Mental Health Evaluations Used in Occupational Therapy

To teach students occupational therapy evaluation techniques (or methods) in psychiatry, evaluations currently being used in the field were identified. Three consecutive surveys were sent to occupational therapy faculty, clinical supervisors, and clinicians to ascertain which evaluation techniques were being taught, those which the students were expected to know about in their fieldwork experiences, and those which were practiced in the field. On an average, occupational therapy schools were teaching four evaluation tools. Affiliating students were expected to know about 3 of 24 evaluation tools listed in the survey, and none of the evaluation techniques were being practiced significantly by occupational therapists. Since 75 percent of the therapists reported that they developed their own evaluation tools, it was suggested that instructors be familiar with the existing evaluation tools and teach students the methodology required for developing their own evaluation tools (or instruments).

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A ssessment and evaluation tools used in psychiatric occupational therapy that had been published or had been presented at workshops and conferences were identified for a 10-week course given at Cleveland State University. In deciding which tools to include in the course, the author first conducted two surveys to find out which tools were taught in other curricula and which ones the students were expected to know about or be proficient in using during their fieldwork experience. For the purpose of these surveys, it was irrelevant to identify which tools were assessments and which were evaluations. Therefore, for lack of a word that was encompassing, the term evaluation was used.

At the time this material was being identified for the course, the newly formed Mental Health Specialty Section was meeting at the 1977 Annual Conference of the American Occupational Therapy Association (AOTA). The most serious concern expressed at this meeting was the need for client evaluation methods or techniques. The specialty section steering committee then planned an institute for the 1978 AOTA conference designed to introduce three newly developed evaluation tools, to instruct participants to their use, and to begin the process of developing norms and standardization for these tools. Before the plan could be carried out, tools traditionally used in practice had to be identified and judged on their need for further development and standardization (1). At the 1978 AOTA conference, when the steering committee discovered that such a survey had been completed, and that another was in progress, it recommended that I do a third survey to find out where clinicians learned about evaluation tools or instruments—in school or through continuing education courses. The answers to this question could provide information not only about which tools needed to be developed and standardized, but also about the effectiveness of introducing new evaluations through continuing education modes. Continuing education was defined as a method an individual chooses in order to further his or her knowledge or skill through any means, such as reading and/or attending workshops, conferences, and institutes.

The purpose of this article is to report the results of three consecutive surveys designed to answer the following questions: 1. Which psychiatric occupational therapy evaluations are taught in occupational...
therapy curricula; 2. Which psychiatric occupational therapy evaluations were the students expected to know about or be proficient in using upon arrival at the fieldwork center; and 3. Which psychiatric occupational therapy evaluations are used in clinical practice?

Method
For the first survey, faculty at 50 professional occupational therapy schools were asked to identify which psychiatric occupational therapy evaluations were taught in the psychosocial component of the curriculum. The 50 instructors were asked to check which of 17 evaluation tools were taught and to add any that were not shown on the list. They were also asked to indicate whether they taught interviewing methods and/or group evaluation methods. Thirty of the 50 instructors, or 64 percent, completed the survey.

The second survey contained the 15 evaluations listed on the first survey plus 9 others gathered from the results of the first survey. To identify the population, a letter was sent to the clinical coordinator of 50 professional curricula requesting a list of psychiatric clinical centers. From the 26 lists returned, 499 clinical supervisors were identified. Since a center may have more than one supervisor, the supervisors were requested to complete the survey individually. One hundred and seventy-four supervisors, or 35 percent, returned the survey. The supervisors were asked: 1. to report whether students were expected to be proficient in the following evaluation methods—individual task, group, interview, and chart review; 2. to add evaluations not listed and indicate whether they were developed by an occupational therapist; and 3. to identify their professional affiliation. Because some schools use non-traditional settings for fieldwork experience, it was thought that if a significant number of students were supervised by nonoccupational therapists, this would affect the results of the survey. However, 97 percent, or 169, of the returns were from registered occupational therapists.

Figure 1
Frequency distribution to show the number of occupational therapy and psychological evaluations taught by any one faculty member.
Table 1
Psychiatric Evaluations Taught by Occupational Therapy Faculty

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Percentage Using Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview</td>
<td>94%</td>
</tr>
<tr>
<td>Group evaluation</td>
<td>61%</td>
</tr>
<tr>
<td>Mosey</td>
<td></td>
</tr>
<tr>
<td>Survey of living task skills</td>
<td>84%</td>
</tr>
<tr>
<td>Group interaction skill survey</td>
<td>77%</td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>84%</td>
</tr>
<tr>
<td>Child care survey</td>
<td>39%</td>
</tr>
<tr>
<td>Work survey</td>
<td>74%</td>
</tr>
<tr>
<td>Recreation survey</td>
<td>68%</td>
</tr>
<tr>
<td>Activity configuration</td>
<td>71%</td>
</tr>
<tr>
<td>Diagnostic Test Battery</td>
<td>58%</td>
</tr>
<tr>
<td>Brayman and Kirby (Comprehension OT Evaluation)</td>
<td>10%</td>
</tr>
<tr>
<td>Buck-Magazine Picture Collage</td>
<td>45%</td>
</tr>
<tr>
<td>Lawn and O'Kane</td>
<td>42%</td>
</tr>
<tr>
<td>Shoemyn</td>
<td>29%</td>
</tr>
<tr>
<td>Fidler Battery</td>
<td>87%</td>
</tr>
<tr>
<td>Azima Battery</td>
<td>74%</td>
</tr>
<tr>
<td>Goodman Battery</td>
<td>52%</td>
</tr>
</tbody>
</table>

