An Evaluation of the Canadian Model of Occupational Performance and the Canadian Occupational Performance Measure in Mental Health Practice

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The Canadian Occupational Performance Measure (COPM) is a client-centred outcome measure designed for use by occupational therapists to demonstrate change in a client's self-perception of occupational performance over the course of occupational therapy. A review of the literature indicated that there had been limited research into the use of the COPM in mental health practice. The aim of this study was to formulate an occupational therapy assessment form based on the Canadian Model of Occupational Performance and incorporating the COPM and to evaluate its effectiveness in mental health practice.

A qualitative approach was used in this two-phase study with seven occupational therapists working in mental health practice. First, semi-structured interviews were completed to gain occupational therapists' reflections on the use of the COPM. Headings were then collated to devise an occupational therapy assessment form that incorporated the Canadian Model of Occupational Performance and the COPM. The second phase involved piloting the form in a variety of mental health settings. The form was evaluated by a second interview to highlight the factors that facilitated or hindered the use of the form in mental health practice.

This study indicates that the combination of the COPM with other assessment categories based on the Canadian Model of Occupational Performance has produced an occupational therapy assessment form that can be used in mental health practice.

An Evaluation of the Canadian Model of Occupational Performance and the Canadian Occupational Performance Measure in Mental Health Practice

Alison Warren

Introduction

It has been a period of change for the provision of health care in the United Kingdom since the late 1980s. Government documentation, for example, *Our Healthier Nation* (Department of Health [DH] 1998), has highlighted the need to examine the clinical effectiveness of health care services. This has been supported further by the guidelines outlined in the *National Service Framework for Mental Health* (DH 1999), which called for interventions to be evaluated from both service users' and clinicians' viewpoints. Occupational therapists have developed limited outcome measurement tools for proving clinical effectiveness, even though Blom-Cooper (1989) recommended that all occupational therapists must demonstrate the effectiveness and value of their interventions in order for the profession to survive.

This study developed from the lack of occupational therapy assessment forms and outcome measures being observed in clinical mental health practice. The Canadian Occupational Performance Measure (COPM) (Law et al 1998) had been advocated as an outcome measure for use by occupational therapists, but its practical use appeared to be limited. The reasons for this were not clear or well documented. The researcher had also noted that occupational therapists used the COPM in clinical practice without having adopted the principles of the Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists [CAOT] 1997). This can lead to the principles of client-centred practice and the focus on occupational performance not being adhered to, causing the rejection of the COPM by clinicians. An occupational therapist's main focus of assessment should be that of occupational performance (Baum and Law 1997). It is also important to ensure that assessments originate from both theoretical knowledge and practical experience if they are to be used successfully by clinicians (Hagedorn 1992).

The Canadian Model of Occupational Performance is a client-centred model of practice based on occupational performance (CAOT 1997). This model illustrates the dynamic interdependence between person, environment and

occupation. Occupational therapy is focused on what people do within their environment, that is, occupation. Blain and Townsend (1993) highlighted that occupational therapists feel that this model of practice explains why they approach a situation differently from other professionals and can therefore be useful in defining the role of occupational therapy in a variety of work settings.

The COPM is a client-centred outcome measure, designed for use by occupational therapists to demonstrate change in a client's self-perception of occupational performance over the course of occupational therapy (Law et al 1998). This outcome measure has been developed in Canada based on the Canadian Model of Occupational Performance (CAOT 1991), which identifies occupational performance as being in the areas of self-care, productivity and leisure.

A client completes Likert scales to identify the importance of these occupations, his or her perception of the performance with these occupations and his or her satisfaction with the performance. Following occupational therapy addressing these problems, the client is asked to re-score the performance and satisfaction with each problem identified at the assessment point. These new scores measure the client's perception of his or her occupational performance over the course of occupational therapy. Therefore, the COPM is an outcome measure of use to occupational therapy.

Studies have been implemented by the CAOT in order to investigate the reliability, validity and practical use of the COPM (Law et al 1998). The research has identified the strengths of and areas of future development for the COPM. Law et al (1990) noted that there could be difficulty with interviewing carers when using the COPM and that some clients disliked using the rating scales (Pollock et al 1990). Some occupational therapists also reported that clients preferred the therapist to be more directive during assessment (Law et al 1994). The advantages of the COPM are that it takes only 30 minutes to complete (Law et al 1994) and that it is a useful tool in identifying priorities for discharge within a physical setting (Ward et al 1996). It has also been found to assist communication within the multidisciplinary team and promote client-centred practice (Fedden et al 1999).

