Client-Centered Assessment

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Key Words: independent living skills (human activities) • motivation • planning process, occupational therapy

When occupational therapists assess function or occupational performance, they must consider each person's unique needs and abilities, as well as the environmental and social factors that may be affecting the clients' performance. Therefore, occupational therapists must use evaluation tools that are individualized and sensitive to the clients' varying needs and situations. One approach to individualized evaluation is the use of a client-centered process of setting goals and assessing change. This paper describes the development of a methodology for a client-centered assessment currently being used in Canada, the Canadian Occupational Performance Measure (COPM). The conceptual model, administration and scoring procedures, and preliminary feedback to the COPM are described.

The idea of client-centered therapy has become more common over the past 20 years due to a number of social influences. The prevalence of chronic disease has increased the need for persons to take responsibility for their own health. The sophistication of, and access to, health care information have made for more critical consumerism among the public. As a result, the idea of health is changing for many people, with concerns over quality of life and lifestyle. Definitions of health have moved from a medical model concept of the absence of disease, through the World Health Organization's definition including complete physical, mental, and social well-being, to more of an emphasis on function, in which health may be viewed as the potential or capacity to achieve preferred goals or perform certain functions (Calnan, 1987). The latter idea is central to occupational therapy. The foundations of our profession rest on functional activity and its relationship to health.

In examining functional activity, occupational therapy is concerned with occupational performance. Reed and Sanderson (1980) described occupational performance as the activities carried out by the client in the areas of self-care, productivity, and leisure, influenced by environmental and societal factors. Performance is predicated on the interaction of the person's mental, physical, sociocultural, and spiritual performance components. It is also related to individual roles and role expectations and developmental stage. It stands to reason, then, that occupational performance is unique to the person; one person's occupational performance needs and abilities will not be the same as any other person's. Yet, in assessing occupational performance, occupational therapists often use measurement tools that are not individualized or sensitive to varying needs and situations. A review of the literature shows that few assessments include the environment or social role expectations in their assessment of occupational performance (Pollock et al., 1990).

In addition to the content of assessments, we need to be concerned with process. Almost without exception, clients are interviewed or observed for testing purposes, but the scores for clients' performance are assigned by the tester. Is the tester in the best position to judge whether a client's occupational performance is adaptive or maladaptive? Is the tester so familiar with that client's environment, life-style, and the demands placed on the client that the tester can make that judgment? As in the case of the Sickness Impact Profile (Bergner, Bobbitt, Carter, & Gilson, 1981), can a panel of experts be used to determine that a problem in family interactions is worth three times as many scale points as a problem in ambulation? I suggest that if we use a truly client-centered approach, then we cannot.

The use of rater judgment in scoring assessments may only reinforce the passivity of clients and the sense of the professional as the answer to the problem. If the person is no longer the problem definers, it is unlikely that...
he or she will be the problem solver either. This disparity can reduce the client’s self-determination and sense of control over health, often leading to what may appear as noncompliance. If the therapy goals are set by the client through a process of client-centered assessment, the potential for active participation is enhanced.

How then can we help clients to define their occupational performance problems? This paper presents a methodology for client-centered assessment currently being used by occupational therapists in Canada.

Development of the Measure

The Canadian Association of Occupational Therapists (CAOT), in collaboration with Health and Welfare Canada, has developed a conceptual model and guidelines for the client-centered practice of occupational therapy (Department of National Health and Welfare [DNHW] & CAOT, 1983). This occupational performance model is based on the belief that the person is a fundamental part of the therapeutic process, and describes a person’s occupational performance as a balance of performance in three areas: self-care, productivity, and leisure.

This model was accompanied by assessment and intervention guidelines for the client-centered practice of occupational therapy (DNHW & CAOT, 1983; 1986). Subsequently, a third collaborative task force focused on the outcome measures in occupational therapy in Canada (DNHW & CAOT, 1987).

The third task force used the occupational performance model to investigate current outcome measures of self-care, productivity, and leisure. The task force recommended that work go forward “to develop tool(s) specifically for occupational therapy and testing (of this tool) should assess the degree to which it captures the important contributions of occupational therapy” (DNHW & CAOT, 1987, p. 39). The result of this work is the Canadian Occupational Performance Measure (COPM), an outcome measure designed to be used by occupational therapists to assess client outcome in the areas of self-care, productivity, and leisure. The COPM identifies problem areas in occupational performance, assists in goal setting, and measures changes in occupational performance over the course of therapy.

The COPM reflects the philosophy of the model of occupational performance. It incorporates roles and role expectations within the client’s environment. It considers the importance of the skill or activity to the client through a semi-structured interview approach.

The advantages of this individualized measure are that it is client centered, is generic (that is, not diagnosis specific), and crosses developmental stages. As well, such an individualized measure can be used with a physically dependent client to evaluate her or his control over the environment.

The COPM measures the client-identified problem areas in daily functioning. When a client is unable to identify problem areas (e.g., when the client is a young child or a person with dementia), a caregiver may respond to the measure. The COPM considers the importance, to the client, of the occupational performance areas, as well as the client’s satisfaction with present performance. The measure takes into account client roles and role expectations and, in focusing on the client’s own environment, ensures the relevance of the problem to the client. It can be used to measure client outcome with different objectives for treatment, including development, maintenance or restoration of function, and prevention of change. During the assessment process, the measure will help engage the client from the beginning of the occupational therapy experience and increase client involvement in the therapeutic process. The COPM supports the notion that clients are responsible for their health and their own therapeutic process. It permits the therapist and client to identify and deal with life span issues and permits the evolution of the use of purposeful tasks and activities.

