review of current treatment plan".
"I like the way you can identify slight changes as well as those more notable changes".
NB questions were not asked about an outcome measure developed for use with the model as this is separate to the model itself. See *** in VdTMoCA and MOHO table below

Limitations (Items marked * reported in both surveys)

- Application in paeds and physical fields is challenging
- Terminology is not always 'user friendly' and presents challenges*
- The assessment tool needs to be made simpler to use with clearer defined concepts plus a manual. The difference between the higher levels of ability is less easy to identify and understand
- Difficulty in applying the model in certain services or that the model cannot be used with all diagnoses - however, the content of comments made suggest that there is a lack of participant knowledge of how the model can be applied
- The model takes time to understand "but this can be viewed as a positive as it emphasises the complexity of occupational beings, OT as a complex intervention and the specialist skills and knowledge of OTs"
- There is a lack of literature and research evidence base

Comparison of VdTMoCA with MOHO (forensic OTs n=7)

Respondents were asked to comment on: ease of use, clarity of concepts when reporting to MDT, benefits to staff and clients

VdTMoCA - OT process: Holistic and client-centred assessment (Ax) that improves understanding of clients, clients understand the Ax process including those with Personality Disorder; better enables use of meaningful activities for Ax, identifies clients' abilities as well as areas for attention. Visual representation of progress on Ax tool is helpful to clients lacking literacy.
Intervention – Improves identification of the 'just right challenge' and the direction of therapy, thus enabling identification of the best intervention and how to grade it. This in turn results in increased client engagement. Clients are better enabled 'to do' successfully resulting in improvement in clients' functioning. Model is applicable for all clients. Better quality of care with specific tailored OT programmes that enable clear progression through the service pathway. Easier to explain clients' occupational performance; MDT report understanding concepts better than MOHOST. The Activity Participation Outcome Measure*** and VdTMoCA Ax tool record more subtle changes than the MOHOST.
Skills & professional identity – improved clinical reasoning, sense of competency (which clients benefit from), and sense of being valued by other disciplines

MOHO - OT process: Ax is more time consuming and Ax activities are not so relevant to individual clients. MOHO difficult to feedback to clients with literacy challenges. Not much guidance on therapeutic use of self. Re-motivation process is similar to VdTMoCA guidance. Communication – "we never talked about MOHO because we couldn't describe it in patient friendly terms"

Conclusion

The findings of the 2013 survey support Chinembiri's (2011) findings that the model is predominantly applied in mental health and learning disabilities services in the UK, but a much broader range of settings is also evident. There is agreement with Chinembiri (2011) and the forensic survey regarding the value and limitations of the model although this survey has collected greater breadth and depth of data, providing new insights into the use of the model in the UK. All data collected on the model indicates that the model is highly valued with good utility for practice, but there are also indications of the need to improve assessment information, literature, ensure adequate training and CPD opportunities and establish a research evidence base.

The findings of this survey informed a survey to be undertaken by the VdT MoCA Foundation (UK) in 2014 on OTs' training/CPD needs and research priorities. This will inform the Foundation's development of CPD opportunities and a Research Strategy 2015-2020 for consideration by OTs in the UK and internationally. The Foundation is also contributing to the writing of a major text on the model to improve resources on the model. Wendy Sherwood has worked with the original author of the assessment tool to improve its clarity and develop an accompanying manual, which are to be tested through research in 2014. OTs are encouraged to collaborate for furthering understanding and development of the model in the UK context, develop and share resources and engage in research and publication.

For information on the VdTMoCA, visit the VdT MoCA Foundation (UK): www.modelofcreativeability.com

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