

A critique of the Assessment of Motor and Process Skills (AMPS) in mental health practice.

Abstract

This critique aims to provide an overview of some of the issues surrounding the use of the Assessment of Motor and Process Skills (AMPS) in mental health practice. It also aims to provoke ongoing discussion and reflection amongst therapists trained in its use, and those considering undergoing the calibration process. While the strength of the AMPS psychometric properties are undoubted, the current literature base around its use in mental health is relatively sparse and limited. Some of the factors influencing its administration include its emphasis on physical function, challenges in following the standardised procedures and the quality of the therapeutic relationship. However if used in a transparent manner, the AMPS can be a valuable tool in collaborative goal setting and clarifying the occupational therapy role in multi-disciplinary teams. A major challenge to its current use in mental health is the cost and availability of training, but this critique concludes that AMPS has a place in this setting provided that therapists reflect upon its suitability for the client at that particular time. Further research, ongoing discussion and better utilisation of resources such as the AMPS Project International are recommended.

Keywords - Assessment of Motor and Process Skills, critique, outcome measure, mental health

Introduction

The Assessment of Motor and Process Skills (AMPS) is one of the best known and widely used standardised assessments in occupational therapy. It measures the quality of a person's motor and process skill performance through therapist observation of everyday tasks. The scores given for each component are then processed via computer software, which has been calibrated to the therapists style of observation. The final results are overall scores for motor and process skills, which indicate where on a continuum of performance that person is at that time.

While there is an extensive literature and evidence base for the AMPS, much of it reports study findings and few authors have taken a critical stance. The aim of this article is therefore to critique the use of AMPS in mental health, and clearly articulate its merits and limitations in this setting. The information is particularly relevant and timely, given the increasingly number of mental health therapists being trained in its use and previously recognised challenges to its implementation in practice (Chard 2000, Chard 2004). A number of issues will be raised, in the hope that therapists will continue to discuss and reflect on this topic in their own workplaces. The following material is based on study, opinion and personal experience, and as such is not presented as a definitive treatment of the subject.

Psychometric properties

One of AMPS greatest merits is its robust psychometric properties, developed over the past 15 years. Reliability and validity have been proven in many studies (e.g. Bray et al 2001, Doble et al 1997, Sellers et al 2001), including some which have tested these properties in non-English speaking cultures (Goto et al 1996, Goldman and Fisher 1997, Buchan 2002). We have an obligation to use the best available tools and technology in delivering therapy to our clients, and it's hard to think of many occupational therapy assessments whose technical foundations are as strong as the AMPS. In the current health service environment, therapists must demonstrate the effectiveness of their interventions using well designed outcome measures. In this respect, AMPS provides this capability to therapists in a manner previously unknown in mental health.

However, it is this very factor which turns many mental health therapists away or at least engenders suspicion in this assessment. Mental health is inherently subjective, and many fear that the use of 'reductionistic' assessments like AMPS will render the rich lived experiences of our clients into little more than a series of numbers. While I understand where such doubts come from, there is only one circumstance where I could foresee this becoming a risk. And that would be if a therapist used AMPS as their only method of assessing a client. It is rare in mental health for a client to be referred to occupational therapy for a single assessment session. While this can happen in certain primary care settings, clients are referred for ongoing treatment if this is warranted. Therefore, therapists using AMPS are still able to use the many other assessment techniques at their disposal in conjunction. This multi-perspective (and in many cases multi-disciplinary) approach ensures that a rounded picture of the client's function is constructed, with the AMPS being just one component.

Evidence base

Another professional obligation for modern mental health therapists is the utilisation of the available evidence base in their practice. To date there have been 24 articles published on the use of AMPS in various areas of mental health, representing a healthy 32% of the total literature on the tool. Elderly psychiatry is by far the best represented, although only one of the articles describes a project with clients with non-dementia related mental health problems (Oakley et al 2002). Adult clients are discussed in three studies, with a fourth article providing



by Danielle Hitch

a clinical interpretation of one of these. There is also another article discussing AMPS from a mental health perspective (Fossey and Urlic 2001), but it is not accessible as the journal is not held in any libraries. A recent contribution by Australian mental health therapists (Urlic et al 2006) provides two case examples of its use in mental health, but was published in a local professional newsletter.

People with learning disabilities have been the subject of a series of studies (Kottorp et al 1995, Kottorp et al 2003a, Kottorp et al 2003b, Kottorp et al 2003c), all of which were completed by the same small group of researchers. There are also three resources relevant to therapists working in neuropsychiatry (Robinson and Fisher 1996, Duran and Fisher 1999, Linden et al 2005), but none were written by therapists actually working in the area. As yet, there have been no contributions from the specialties of child and adolescent or dual diagnosis services. What at first glance appears to be a good body of evidence is in fact incomplete and lacking in variety. A sizeable proportion of the articles are based on opinion rather than research, and quantitative methodologies are dominant. While therapists could apply the existing evidence to their practice, there is an urgent need for more research to be conducted in this area particularly from a qualitative standpoint. Using multiple methods and gathering data from different viewpoints can only strengthen the evidence base, and would provide more opportunities for clients and carers to become involved in AMPS research. This may be a need with which the AMPS International Project could assist, as they can provide valuable experience and support to investigators.