Administration and Scoring of the COPM

The COPM is a five-step process based on a semi-structured interview conducted by the therapist together with the client or caregiver or both. The five steps are problem definition, problem weighting, scoring, reassessment, and follow-up.

Step 1: Problem definition. In this step, the occupational therapist interviews the client or caregivers or both to determine whether they are having any problems in occupational performance. For each performance area, the therapist asks the client if he or she needs to, wants to, or is expected to perform these activities. If the answer to any of these three questions is yes, the client is asked if he or she can perform, does perform, and is satisfied with how he or she performs these activities. When the client identifies a need as well as an inability to perform an activity satisfactorily, this performance area is identified as a problem. If the client does not identify a need or expectation to perform, this area would not be addressed further. Activities in each area of self-care (e.g., dressing, mobility), productivity (e.g., school, paid work), and leisure (e.g., socialisation, hobbies) are discussed.

Step 2: Problem weighting. Once the specific problem areas have been identified, the client is asked to rate the importance to her or him of each of the identified activities on a scale of 1 to 10 with the anchor points being “not important at all” and “extremely important.”

Step 3: Scoring. On the basis of the importance rating from Step 2, the five most urgent problems are identified. The client is then asked to rate his or her ability to perform the specified activities and his or her satisfaction with that performance on scales of 1 to 10. The ratings of ability and satisfaction are each multiplied by the impor-
tance rating to determine a baseline score. The importance rating acts as a weighting factor through this multiplication. The possible range of scores is from 1 to 100 for satisfaction and 1 to 100 for performance for each problem identified. The scores are added to create an overall summative score that is divided by the number of rated activities, yielding a score that can be used for comparisons across time and across clients. There are two scores, one for performance and one for satisfaction.

The client and therapist must then decide on the goal of treatment. If the goal is to develop or restore function, one would expect an increase in performance or satisfaction scores or both. If the goal is maintenance or prevention, no change in performance score may be the desired outcome.

To understand the reasons for performance problems, to set short-term objectives, and to plan therapy, the therapist may need to assess performance components contributing to the client’s difficulties in the identified problem areas. Such assessments, although not the primary outcome of occupational therapy, assist the therapist in evaluating causes of dysfunction and planning an appropriate intervention to achieve the goal identified by the client. The therapist may need to observe the client performing certain tasks, to use standardized tests to evaluate skill areas, to assess the client’s environment, or to use any number of other approaches to understand the client’s problems and plan treatment. The COPM is not meant to replace other assessments; it is meant to focus on occupational performance problems and to operationalize a client-centered approach.

Step 4: Reassessment. This step follows the intervention process. The therapist again asks the client or caregiver to rate his or her abilities and satisfaction with performance in the activities identified as problems in Step 2. These ratings are multiplied by the original importance ratings, summed, and divided to calculate the change seen in the client over time. This process enables the client and therapist to have a concrete image of changes that have occurred during the therapy process.

Step 5: Follow-up. The purpose of this step is to plan for treatment continuation, follow-up, or discharge. With a new COPM form, the therapist asks the client or caregiver the six questions used in Step 1 to decide whether occupational performance problems remain or whether new difficulties have emerged over time. The client and therapist then decide on the best course of action as in the first use of the measure.

Pilot testing of the COPM has been completed with approximately 200 clients in different centers across Canada. Feedback from both therapists and clients has been positive, reporting that the COPM was easy to administer and took 20 to 40 min. The format and rating scales were clear and easy to employ. Most therapists believed that the COPM provided a useful framework for their initial assessment of all areas of occupational performance.

Through this process, the true priorities of the clients became evident. These priorities often differed from the therapists’ initial ideas. Clients’ insight into their abilities and difficulties in occupational performance frequently increased through the assessment process. Some clients have commented that they appreciated the feeling of being in control of the process of problem identification.

Some concerns have been raised about the appropriate timing of the use of the COPM. It will serve well as an initial assessment, but the client may lack the insight to be able to respond to the COPM early in the therapeutic process, so it may be advantageous to do the COPM later. With some clients, it may be necessary to use caregivers as proxy respondents, and may therefore raise the question of who is the real client. Our experience has shown that it is possible to use the COPM with families as respondents, but more difficult, particularly when judging the importance of the activity on behalf of the client.

We have completed the pilot testing of the COPM and have initiated studies to examine the reliability, validity, and responsiveness of the measure. We welcome comments from users of the measure and encourage others to do research on the COPM.

Summary

The COPM is an individualized measure designed to assess client-identified problem areas in daily functioning. It considers the importance of the activity to the client, as well as his or her satisfaction with performance of those activities. The COPM takes into account client roles and role expectations and, in focusing on the client’s environment, ensures the relevance of the identified problem areas. The COPM supports the notion that clients are responsible for their health and their own therapeutic process. It stands as one example of client-centered assessment.

Acknowledgments

I acknowledge the other members of the COPM Research Group: Mary Law, MSc, Sue Baptiste, MSc, Anne Carswell-Oppenheimer, PhD, MaryAnn McColl, PhD, and Helen Polatajko, PhD. The COPM is available from the Canadian Association of Occupational Therapists, 110 Eglinton Avenue West, Third Floor, Toronto, Ontario M4R 1A5.

This manuscript is based on a paper presented at the Symposium on Measurement and Assessment: Directions for Future Research in Occupational Therapy at the University of Illinois at Chicago, October 16–18, 1991. The symposium was jointly sponsored by the American Occupational Therapy Association, the American Occupational Therapy Foundation, and the Occupational Therapy Center for Research and Measurement at the University of Illinois at Chicago.

References


