Research Article

Cognitive assessment across the continuum of care: The importance of occupational performance-based assessment for individuals post-stroke and traumatic brain injury

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Background/aim: When working with individuals following stroke or traumatic brain injury, an important role of the occupational therapist is to assess the impact of cognitive impairment on their ability to engage in occupations and resume important life roles. The aim of this study was to survey therapists’ reasons for selection of and challenges with using various cognitive assessment approaches, across the continuum of care, when working with individuals following stroke and traumatic brain injury.

Methods: A cross-sectional survey, completed via post or online, with responses from 209 Australian occupational therapists was conducted. Participants included clinicians working in acute, inpatient rehabilitation and community settings.

Results: Occupational performance-based assessments were ranked as the most important assessment method, with 69% of participants reporting using these assessments for more than 75% of their clients with cognitive impairment. Participants identified the lack of quantitative data provided by these assessments as a frequent challenge. The identification of cognitive deficits was the highest ranked reason for using cognitive screens and batteries. Challenges identified with using cognitive screens and batteries included difficulty linking assessment results to occupational performance, and difficulty using results to generate intervention strategies. The majority of participants reported using a combined approach to assessment, and used screens and batteries to support findings of occupational performance-based assessments.

Conclusions: Targeted efforts to further incorporate standardised occupational performance-based methods into clinical practice, research, and ongoing professional development is required to enhance occupational therapy services when working with individuals with cognitive impairment.

KEY WORDS assessment outcomes, brain injury, cognition.

Introduction

Cognitive impairment is a common consequence associated with stroke and traumatic brain injury (TBI) and often impacts an individual’s ability to participate in everyday activities and associated quality of life (Guggel, Peleska & Bode, 2000; Ozdemir, Birtane, Tabatabaei, Ekuklu & Kokino, 2001). There are up to 60,000 strokes reported in Australia each year, with up to 45% of individuals admitted with acute stroke presenting with cognitive deficits (National Stroke Foundation, 2009). It is estimated that the 2004–2005 cost of Australian hospital admissions for individuals with TBI exceeded $184 million, with many individuals requiring ongoing support for living in the community due to changes in both physical and cognitive capacities (AIHW (Australian Institute of Health & Welfare), 2007). When working with individuals following stroke and TBI, occupational therapists’ assessment of cognition is important in determining an individual’s ability to live at home safely and independently, resume important life roles and activities, and re-establish old, or form new, habits and routines (Fry & O’Brien, 2002; Hartman-Maeir, Katz & Baum, 2009b; Poole, Dunn, Schell, Tiernan & Barnhart, 1991). With approximately 88% of stroke survivors returning home following discharge from hospital
(AIHW, 2006), many of whom have cognitive impairment, completion of thorough assessment of these individuals’ cognitive abilities is essential in order to inform development of an effective client-centred cognitive rehabilitation program that facilitates community reintegration.

In accordance with the World Health Organisation’s International Classification of Functioning, Disability, and Health (2001), occupational therapists evaluate an individual’s cognitive performance at two main levels throughout the cognitive rehabilitation process. The first level, ‘body structure and function’, considers cognition in terms of performance of cognitive components such as attention, memory, perception and executive functions. This is also known as the ‘bottom-up’ approach, and includes assessment tools such as cognitive screens (e.g., Mini-Mental Status Examination), standardised assessment batteries for specific cognitive domains (e.g., Rivermead Behavioural Memory Test), and some components of occupational performance-based (OP-based) assessments (e.g., Perceive, Recall, Plan, and Perform (PRPP) system of task analysis) (Hartman-Maeir et al., 2009b). Cognitive screens are defined as those tools that provide a brief snapshot of cognitive functions, typically take less than 15 minutes to administer, and include both standardised and non-standardised tools (Hartman-Maeir et al.). Standardised assessment batteries are defined as those tests that follow a specified protocol for administration and scoring, have determined psychometric properties, and provide a profile of the underlying cognitive domains necessary for occupational performance (Hartman-Maeir et al.). The second level, ‘activity and participation’, considers cognition as it relates to the individual’s ability to successfully engage in daily occupations, such as basic and instrumental activities of daily living (ADL). This is also known as the ‘top-down’ approach and includes assessment tools such as interviews with the client and relevant others, questionnaires and OP-based assessments (Arthanat, Nocajski & Stone, 2004; Douglas, Liu, Warren & Hopper, 2007; Hartman-Maeir et al.). OP-based assessments are defined as those standardised or non-standardised methods that involve therapist observation of an individual’s performance of daily activities (Douglas et al., 2007).