Administration issues

From a pragmatic standpoint, there are also several administration issues which impact on the use of AMPS in mental health. It is interesting to note that much of the current research evidence has involved elderly clients. This supports the anecdotal evidence that mental health therapists tend to be more likely to use AMPS when the client presents with a secondary physical disability. This snapshot of overall function can be particularly useful in situations where co-morbidities produce a clouded and contentious clinical picture, as it refocuses the therapist on functional performance rather than diagnosis. Even in the absence of secondary disabilities, there is evidence to suggest that people with mental health problems have generally poorer levels of physical health than the general population (Mutrie and Faulkner 2003). Therefore the format of AMPS not only improves therapists' observational skills, but also raises awareness of any physical health issues which are impacting on the quality of their performance.

It is essential to the standardisation that the protocol for organising and conducting this assessment is followed closely. McNulty and Fisher (2001) state that it is preferable to conduct AMPS assessments in the home, but the environments in which many mental health clients live do not have the resources necessary to complete the tasks in their intended manner. For example, task L-6 (ironing multiple garments and putting garments away) states the use of a table-top ironing board

is not acceptable. A large number of clients I worked with in the community do not own ironing boards, and this effectively reduces their possible choices of task. However, the element of choice usually allows for the AMPS to support efforts towards client centred practice. While choices may be limited at times, at least clients can indicate which of the tasks within the 'just right challenge' range they would like to do.

The full standardised method of administration is also difficult to achieve in situations where a client's engagement with the mental health service is tenuous. Just as you would not use AMPS as your only method of assessing someone, I would suggest you could also not use it with clients who are not well engaged at that time. Allowing someone to watch your performance that closely is an uncomfortable experience, and requires a certain level of trust within a working relationship. Clients who are actively experiencing symptoms of paranoia or have had negative experiences of assessment in the past may find the AMPS overwhelmingly intrusive. However, I have successfully used AMPS with clients of assertive outreach teams when their relationship with services and mental state have been relatively settled. This is facilitated by the fact that AMPS is relatively quick to administer following completion of the preparatory stage, so clients are not unduly inconvenienced.

Applications to practice

If the therapeutic relationship is relatively good, I believe the AMPS can actually become a tool for improving engagement. I have often sat with clients and talked through their AMPS results during goal setting sessions. Many are very interested in the process of scoring, and appreciate the easy to understand graphical reports. On those occasions when I have been able to repeat the assessment with the same client several times, these discussions have become even more meaningful. While we often emphasise the signs of recovery we observe in clients, having an objective measure enables them to believe and acknowledge that they have learnt, grown and changed. To use AMPS in this way therapists need to be comfortable in explaining the tool in 'everyday' language, and the training course provides the necessary background knowledge. While this focus on outcome rather than process is somewhat at odds with the values of occupational therapy (Turner 2002), it is a presentation style that clients can relate to.

Another advantage of providing explicit feedback from the AMPS assessment is the opportunity to highlight the capabilities of occupational therapy and the complexity of our skills. Colleagues from other disciplines (particularly those who have a reductionistic paradigm) may find the AMPS results more accessible than those of qualitative reports. When clients have consented, I have invited colleagues and students to observe the assessment process as a means of illustrating what I do. It transforms the deceptively simple act of watching someone mop the floor into the highly complex and skilled assessment that it is in reality. Therefore, the application of AMPS in mental health services can extend from individual assessment to include effective marketing in a setting when role boundaries can be difficult to define.

While there are many merits to the use of AMPS in mental health, I believe one of the biggest challenges is the cost and availability of training. In a climate where mental health services are frequently being reduced to fund shortfalls in the physical health sector (Gould 2006), it is becoming increasingly difficult to justify the course fees and study leave required to become a fully calibrated assessor. The courses are also offered relatively infrequently outside of the UK and USA, where they may only be available on a bi-yearly basis. This situation has recently been heightened by the requirement to purchase new software, without which therapists were required to re-train. I know of many experienced AMPS assessors in mental health who were unable to secure funding for these new resources, and are now no longer able to use this tool. When you also consider the growth of occupational therapy in the developing world, training in the use of AMPS may need to be reviewed to ensure this tool remains accessible to as many therapists working in mental health as possible.

Conclusion

As with any occupational therapy outcome measure, AMPS has both advantages and disadvantages to its use in mental health settings. While its psychometric properties are virtually unmatched, the current literature base does not provide a substantial amount of evidence for therapists to apply it in practice. This is an area which needs urgent attention, and the AMPS International Project may be a good resource for mental health therapists wishing to use AMPS in audit or research projects.

AMPS enables mental health clinicians to retain a truly holistic focus by highlighting the importance of physical function, and can be a valuable tool in improving therapeutic relationships by tracking changes and transparent practice. The format of the tool supports client centred practice to some degree, and can support therapists in asserting their roles within multi-disciplinary teams. Engagement is another influential factor, and (in common with most assessments and interventions) the suitability of AMPS is largely dependent on the quality of the therapeutic relationship between therapist and client.