A single case study design, completed by Waters (1995), used the COPM with a person recovering from a depressive episode. The COPM was found to measure outcome and ensured a focus on occupational performance. Mirkopoulos and Butler (1994) completed a quality assurance study to examine clients' perceptions of goal performance and satisfaction within an adult mental health setting by using the COPM. This study indicated that the COPM was sensitive to change in occupational performance over the course of occupational therapy, therefore making it an example of an effective outcome measure for use by occupational therapists. This was further supported by the research of Chesworth et al (2002), which identified the COPM as an appropriate instrument for detecting change with clients who have mental health needs.

Allen (1997) explored outcome measures currently in use by occupational therapists in mental health practice and the degree to which these were felt to be useful. It was concluded that further research was required to develop a suitable tool for occupational therapists to use to measure outcomes in community mental health settings and that an adaptation of the COPM might fulfil this role. This recommendation was supported by Cresswell (1998), who discovered the COPM to be an effective and clinically useful tool for community mental health occupational therapists.

Through examining relevant literature, it could be suggested that the Canadian Model of Occupational Performance and the COPM might be implemented successfully by occupational therapists in mental health practice. By incorporating both the model and the outcome measure, a theoretical framework from assessment through to the evaluation of occupational therapy could be provided. This study aimed to formulate an occupational therapy assessment form based on the Canadian Model of Occupational Performance and incorporating the COPM and to evaluate its effectiveness in mental health practice.

Method

The study involved gathering information from seven occupational therapists on the headings/categories to be used in a mental health occupational therapy assessment form. This information was used to formulate an occupational therapy assessment form, based on the Canadian Model of Occupational Performance and incorporating the COPM (research assessment form). This form was then piloted in mental health practice. Following this piloting over approximately 6 months, the researcher interviewed the seven occupational therapists, again using an interview schedule, in order to evaluate their use of the research assessment form. The interviews highlighted:

- Factors that facilitated or hindered its use
- The attitudes of the occupational therapists towards the form.

Participants

A convenience sample (Robson 2002) was used to recruit the seven participants for the study who worked in three different NHS trusts. The participants had completed education and training to either diploma or degree level in occupational therapy and were working in mental health practice at the beginning of the project. Mental health practice refers to working with clients/patients over the age of 18 years who have functional or organic mental health diagnoses. Child and adolescent psychiatry was omitted from the study because another researcher was investigating that area. It was also a specialised area within which it would have proved difficult to recruit subjects.

Pilot of interview schedules

The two interview schedules were piloted with one occupational therapist working in mental health. There were no recommendations regarding changing the interview schedules.

Procedure

Phase I: Formulation

The first semi-structured interview collected demographic data relating to the participants and used open-ended questions focusing on several areas. These included the participants' awareness of outcome measures and the identification of headings/categories to include in an occupational therapy mental health assessment form.

Following the interviews with the seven participants, the occupational therapy assessment form based on the Canadian Model of Occupational Performance and incorporating the COPM was devised by the researcher (research assessment form). This included headings/categories suggested in the first interview and guidelines for its use in clincial practice.

The research assessment form consisted of five pages:

- *Page 1:* Client's contact information and space for an assessment summary and a reassessment summary.
- *Page 2:* Performance components and environmental categories.
- *Page 3:* Occupational performance needs under the headings of self-care, productivity and leisure (COPM).
- *Page 4:* Problems with occupational performance, COPM self-rating scores and outline of treatment programme.
- *Page 5:* Review of occupational performance problems, COPM self-rating scores and further areas for treatment.

A training manual was also devised by the researcher, which included information on the Canadian Model of Occupational Performance, the COPM, the procedure for using the research assessment form and a reflective diary. This was given to the participants individually and they were informed that they could access the COPM training video and the researcher for further information if required.

Phase II: Evaluation

The seven participants were requested to use the research assessment form in mental health practice for 6 months.

The second semi-structured interview used open-ended questions focusing on several areas. These included the use of the research assessment form in clinical mental health practice, factors that facilitated or hindered its use and any improvements that could be made to the form.

Data analysis

The qualitative data from this research project were analysed using NUD.IST (Qualitative Solutions and Research 1997). This is a computer programme designed for the storage, retrieval and analysis of text (Weitzman and Miles 1995). The researcher screened the participants' responses by using the software package for key words and phrases, in order to identify the similarities in and differences between the responses. These themes were translated into charts or descriptive text.