Evaluations are listed as they appeared in the first survey (N = 30). *Those evaluations that received higher than 70 percent agreement.

The third survey was sent to occupational therapists who reported membership in the Mental Health Specialty Section on their 1978 registration. Of the 2,793 questionnaires sent, 241, or 12 percent, were returned. Therapists were requested: 1. to indicate the evaluation methods they used—individual task, group, interview, and chart review; 2. to check which of the 24 listed evaluations they used; 3. to report whether they learned about the evaluation through basic professional education or through continuing education; 4. to indicate whether a formal evaluation procedure other than the 24 on the list was used; and 5. to add any evaluation tools that were not shown on the list.

Results
The results from the first survey are illustrated in Table 1. Of the 30 instructors responding, 94 percent were teaching interviewing methods, and 61 percent were teaching group evaluation methods. Mosey's Survey of Living Task Skills, except for the Child Care and Recreation portions, the Azima Battery, and the Fidler Battery, were evaluations taught most often. The Comprehensive Occupational Therapy Evaluation (COTE) was taught least often. The respondents added an
unexpected total of 72 psychological tests as being "other evaluations" they taught to occupational therapy students.

A frequency distribution was done to compare the number of occupational therapy evaluations taught with the number of psychological tests taught at any one curriculum (see Figure 1). The mean number of occupational therapy evaluations taught by one faculty was 4. The mode, or number of occupational therapy evaluations taught most often, was 5. One faculty reported teaching none, whereas two faculty reported teaching 7 evaluations. With regard to the number of psychological tests taught by any one faculty, the mean was 2 and the mode was zero. Seven faculty reported teaching none, whereas one reported teaching 8 psychological tests. That no two faculty members were teaching the same psychological tests (except for the Draw-a-Person and the House-Tree-Person) was striking.

The results from the second survey show that clinical supervisors expected students to be proficient in the following: individual task, 70 percent; group evaluation, 59 percent; interviewing, 63 percent; and chart review, 55 percent. All respondents expected students to know a formal evaluation procedure. The data in Table 2 record the frequency with which clinical supervisors responded, according to the level of performance expected from students. A chi-square goodness of fit was calculated to ascertain whether the differences in responses resulted by chance. In general, there was a higher, significant number of supervisors who indicated neither knowledge nor proficiency in any of the evaluations listed. Also, a higher, significant number of supervisors expected students to know about Mosey's Survey of Living Task Skills and Mosey's Group Interaction, as well as Matsutsuyu's Interest Checklist. There were no differences in the responses of supervisors to Mosey's Activities of Daily Living Survey.

The data from the third survey show that 75 percent of the 241 respondents used only individual task or interview methods as a means of evaluating patients; 43 percent used group evaluation, and 35 percent used observation. All respondents reported using a formal evaluation procedure. The same 72 psychological tests identified through the first survey as being taught to students were added by the respondents. Again, no two therapists used the same psychological tests in practice.
Table 3 represents the frequency with which these evaluations were used in the field. The data demonstrate that the 24 evaluations listed in the survey are not being significantly used. Table 3 also lists the frequency of use of those evaluations learned about through either continuing education or school. Again, a chi-square goodness of fit statistical test was applied. None of the evaluations were used in significant numbers. There was no significant difference between the method of learning about the evaluations and their use. Although 20 evaluations first introduced to the therapist in school were used to some degree, the Lawn and O’Kane, Lafayette Clinic Battery, Social Adaptability Test, and the Occupational Behavior Rating Scale were not used. The Interest Checklist was most often introduced in school and was used more often than any other occupational therapy psychiatric evaluation. The results regarding those evaluations first introduced to the therapist through continuing education show that both the Diagnostic Test Battery and the Lawn and O’Kane Evaluation were not used and that the COTE was used the most.

Discussion
A comparison of the three surveys reveals a discrepancy between that which is taught in basic professional education and that which is used in practice. Evaluations taught to students in school, and about which they were expected to be knowledgeable at their field centers, were not used significantly by therapists in the field. On the other hand, standardized psychological tests and interviewing methods were tools taught in school and were also used by practitioners. In addition, the data from the third survey appeared to reflect that which was expected from students in the second survey in that none of the evaluations were used significantly. Since clinical supervisors are practicing therapists, perhaps the respondents in the third survey are representative of the population tapped in the second survey.