However mental health therapists can struggle to meet the standardised protocols as described in the AMPS manuals, due to the living circumstances and resources available to clients. It falls to each therapist to consider whether alterations to the procedure will diminish the validity of the assessment, and document these deviations from procedure in their reports. Another constraint is the cost of training in AMPS, which may prevent its use in a service setting where funding is often at a premium.

From my conversations with colleagues, I believe there is a lot of mis-information about the use of AMPS in mental health in circulation. Some of this stems from misunderstandings about the nature of the tool, some from a mistrust of the reductionist paradigm and some from frustration at a lack of support around accessing the training. My experiences with AMPS have not converted me into a devoted follower, but rather encouraged

reflection on my values as a therapist and the realities of current practice. Like all standardised assessments, it has to be applied mindfully and it won't be right for every client in every situation. However I believe AMPS does have a place in mental health occupational therapy practice and this needs to be supported through further research, ongoing discussion and better utilisation of existing resources.

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Author details

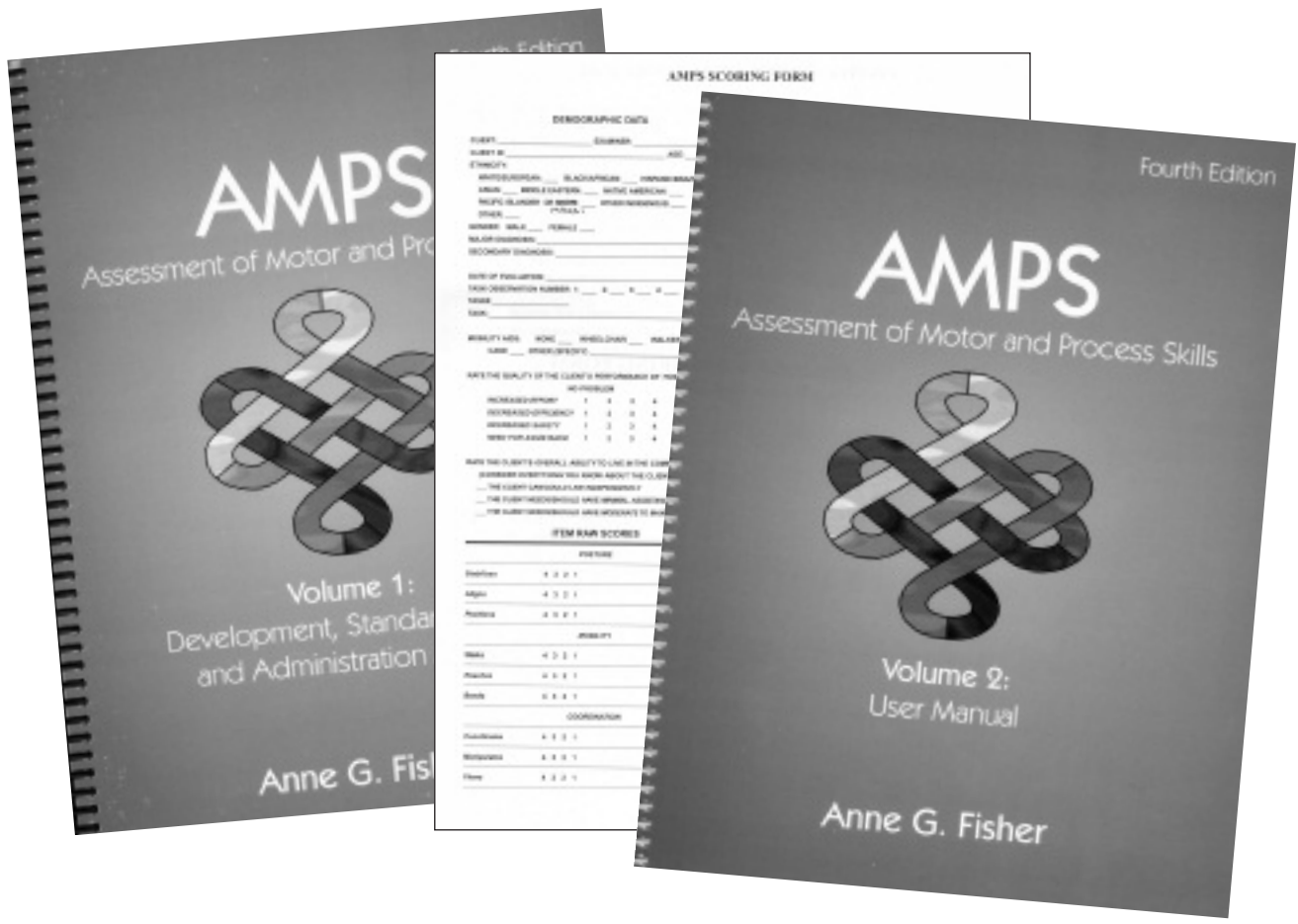
Danielle works in private practice through Optimal Occupation in Melbourne, Australia.
Email: info@optimaloccupation.com.
Web: www.optimaloccupation.com

The Assessment of Motor and Process Skills (AMPS).

The AMPS is a standardised assessment of function which occupational therapists can with specific training then use. The client is scored in motor skills and process skills, and this gives a prediction as to whether the person will be able to live independently. There is inter-rater calibration within the way that the formal assessment of those who train to use it; this means that one assessing occupational therapist will score the same as another. The tool can be used as an outcome measure and a measure of change when used on more than one occasion.