Previous research investigating cognitive assessment in occupational therapy has largely focussed on three main areas: (i) frameworks that guide cognitive assessment practices; (ii) identification of cognitive assessment tools used in occupational therapy practice; and (iii) comparison of standardised assessment batteries and screens and their associated psychometric properties.

Frameworks guiding cognitive assessment
Frameworks that aim to guide clinical reasoning throughout the cognitive assessment process highlight the complexity and multifaceted nature of selecting appropriate assessment tools for clients. Hartman-Maeir et al. (2009b) developed a comprehensive ‘Cognitive functional evaluation’ process that conceptualises cognitive assessment into six stages, providing recommendations regarding specific assessments for use throughout each stage. Furthermore, Groves, Coggles, Hinrichs, Berndt and Bright (2010) developed an algorithm to facilitate clinicians’ identification of an individual’s need for cognitive assessment. In addition, Lee, Powell and Esdaile (2001) developed the ‘Functional Model of Cognitive Rehabilitation’ that proposes a framework outlining the various personal, temporal and environmental factors for consideration when selecting and administering cognitive assessments for individuals with cognitive impairment. Whereas these frameworks provide a theoretical basis behind cognitive assessment, they are yet to be empirically tested. There is also a lack of research which has investigated the actual, opposed to theoretical, clinical reasoning processes of clinicians throughout the cognitive assessment process.

Assessment methods used in practice
To identify the current cognitive assessment approaches and tools used in occupational therapy practice, researchers have surveyed clinicians working in various clinical settings across USA, Canada, and Australia (Alotaibi, Reed & Nadar, 2009; Douglas et al., 2007; Koh, Hoffmann, Bennett & McKenna, 2009; Korner-Bitensky, Barrett-Bernstein, Bibas & Poulin, 2011; Wheateley, 1994). Many of the tools reported to be used by occupational therapists were focussed towards assessment at the ‘body structure and function’ level rather than ‘activity and participation’ (Alotaibi et al.; Douglas et al.; Koh et al.; Korner-Bitensky et al.). Whereas it is well documented throughout the literature that one of the unique roles of occupational therapists within the practice of cognitive assessment is to complete OP-based assessment, previous surveys indicate that only a small proportion of therapists reported using this method of assessment as part of their daily practice (Baum & Katz, 2010; Douglas et al.; Koh et al.). A limitation of previous studies is the potential for self-report bias, with survey respondents potentially placing greater emphasis on reporting use of those standardised assessment approaches considered to be more ‘formal’ assessments of cognition such as screens and batteries (Douglas et al.).

Comparison of standardised cognitive assessment tools
Cognitive screens and standardised assessment batteries have an important role in identifying underlying cognitive strengths and deficits at the ‘body structure and function’ level. Previous studies have provided comprehensive comparisons on utility and psychometric properties of these assessments, including which tools are better able to predict an individual’s functional outcome
(Douglas, Letts & Liu, 2008; Lewis, Babbage & Leatham, 2011; Woodford & George, 2007; Zwecker et al., 2002). Whereas the literature has acknowledged the lack of ecological validity of many of these assessments, it is unknown whether clinicians use these assessments for the purpose of predicting functional outcomes for their clients. In response to the need for more ecologically valid measures of cognition at an ‘activity and participation’ level, authors have investigated the application and utility of various standardised OP-based assessments of individuals post-stroke and TBI. These include the PRPP system of task analysis, the Kettle Test, and the Kitchen Task assessment (Baum & Edwards, 1993; Fry & O’Brien, 2002; Hartman-Maeir, Harel & Katz, 2009a; Nott & Chapparo, 2008).

There is a lack of research investigating therapists’ clinical reasoning behind selection and utility of cognitive assessment approaches for clients with neurological conditions. This study aimed to survey therapists’ reasons for selection and challenges with the use of various cognitive assessment approaches across the continuum of care when working with individuals post-stroke and TBI. In addition, this study aims to further examine the utility and perceived importance of OP-based assessments in occupational therapy practice.