When examining the mode of acquiring knowledge about various evaluations, neither the basic professional education nor the continuing education modes decisively influenced the use of evaluation tools. And neither the type of evaluation nor whether it had been published, presented at a conference, or learned in school made a difference—none of the psychiatric occupational therapy evaluations were being used.

The reasons the clinicians were not using the evaluations listed in the survey may be many. For example:

1. The majority of respondents were new graduates and did not use the traditional instruments. Since the curriculum could not influence the use of an instrument, perhaps the faculty chose not to teach the use of these traditional instruments. This is supported by the fact that few were teaching the use of specific evaluations tools and 94 percent of the faculty respondents were teaching students the interviewing methods.

2. The clinicians surveyed worked with a population for which the evaluations listed were not appropriate. Since instruments listed in the survey were designed to be used with adults, it would be inappropriate for respondents working with children to use any of them.

3. A difference in philosophy regarding the use of evaluation tools may exist among therapists. The number of therapists reporting the use of a formal evaluation procedure was 24; however, 75 percent used interviewing methods as their only means of evaluation. Therapists who believe that an interview is adequate for planning patient treatment might not feel the need to use additional data-gathering methods.

4. The evaluations listed in the surveys that had been presented at workshops and conferences were unfamiliar to the majority of the therapists. This may be because the proceedings of these meetings were not published or distributed to other than the few who attended these meetings.

5. The methods for introducing new instruments perhaps merely inform, rather than instruct, the clinician in administering and using the results of the evaluation. The information given in published articles is meant to inform the reader about a tool, not to train the reader in its use. The data demonstrated that the Diagnostic Test Battery, the COTE, the Buck-Magazine Picture Collage, the Lawn and O’Kane, the Shoemyn Battery, the Interest Checklist, Moorhead’s Occupational History, and the Adolescent Role Assessment, all published in The American Journal of Occupational Therapy, do not train therapists in their use. Because of limited space, it is impossible to publish an entire assessment (evaluation) protocol that would include the rationale, the literature review, the definition of terms, the rating scale, the administration procedures, the research studies, the limitations, and its application. If an individual is not taught how to apply and interpret an evaluation, the likelihood of its being used is limited.

6. The therapists are dissatisfied with the present occupational therapy evaluations and have turned to...
standardized psychological tests. This was supported by the fact that 72 standardized psychological tests were reported as being used by clinicians. None of the evaluations listed in the surveys is standardized and therapist respondents expressed the need for standardized occupational therapy evaluations. Perhaps, without normative data to compare patients' pathology, therapists resort to tests that give reliable information.

**Recommendations**

Efforts toward planning continuing education need to be carefully considered in view of the present methods of disseminating information about evaluations. Since many therapists reported using evaluation instruments of their own design, the specialty sections and other groups can continue to provide institutes to teach the procedures necessary to develop an evaluation tool. Other institutes can be designed to teach practitioners how to standardize or improve existing evaluation tools. The participants can seek advice, present their work for a critique and, when introducing a new tool, can teach the skills required for its administration, interpretation, and use.

In order to reach a larger audience, the proceedings of a workshop, institute, or conference could be published in their entirety and made available to practicing therapists at cost. In these cases, the material published would depend upon the presenters extending their permission to record and publish their material and, where necessary, signing copyright release forms. Some therapists fear that their evaluations or assessments might become compromised because clinicians might adapt parts of them or change their appearance in some way.

Publication of new evaluations would keep faculty abreast of new developments, and it is recommended that they become familiar with the traditional evaluations as well as teach them to their students, including their assets and limitations. To encourage the use of evaluations, standardization procedures employed when developing or improving the evaluations should be included in this instruction. By learning traditional evaluations and new evaluation tools, students will enter the profession with a repertoire of methods for evaluating patient needs to complement the interview mode.

**Summary**

This study shows that existing psychiatric occupational therapy evaluations were not being used by practicing therapists. Possible causes for this were lack of standardization, inadequate dissemination, failure of the faculty to teach the evaluations, and failure of continuing education programs to teach therapists in the use of evaluation tools. Recommended solutions to these problems were: Continue to provide research institutes, provide more avenues for publishing and presenting evaluation material, and teach existing evaluations, pointing out their strengths and weaknesses.

These solutions would not ensure the use of an evaluation; however, when therapists are confident that evaluations measure what they are stated to measure, are assured of reliable data that can be compared with norms, are effectively trained in the use of the evaluations, and are better informed about their existence, the probability is greater that these specific evaluations will be used.

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**REFERENCE**

1. Critical issues identified. Mental Health Specialty Section Newsletter 2:1, 1979

**RELATED READINGS**


Mosey A: Activities Therapy, New York: Raven Press, 1973


The Lafayette Clinic Battery, Object History, Play History, Social Adaptability Test, Occupational Behavior Rating Scales, and Self Puzzle have not been published.