The occupational therapist and client choose two or three of the detailed activities of daily living in the manual and the client is then observed performing these tasks. The occupational therapist scores each 'skill item' which the tasks demonstrate. These scores are fed through a computer programme and tables and graphs indicating the prediction of function against highly researched 'cut off points' are produced.

For more information, see <http://www.ampsintl.com/>



Commentary on 'A critique of the Assessment of Motor and Process Skills (AMPS) in mental health practice'.

Hitch (2007) states the aims of her paper as being to 'provide an overview of issues surrounding the use of the Assessment of Motor and Process Skills (AMPS) in mental health practice' (p.4); and 'to provoke ongoing discussion and reflection' (p.4). The paper opens by emphasising the strong psychometric properties of the AMPS. It then briefly reviews the evidence base, highlighting the relatively sparse literature to support the use of AMPS within the wider spectrum of mental health services. A number of issues related to the application of AMPS in practice are then addressed. This commentary reflects further on some of the issues raised.

The author highlights the perception of some practitioners that AMPS is a 'reductionistic' assessment that in some way will limit their ability to understand a client's story. She rightly points out that this will only happen if a therapist relies on the AMPS as their only method of engaging and assessing a client. As in all settings, each occupational therapist needs to gather together their own 'toolbox' of models, frameworks, assessments and interventions that are relevant to their specialty and service setting. The most appropriate combination can then be selected for each individual client, based on understanding that individual's story. This understanding can only be gained by firstly establishing rapport and working in partnership with the client. The need to 'utilise standardised assessments, or assessments derived from recognised models of occupational therapy' (College of Occupational Therapists (COT) 2003, p 17) must not be forgotten.

Occupational therapists must base their work on 'current guidance, research, reasoning and the best available evidence' (COT 2005, p 16). The relative paucity of evidence related to using AMPS in mental health practice is therefore a concern. However, lack of evidence does not equal lack of efficacy. What it does reflect is the need for our profession to more actively disseminate the many examples of good practice that do exist. More practitioners need to follow this author's example to commit their thoughts to print in order to promote debate and discussion such as this. Hitch is also right to highlight the need to further explore options and avenues to expand the current evidence base.

The author highlights the potential challenges in following the standardised assessment procedures. From my own experience of using the AMPS primarily with older people living in the community, I could certainly illustrate the frustrations of ensuring the right equipment and materials are in the right place at the right time, in order to set up the assessment environment. These examples range from the entertaining to the downright ridiculous but more seriously raises the question as to

the potential effect that following the standardised protocol can have on the therapeutic relationship. Initially the client is asked to select personally meaningful and familiar tasks, but is then given very directive instructions as to how to carry these out. This can be particularly difficult to handle when assessing clients in their own home.

Remaining client centred as opposed to therapist led depends on the strength of the underlying therapeutic relationship that has already been established. Indeed, the author highlights the potential usefulness of the initial AMPS interview and subsequent feedback of results in further developing this relationship, as the tasks that are discussed are so inextricably linked to the individual's own routine and values.

On a more practical note, a recent meeting of the London AMPS User Group explored the possibilities of using AMPS when there is no access to a kitchen. It became clear during the lively debate that there are indeed many tasks that can still be offered to clients despite the absence of such facilities.

The suggestion to use AMPS to explain and market the potential and practice of occupational therapy to colleagues reflects a recent experience of my own. Having used the AMPS for the first time in a new setting, much interest was generated by the subsequent report and the amount of information that had resulted from 'just watching the client making a cup of tea'. It certainly did demonstrate to my colleagues that there really 'is more to occupational therapy than just meets the eye'.

The cost and availability of training is certainly a major issue. This has always been the case, but within the UK it is currently very topical. Time and money for training are continually reducing to the point of being non-existent in some areas. Added to this, was the sudden and unexpected withdrawal of the AMPS UK licence at the end of 2006. Hence, the immediate future for AMPS training in the UK is very uncertain, but beyond the remit of this commentary to speculate about.

The failure of some services to invest in the updated software for existing users is at best, short sighted. However, should practitioners faced with this situation take more personal responsibility and purchase their own software in order to maintain their own calibration status rather than depending on their employers to do so?

Concern is consistently expressed about the lack of



by Jennifer Wenborn

mental health examples within the AMPS training course. However, the lack of such materials is quite understandable bearing in mind the ethical maze of gaining consent from such potentially vulnerable clients. I am sure that AMPS trainers everywhere would be pleased to receive any suggestions as to how this dilemma might be overcome.

Following the investment of time and money to attend the training course, is the challenge of achieving calibration and then actually implementing the AMPS. The potential range of barriers to effective implementation have previously been well described (Chard 2000, Chard 2004); and albeit, based on a small sample, appear to be consistent regardless of the service setting or level of therapist experience. The most significant factors are workplace related. Firstly, having the time to practise the new skill in order to achieve competence. Secondly - and the most vital - is having the management support to enable the newly learnt skills to be integrated into existing practice. Therefore, managers not only need to understand the potential of the tool, but must also be prepared for the longer term investment of time and money required to enable its successful implementation. It would be interesting to explore whether the level of management support differs between those managers who are occupational therapists and those who are from other professional backgrounds. The latter being a situation applicable to many occupational therapists working in mental health.