This research project aimed to increase its trustworthiness by using member checking for credibility following convenience/purposive sampling (Holloway 1997). The method of the participants checking their transcripts was not employed but, rather, the information was fed back during the interviews by the researcher in order to seek clarification. This increased the credibility of the information obtained during both interviews by ensuring that the information collected reflected the ideas of the participants.

Ethical approval for this research was gained from the School of Healthcare Studies Research and Ethics Committee, University of Wales College of Medicine.

Results

Phase I

The interview in phase I was concerned primarily with gathering demographic data and a list of headings/categories and standardised assessment tools to include in an occupational therapy mental health assessment form. This information was collated to devise the research assessment form and a training manual.

Participants: demographic data

Figs 1 and 2 demonstrate that the participants provided a cross-section of occupational therapists in mental health practice owing to the variety in their grading and current clinical field. The average length of mental health experience was 8 years, with the range being from 5 months to 18 years.

Five out of the seven participants were familiar with the COPM but only three had received training on the COPM. Three participants currently used the COPM in clinical practice.

Fig. 1. Professional grade of participants.

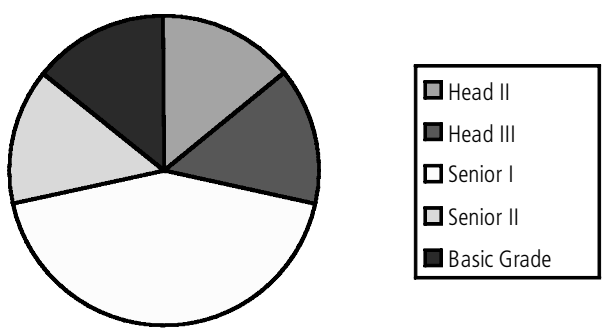
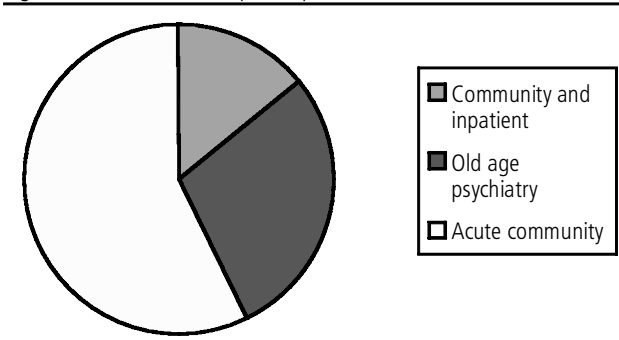


Fig. 2. Clinical fields of participants.



Headings/categories to be included in an occupational therapy mental health assessment form

The participants were requested to list headings/categories to be incorporated in an occupational therapy mental health assessment form. The information was converted into the categories of performance components, occupational performance and other by the researcher. A comprehensive list of headings/categories that could be used in the research assessment form was collated from the participants.

Phase II

The interview in phase II was concerned with questioning the participants on the practical application of the research assessment form in mental health practice. Overall, the response from the participants was positive. One participant referred to the form working extremely well with both a known and a new referral:

> He was impressed by the format and the reasons why we were doing it and why we were looking at that. And the fact that somebody for the first time ever, was accepting what was important to him.

The form identified areas for occupational therapy and encouraged client-centred practice. The form disciplined the participants to evaluate practice.

Factors that facilitated use of the form

The research assessment form was stated to work well if the participant had already met the client. It was also stated to work well with people with a functional mental health problem and/or a physical problem. The participants felt that the research assessment form was clearly set out, which made it easy to become familiar with. Learning to rephrase the rating scales into a language that was more easily understood by clients assisted the successful use of the scales. It was also felt that having the scales occasionally made it easier for clients and enabled them to become more focused on their assessment/intervention. The comments from clients had been positive. One participant reported that a client had found it extremely useful:

> .... reassessed using the COPM, he found it a very positive fact to note the change in himself.

The participants reported that some clients did not comment but their facial expression was that of surprise when asked to participate in the assessment process. Some clients appeared confused but accepted it without questioning. When working with clients and carers, the form provoked discussion around how an occupational therapist was different from a nurse and assisted by focusing the intervention on 'real' issues.

The participants found the form useful when completing home visits and for presenting information in ward rounds. It also facilitated the co-worker role in multidisciplinary teams. One participant found the form useful for determining which referrals were appropriate for occupational therapy.

The participants reported that the training manual provided also facilitated the use of the research assessment form.