Chard (2000) highlights the value of support from other AMPS trained therapists. A variety of models can be utilised to provide this. Support from colleagues within the service itself or at a very local / unit level can build confidence and be used to maintain inter-rater reliability. Ongoing support can also be obtained through regional AMPS User Groups. The London AMPS User Group (Wenborn 2006) enables therapists from different specialties and at differing levels of experience in using the AMPS to come together to debate and further develop their knowledge and skills.

There is also a case for support to commence before even attending the AMPS course. Therapists who are interested in using the AMPS need to: fully understand the advantages and limitations of the AMPS; to make an informed decision about its potential use in their own clinical area of practice; and anticipate the potential barriers to its implementation; before embarking on the training. For example, an experienced AMPS user can guide potential users through a preparatory phase of self directed learning to enhance their understanding of the tool and the practical implications before attending the course. Support then continues throughout the calibration period and subsequent process of integrating its use into practice.

Client centred practice has always been central to the occupational therapy philosophy and will continue to be so, especially in light of the current focus of mental health services to enable clients to achieve recovery and well-being. This central role is highlighted in the recently published COT Mental Health Strategy which states that we must, 'work in partnership with service users and carers, putting their needs, values and aspirations at the

centre of planning and implementing interventions' (COT 2006, p10). Using a client centred assessment tool such as AMPS is just one way of achieving this goal. Using AMPS can also be a useful tool in meeting another challenge within the Strategy, to 'use outcome measures that give clear evidence that occupational therapy has made a difference to people's occupations' (COT 2006, p 13).

Hitch successfully provides an overview of some of the issues surrounding the use of the AMPS in current mental health practice. It is hoped that her paper, along with this commentary, will provoke further discussion and debate.

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Author details

Jennifer Wenborn MSc DipCOT
OT Coordinator, North East London Mental Health NHS Trust & London AMPS User Group coordinator
jennifer.wenborn@nelmht.nhs.uk

Occupational Therapy article in British Medical Journal.

Have you seen the article where the Assessment of Motor and Process Skills (AMPS) was used as the research outcome measure? The article describes a single RCT looking at occupational therapy intervention to people living at home with mild to moderate dementia and their carers.

The results were that there was a significant improvement in the functioning of patients with dementia and the sense of competence of their care givers when 10 sessions of occupational therapy was given to the care givers over a five week period. The occupational therapy interventions included cognitive and behavioural techniques. The improvement was shown as sustained when checked at 12 weeks after the end of intervention.

Graff MJL, Vernooij-Dassen MJM, Thijssen M, Dekker J, Hoefnagels WHL and Olde Rikkert MGM (2006) Community based occupational therapy for patients with dementia and their care givers: randomised controlled trial. *British Medical Journal*, 333 pp1196-1199

Response to: A critique of the Assessment of Motor and Process Skills (AMPS) in mental health practice.

by Anne Fisher and Birgitta Bernspång

First of all, we want to thank Hitch for bringing a thoughtful critique of the Assessment of Motor and Process Skills (AMPS) to the occupational therapy community. The issues she raises have been circulating, in different forms, for some time. Most of the issues that Hitch brings up are relevant to almost any area of practice where the AMPS is used; they are not unique to mental health.

An interesting point to make is that the foundation for the AMPS originated in psychiatry, specifically for use with clients with schizophrenia and depression (for this, Susan Doble, Halifax, Canada should be given credit). The basic idea behind the AMPS was to develop a tool that enabled clients to perform familiar tasks, and allowed them to choose which ones they would perform, so as to support their motivation and engagement in their task performances. The AMPS has since been developed to be used in all areas of occupational therapy practice and with all diagnostic and age groups.

Unfortunately, the published research related to the AMPS reflects the practice arenas where research is most often implemented. The AMPS reference list posted on the AMPS Project International website (www.ampsintl.com) includes ten articles (slightly more than 10% of the total number listed) that are related to persons with mental health problems other than dementia or learning disabilities; two pertain to children with disorders of attention (Baron 1994, Fossey & Urlic 2001, Girard et al 1999, Gol & Jarus 2005, McNulty & Fisher 2001, Oakley et al 2002, Pan & Fisher 1994, Robinson & Lumb 1997, Sharp 2003, White & Mulligan 2005). Of these, only a few were cited by Hitch. Yet, they clearly remain a minority.

From the Swedish, or Scandinavian horizon, where we work, research that has involved the use of the AMPS has mainly been conducted with clients with dementia, stroke, brain injury, or learning disabilities. Not surprisingly, this also reflects the practice areas where most occupational therapists are doing research. But we wonder if the relatively low number of research studies in mental health is also a reflection of practice within this area where there is often a focus on behavioural problems rather than occupation, and using tools that involve assigning numbers has been less common. As Hitch points out, occupational therapists in mental health are 'inherently subjective,' and this may be the reason why the use of a seemingly 'reductionistic' assessment like AMPS has rendered little research effort. When implementing research using the AMPS, the design of the studies is generally quantitative. This does not diminish the importance of qualitative research. An objective tool like the AMPS can help us to understand how much ADL ability the client has, but it will never enable us to understand the client's experience of limited ADL ability or participation in daily life. Conversely, qualitative research is not well suited to enabling us to know how much ADL ability a client has.

Hitch stated that a sizable proportion of the published AMPS articles are based on opinion rather than research. This comment is rather confusing, as almost 90 AMPS-related articles and book chapters have been published, and approximately 75 of those were research studies published in peer-reviewed journals. About 10 of the others, like Hitch's article and this response to her article, are subjective commentaries (opinions) that seek to stimulate dialogue. We certainly agree with Hitch that such dialogue is needed. What we would also welcome is more and clearer information about the type of research evidence that she feels is lacking. Such a dialogue could play a very important role in stimulating the very research she would like to see published. Perhaps this would also help the AMPS Project International to provide better support to investigators.

The majority of the AMPS-related research papers, in one way or another, support evidence that the AMPS measures are reliable and have usability in clinical practice (test validity). Of these, there is a growing body of research that suggests that the AMPS is sensitive enough to detect changes that occur during intervention (Fisher et al in press, Gol & Jarus 2005, Graff et al 2006, Kinnman et al 2000, Kottorp et al 2003, Lindén et al 2005, McAdam et al 2001, Oakley et al, 2002, Oakley & Sunderland 1997, Pierce et al 2002, Tham et al 2001, Wittenberg et al 2003, Wæhrens & Fisher in press). The use of an objective assessment can help us to provide evidence that occupational therapy services are effective which is critical for evidence-based practice. We would like to see similar studies implemented in mental health.

Another point of confusion that we would like to see clarified pertains to Hitch's point that the AMPS focuses on physical function (this seems to be a critique). Yet, she also states that this focus is essential to improve the therapist's observational skills since people with mental health problems generally have poorer levels of physical health. It seems almost ironic that in some areas of the world, the AMPS is incorrectly viewed as a mental health assessment and as not relevant to physical medicine. We wonder where these and other misconceptions arise, and what can occupational therapists do to prevent such misconceptions, whether they pertain to the AMPS or not. Our favourite misconception, published in many occupational therapy textbooks, written by occupational therapy scholars, is that the AMPS is an assessment of underlying physical and cognitive functions.

The AMPS is an assessment of the quality of occupational performance, not underlying impairments. Therapists who work in mental health settings often comment during AMPS courses, that once they have started to observe and evaluate ADL motor skills, they realize that many of their clients, to their surprise, have problems with both ADL motor and ADL process skills. Moreover, while the ADL motor skills of the AMPS pertain to the degree of ADL ability clients demonstrate

as they interact with task environments and move themselves and tasks objects during their performances of naturalistic ADL tasks, the ADL process scale reflects efficiency (time and space organization) of ADL task performance, a problem that is common to persons with psychiatric disorders (Girard et al 1999).

It is very important to stress is that the AMPS is not an appropriate tool to use if a person does not have a problem with ADL task performance. Many higher functioning clients with psychiatric disorders manage personal and domestic ADLs quite well. That is not a problem with the AMPS. What we need are more tools that enable us to better assess occupational performance within the work and social arenas where higher functioning clients experience their problems. Our hope is that researchers within our profession will develop needed tools to fill this critical gap.

We would like to conclude by pointing out that we agree with Hitch on several points:

- The AMPS has a place in practice, but only if the therapist reflects on its suitability – does the client have a problem with personal and/or domestic ADL?
- The AMPS can promote good practice, including enhancing engagement (by ensuring a client performs tasks he or she feels are relevant to address, a key feature of an AMPS administration), providing a basis for explicit feedback on occupational performance, and helping others to better understand our focus in practice.
- The appropriate use of the AMPS supports client-centred practice and therapists' ability to asserting their roles, with our focus on occupational performance, within multidisciplinary teams.
- The AMPS is one of many tools that an occupational therapist can use when assessing a client.
- While the AMPS has a robust psychometric and research base, there is always a need for more research. We would, for example, like to see more research documenting the evidence of the effectiveness of occupational therapy in mental health settings (not to mention other arenas of practice). With that, we might explore what tools and methods best capture the changes that occur.
- It can be very difficult, if not impossible, to administer any informal or standardized assessment based on observation or interview if the client is not engaged. This problem is not unique to mental health or the AMPS, but certainly, it applies to the use of the AMPS in mental health. There is a case study in the AMPS manual that addresses this issue.
- While AMPS courses are relatively inexpensive when compared to other five-day courses, and are offered in at least 20 countries around the world, some occupational therapists feel that costs and availability of AMPS training remains an issue. As AMPS course fees are set locally, and vary from country to country, persons interested in AMPS training may want to compare prices.

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Author details

Anne G. Fisher, ScD, OTR
Professor, Division of Occupational Therapy, Umeå University, Umeå, Sweden and Director, AMPS Project, International, Ft. Collins, CO, USA

Birgitta Bernspång, PhD, LegOT
Professor, Division of Occupational Therapy, Umeå University, Umeå, Sweden and Country Coordinator for AMPS in Sweden

Commentary on: *A Critique of the Assessment of Motor and Process Skills (AMPS) in Mental Health* by Danielle Hitch.