Factors that hindered use of the form

Some diagnoses of clients appeared to have been a hindrance on the use of the research assessment form. Clients diagnosed as hypomanic, paranoid, suicidal, personality disordered, severely depressed or had dementia could be difficult to obtain information from. The fluctuating nature of a client who was acutely unwell could give inaccurate information, although one participant reported that a client with a psychotic illness had found the experience positive:

> .... this chap who was very psychotic and very agitated, he got an enormous amount out of umh, identifying things that he was doing well.

When the participants had difficulty in assessing someone with dementia, they interviewed the carer. One participant suggested that using the score cards with clients with dementia might distract them during the assessment and they might forget what they were talking about. Problems with scoring were a hindrance because some clients were unable to understand the numbers or found the concept of self-rating difficult.

If clients were unable to identify any occupational performance problems, it hindered the use of the research assessment form. Some participants also had to complete generic team assessment forms and completing two pieces of paperwork could be a laborious process. Clients that only required equipment were not involved in the use of the research assessment form.

Alterations to the research assessment form

One participant felt that the form needed no alterations or improvements. Several participants identified that there was not enough space on the form, especially when adding the results of standardised assessment tools, such as the Large Allen's Cognitive Levels screen (Allen et al 1992). There was also no space on the form for a carer's profile. One participant did not always use the reassessment summary due to only doing an assessment summary prior to someone's discharge. Another participant found it useful to put future planning under the reassessment summary. This participant also felt that another sheet was needed for continuing problems and questioned whether a copy should be given to the patient because it might be useful. One participant felt that the form would be improved by reordering the sheets to problem identification, assessment and summary.

The scoring raised discussion and one participant felt that this needed to be improved. A participant suggested using colours on the scale rather than numbers. The score cards needed more comments along the scale to assist clients in choosing a number. With the self-rating, one participant felt that there needed to be a point when the occupational

therapist could bring in ideas. The issue was raised of the procedure that could be followed if the occupational therapist disagreed with the scores that he or she was being given. On a practical note, one participant felt that lines on the form would improve its presentation and putting the form on disc would be helpful.

Time

The research assessment form took between 15 and 90 minutes to complete. Most participants reported that it took an average of 30-45 minutes once the occupational therapist had become familiar with the form. This time did not include writing up the form, which doubled the time needed for the assessment. One participant did not perceive the research assessment form as a quick method of assessment.

Guidelines

All the participants stated that they would continue to use the guidelines from this research project in future clinical practice. One participant felt that it enabled occupational therapists to be:

> … more focused on what our role is.

The participants stated that training would be required for team members on the philosophy and practical application of the COPM if it was to be used in clinical practice. It was also acknowledged that the form and guidelines could be used in physical clinical practice.

Discussion

When requested to list headings/categories for use in an occupational therapy mental health assessment form, the responses by the participants were varied. The participants found it easiest to list the general sections, such as past history, support systems and performance components. Occupational performance was not emphasised by all the participants, which is a cause for concern because this should be the main focus of occupational therapy (Kwai-Sang Yau 1995). This supports the findings of Pollock et al (1990), where over half of the occupational therapy assessments examined contained only performance components. The participants demonstrated an awareness of standardised assessments, although the majority were for use across disciplines.

Initially, it was envisaged that individual training sessions would have been used to introduce the participants to the Canadian Model of Occupational Performance, the COPM and the research assessment form. As the majority of the participants already had an awareness of the model, the training was adapted to incorporate a training manual. This was received well by the participants, who stated that they found the training in this research project useful. The variety of a training pack, individual discussion and access to the COPM training video if required was adequate. Including information on the model and client-centred practice in the training pack appeared to facilitate the use of the COPM. This supports the findings of Scull (1997), who recommended completing this procedure. The only area that required further training was rephrasing the score cards. There are examples of this in the COPM manual (Law et al 1998), but these could be expanded on in the future.

The participants stated that the assessment took an average of 30-45 minutes, which supports the findings of Toomey et al (1995). The time was doubled to include the writing up of the assessment. One participant felt that this was a long time to complete an assessment. Although it may appear to be a reasonable amount of time in which a comprehensive initial occupational therapy assessment could be completed, further investigation is required to make comparisons with other occupational therapy assessment forms and tools.

All the participants stated that they would continue to use the guidelines for the use of the Canadian Model of Occupational Performance and the COPM from this research in the future. All occupational therapy staff would need to be involved in training in order to introduce the guidelines to an occupational therapy service. This training may also need to involve other professionals to raise the profile and explain the unique focus of occupational therapy. The participants felt that the guidelines provided a focus for occupational therapy. The positive response of all the participants working in mental health settings supported the recommendation by Allen (1997) that an adaptation of the COPM might work well in community mental health.