How short our memories are! The Assessment of Motor and Process Skills (AMPS) was one of the early assessments that provided evidence of outcomes in occupational therapy (Fisher 2003 1993). Fisher developed and validated a powerful tool that can be used to measure changes in ADL motor and ADL process skill ability in the context of activities of daily living. Valid and reliable administration of the AMPS was and still is dependent upon participation in a 5-day workshop plus rater calibration process. Hitch (2007) rightly notes that one of the biggest challenges to using the AMPS is the cost and availability of training; surely such rigour in the application of assessment tools must be a good thing. AMPS courses are provided across the world (www.ampsintl.com); however frequency of courses and distances for travel are dependent on demand in any particular country as well as availability of trainers. Planning ahead or taking responsibility for organizing a course in your own locality is always an option when course availability is limited.

Training issues

Powerful assessment tools such as the AMPS do not come easily and therapists must be willing to commit money for training and time for learning. The utilisation of new knowledge within practice has been demonstrated to be low (Chard 2003, Wye & McClenahan 2000). These studies found that embedding new skills and procedures in clinical practice is between 9% - 14%. This is a strange paradox when therapists are willing to commit five days of their employer's time and up to £1,000 of funding to attend an AMPS course not to fully implement it into their practice. The dilemma for therapists appears to be introducing something new into a team with established assessment procedures; expectations of the team and changing practice appear to make utilization more problematic rather than difficulties using the AMPS itself. Critical in this process is gaining the support of managers or senior clinical leaders before attending training (Chard 2006). Therapists have a responsibility therefore, to make adequate preparations before attending an AMPS training course to ensure, as far as possible, that implementation of the AMPS will be successful within their team.

Once trained, the AMPS must be used regularly to maintain competence in administering and scoring it, otherwise the reliability of the AMPS results may be compromised. I would argue that this is the same when using any therapeutic skill and why continuing competency courses are alive and flourishing. It is not necessary to retrain to use the AMPS if it is used regularly and with current documentation. Purchasing up-dated AMPS software supports and enhances practice, enabling therapists to provide improved and up-to-date outcomes of occupational therapy. It is interesting to reflect that the purchase of Microsoft Office updates or Windows XP or Vista do not seem to cause the same consternation. To

maintain currency and obtain updates of any new software or tool is the responsibility of the user. If ongoing funding cannot be secured (and often it cannot) then it is therapists' responsibility to decide whether to purchase it themselves. I would argue that the funding for attending courses and up-grading assessment tools should be reviewed rather than, as Hitch suggests, the AMPS training. I doubt such funding would be an issue in medicine and suggest that we continue to lobby to maintain and increase funds that provide training specifically to enhance evidence for practice.



by Gill Chard

Using the AMPS in mental health settings

Hitch (2007) notes that there are many advantages to using the AMPS in mental health but studies investigating its implementation are limited. McAdam et al. (2001) found it an appropriate tool for mental health practice and limitations focused on its implementation. The AMPS has robust psychometric properties and it has been validated for many cultures across the world, with all ages from three years upwards and with many different diagnostic groups including mental health (Fisher 2003). There are few standardized assessments that could make that claim. Hitch states there have been 24 articles published on the use of the AMPS in mental health, but unfortunately does not provide references or evidence of these. A cursory survey of the AMPS literature revealed six research studies focusing specifically on outcomes of occupational therapy with clients in psychiatric settings (Fossey et al. 2006, Oakley et al. 2002, McNulty & Fisher 2001, Girard et al. 1999, Robinson & Lumb 1997, Pan & Fisher 1994). A further 12 studies focusing on clients with cognitive impairment and dementias (Graff et al. 2006 & 2003, Nygard 2003, Nygard et al. 1998 & 1994, Oakley et al. 2003, Oakley & Sunderland 1997, Cook et al. 2000, Doble et al. 2000 & 1997, Hartman et al. 1999, Robinson & Fisher 1999) and three studies in neuropsychiatry (brain injury) (Linden et al. 2005, Johansson & Bernspång 2001, Darragh et al. 1998). As Hitch points out elderly psychiatry is by far the area offering most research evidence. She describes the scope and breadth of evidence for AMPS use in mental health as 'sparse' or limited (abstract). I wondered how much is 'enough' evidence and how the evidence base of other occupational therapy-specific assessments compare? She rightly points out that many other studies are based on opinion, but this contributes towards the evidence too as it strengthens (or limits) the utility of the AMPS. There are few practice evaluations of the AMPS within mental health settings but this is dependent on mental health practitioners carrying out such studies and writing them for publication.

Hitch notes anecdotal evidence that mental health

therapists are more likely to use the AMPS when the client presents with a secondary physical disability. The AMPS can simultaneously assess both motor AND process skills, surely an advantage to any therapist? Selecting the right assessment for clients is critical and requires sound clinical reasoning; unless the client is ready to engage in activities why would you use the AMPS? Readiness of clients for assessment and transparency of what we are doing are an ethical requirement. We should not be assessing a client surreptitiously or without consent, but finding ways to deal with this sensitively and therapeutically. Similarly, assessing clients who feel anxious can also be problematic. McAdam et al. (2001) noted that mental health clients were perceived to feel more comfortable than therapists, thus supporting Hitch's plea for mental health occupational therapists to conduct qualitative studies to provide evidence of how clients feel during this process.

Conclusion

Hitch highlights some important points: not all assessment tools are right for all clients in all circumstances and should be selected and used based on clinical need as well as evidence, and this includes the AMPS. We need to conduct and publish more practice evaluations, especially in mental health settings, of the use of the AMPS in supporting client centred practice. Hitch's paper has triggered much food for thought. Firstly, the need for reflection on practice and to take personal responsibility to ensure our practice is current and evidence-based. Secondly, selecting and using tools that support collaborative partnership with clients and their families. Thirdly, we need to lobby politicians and policy makers for initiatives that establish secure funding for on-going training and professional development.

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Author details

Gill Chard, PhD, BSc, DipCOT
Associate Professor of Occupational Therapy and an AMPS trainer, Faculty of Rehabilitation Medicine, University of Alberta, Edmonton, Alberta, T6G 2G4
gill.chard@ualberta.ca

A reply from Danielle Hitch to the Fisher and Bernspång response to: A critique of the Assessment of Motor and Process Skills (AMPS) in mental health practice.

Thank you very much for your detailed and thoughtful response to 'A critique of the Assessment of Motor and Process Skills (AMPS) in mental health practice'. As you rightly emphasise the issues raised are not unique to this practice setting, highlighting the universal nature of occupation. I was particularly interested in several of your comments, and would like to make some brief comments in reply.

The general lack of studies around AMPS from mental health certainly does reflect a lower level of formal research activity within this area of practice. It's virtually impossible to complete projects of this nature unless a researching role is written into your job description - clinicians usually don't have the time or resources. I think this is more of an influence on its lack of utilisation than any perceived 'reductionism'. However, I have recently been involved in two practice evaluations looking at AMPS in mental health (one focussing on its utilisation by clinicians, and the other on building a profile of AMPS results for people with schizophrenia). I am also aware of a great qualitative project by a Tasmanian colleague, which I hope she publishes in the near future. Practice evaluations, clinical audits and quality assurance tasks can provide clinicians with accessible means to participate in research activities using the AMPS. As some of the

published articles are difficult to access, it might also be useful to gather them together in one place for borrowing or place them online.

I would also like to clarify an area of misunderstanding. I do not mean to imply that AMPS focuses on physical function, and I'm not aware of people believing that AMPS is solely a mental health assessment. I have always held that it's an assessment that looks at both physical and cognitive functional performance, and raised this only to highlight its potential for promoting holistic practice in mental health. I would also comment that it comes as no surprise to most mental health clinicians that their clients also have difficulties with motor skills. Perhaps a 'myth busting' article about AMPS would be useful.

The final comment I would like to make involves the issue of course costs. While I can understand how therapists in Europe could 'shop around' and compare prices between countries, this will never be feasible for therapists in the more far flung corners of the occupational therapy world. It is my sincerely hope that this article and subsequent dialogue will stimulate further informed discussion and utilisation of AMPS in mental health practice, as I believe it to be a powerful tool for both therapists and clients alike.



Gambling treatment MUST be available on the NHS, say doctors...

In its hard-hitting report, *Gambling addiction and its treatment within the NHS*, released on Monday 15 January 2007, the BMA is calling for gambling to be a recognised addiction that requires treatment on the NHS.

"This recommendation is part of a tough set of proposals aimed at helping healthcare professionals deal effectively with the growing problem of gambling addiction in the UK. The report is timely given the 2005 Gambling Act is due to come into force this September. The new UK legislation will increase gambling facilities and subsequently problem gambling may rise too – health professionals must be prepared for this."

The Cochrane library produced a review of **drama therapy for schizophrenia** or schizophrenia-like illnesses in November 2006 (see <http://www.cochrane.org/>

<http://www.cochrane.org/reviews/en/ab005378.html>). Findings indicate that "drama therapy is one of the creative therapies suggested to be of value as an adjunctive treatment for people with schizophrenia or schizophrenia-like illnesses. Randomised studies have been successfully conducted in this area but poor study reporting meant that no conclusions could be drawn from them. The benefits or harms of the use of drama therapy in schizophrenia are therefore unclear and further large, high quality studies are required to determine the true value of drama therapy for schizophrenia or schizophrenia-like illnesses."

Another recent addition to the Cochrane library is **Interventions to reduce weight gain in schizophrenia** which states that "weight gain and obesity is a common problem for people with schizophrenia and both pharmacological (medication) and non pharmacological (diet/exercise) interventions have been

tried to treat this problem. In this review we are able to show that small weight loss is possible with selective pharmacological or non-pharmacological interventions but it is difficult to be sure of the results because the studies were small and compared different interventions over different time periods."

Scientists identify gene that may indicate predisposition to schizophrenia.

In a new study from The American Journal of Human Genetics, a research team lead by Xinzhi Zhao and Ruqi Tang (Shanghai Jiao Tong University) present evidence that genetic variation may indicate predisposition to schizophrenia. Specifically, their findings identify the chitinase 3-like 1 gene as a potential schizophrenia-susceptibility gene and suggest that the genes involved in biological response to adverse conditions are likely linked to schizophrenia.