The participants expressed that they found it easiest to use the form with clients with a functional mental health diagnosis. This was also reported in the Canadian study by Toomey et al (1995). It was most appropriate to complete the research assessment form incorporating the COPM when the client's symptoms were stable. It was promising to discover that clients with a psychotic illness found the experience of completing the research assessment form positive, in that it enabled them to reflect on the occupations that they could complete successfully even when they felt unwell.

The participants used the research assessment form successfully with inpatients, community patients and day patients. This highlighted that the participants agreed with the findings that the COPM could be used in mental health (Waters 1995, Scull 1997, Chesworth et al 2002).
The participants found it useful to interview the carers of people with dementia. Unlike the findings of Law et al (1990), no problems were highlighted with this process. As suggested in the literature, occupational therapists should take caution when following this procedure because it is the carer's, and not the client's, perceptions that are being rated. Bodiam (1999) excluded clients with cognitive impairments from being assessed by using the COPM. It could be argued that occupational therapists should attempt to use the research assessment form with clients with the early to middle stages of dementia.
The success of this will obviously depend on the insight of the individual and his or her ability to follow verbal instructions and requires further investigation.

When only issuing equipment to clients one participant did not complete a full assessment, which was also discovered by Toomey et al (1995). This should be discouraged because the clients are not receiving a comprehensive occupational therapy assessment (Creek 1997), which may lead to areas of intervention being overlooked. The use of the research assessment form with clients prompted positive comments. It provoked discussion about occupational therapy and the role differences between different professions.

The participants reported that some clients found the concept of self-rating difficult. They wanted to be given more direction because they were not familiar with the client-centred approach (Law et al 1990). The participants stated that the self-rating scales and the form focused occupational therapy. If individual clients find it difficult to use the self-rating scales, the research assessment form can still be used because it will encourage a thorough client-centred approach to practice. It would only be the outcome score component that is omitted.

All of the participants indicated that they felt that the research assessment form was useful because it highlighted individuals who required occupational therapy. The form had a clear layout, which assisted completion by the participants. The form assisted communication and structured assessment/report writing. This supports research that discovered that the COPM identifies abilities/disabilities and focuses occupational therapy (Law et al 1990, Waters 1995). The research assessment form encouraged client-centredness by placing the individual at the heart of the therapeutic process (Law et al 1990). It also completed the occupational therapy process by encouraging occupational therapists to evaluate practice.

The research assessment form assisted in defining the role of the occupational therapist clearly, which can facilitate co-working with other disciplines. It was also felt to be useful for all members of the multidisciplinary team. It fits well with the *Health of the Nation* outcome scales (Carlisle 1992) and the care programme approach (DH 2002), which are now compulsory for use in all mental health settings. The form provides a professional identity and clarifies the role of occupational therapy. This clarity of role should not become too rigid because it may lead to poor teamwork (Couchman 1995).

Following the piloting of the research assessment form, there were several suggestions made by the participants with regard to improving the form. These were included in a second draft of the form, which is now used in clinical practice.

Limitations of the study

Most of the participants were familiar with the COPM prior to commencing the study. This may have facilitated the use of the research assessment form in mental health practice. It would have been useful to include participants with no previous knowledge or awareness of the COPM or the Canadian Model of Occupational Performance.

Although the participants provided a cross-section of occupational therapists working in mental health practice, they cannot be a representative sample that is generalisable to all occupational therapists in mental health due to the size of the group.

Conclusion

The aim of this study was to formulate an occupational therapy assessment form based on the Canadian Model of Occupational Performance and incorporating the COPM and to evaluate its effectiveness in mental health practice. By devising the research assessment form, the use of the COPM in mental health has been facilitated. Although the participants suggested several alterations, they stated unanimously that they would continue to use the guidelines in the future.

The factors that facilitated the use of the research assessment form in mental health practice included training in the use of the form, the Canadian Model of Occupational Performance and the COPM. The participants also highlighted that using the research assessment form with clients with a functional mental health diagnosis or involving the carer when a client was unable to participate in the process assisted the use of the form.

The factors that hindered the use of the research assessment form in mental health practice included the introduction of a generic team assessment and the use of the self-rating scales with some clients.

This study has demonstrated that combining the COPM with other performance components and environmental categories based on the Canadian Model of Occupational Performance can produce an occupational therapy assessment form that can be used successfully by occupational therapists in mental health practice.

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