Methods

Design

This was a cross-sectional survey.

Participants

Participants included occupational therapy clinicians working within public or private acute and inpatient rehabilitation hospital settings, home-based and community-based rehabilitation settings, and private practice settings across Australia. Clinicians had to be working with adults with cognitive impairment post-stroke or TBI to be eligible. Exclusion criteria included occupational therapists working in generic roles (e.g., case management), occupational therapy students and occupational therapy assistants.

Procedure

Ethics approval was granted from the Human Research Ethics Committee, St Vincent’s Hospital, Melbourne. A shortlist of health facilities was generated via website review of each Australian public and private health network’s services to clients with neurological conditions. Information sheets that included details about the online survey and 755 printed copies of the survey were mailed out to occupational therapy departments across Australia within both hospital and community therapy settings that provide occupational therapy services to clients following stroke and/or TBI. Private practitioners working with this client demographic were contacted via email using the online listings of private practitioners from Occupational Therapy Australia. This email directed them to a link for the online survey that was provided on the Occupational Therapy Australia website. The information sheet explained that consent to participate was implied by completion of the survey.

Survey

The survey questions were developed following a literature review, conducted by the first author, of cognitive assessments used in occupational therapy practice, along with their reported benefits and limitations. The survey consisted of four sections that comprised 17 questions in total, and used the online Survey Monkey program (www.surveymonkey.com). Prior to commencement of data collection, the survey was piloted with ten occupational therapy clinicians who met the eligibility criteria to allow for feedback and minor revisions to questions. The survey took approximately 15 minutes to complete.

In the section Demographic information, participants provided information regarding their practice setting, region within Australia and number of years they had been practicing.

In the section Information gathering and approaches to evaluation of cognition, participants were asked to rank their perceived level of importance of various methods of information gathering in relation to a client’s cognition using a five-point scale (i.e., where 1 = not important, 5 = very important). Information gathering methods were: initial interviews, collaborative history from family/relevant others (e.g., carers, general practitioners), cognitive screens, home assessments, OP-based assessments, liaison with the multidisciplinary team and standardised assessment batteries. Participants were also asked to indicate the percentage of clients over the past month for which they used a combination of assessment methods (e.g., OP-based assessments combined with cognitive screens or OP-based assessments combined with standardised assessment batteries).

In the section Screens and standardised assessment batteries, participants were asked to indicate the percentage of clients in the last month for which they used cognitive screens and batteries; rank their main reasons for selecting these tools from a list of 16 available options generated from the literature; and indicate the most challenging factors associated with use of these tools from a list of options also generated from the literature.

In the section Assessment of activity and participation, participants were asked to indicate the percentage of clients in the last month with whom they used OP-based assessments; indicate the percentage of these clients with whom they would complete these assessments in the client’s own home environment; rank their main reasons for using OP-based assessments from a list of options generated from the literature; and indicate the most chal-
lenging factors associated with using these assessments from a list of options generated from the literature.

Questions that provided a list of fixed-choice options also contained an ‘other’ response option so that participants had the opportunity to provide additional information.

Data analysis

Data were analysed using the Statistical Package for the Social Sciences (SPSS) program, version 11.0. Data were analysed for the group as a whole, and also the clinical groups across the continuum of care (acute, inpatient rehabilitation, and community settings). Community settings included home- and community-based rehabilitation services and private practitioners.

For questions requesting participants to rank their five most important reasons for selecting assessments from a list of options (i.e., where 1 = most important), each ranking was attributed a numerical value to then allow for total scores to be calculated for each option. The overall ordered rank was then attributed accordingly, with the percentage of respondents that contributed to each ranking also calculated for each available option (i.e., n%).

Per cent responses for each question were calculated using the total number of respondents for each question, not the total number of participants. For example, where participants indicated that they did not use a specific form of assessment in their practice, and therefore did not provide further responses to questions regarding these assessments, the per cent response was calculated based on the actual number of respondents that responded to that question.

Results

Of the surveys posted (n = 755) and available online, 211 responses were obtained. One hundred and thirty-five (64%) of these were received by post (giving a 17.9% postal response rate) and 76 were completed online. As the number of therapists that had access to the online survey is unknown (i.e., the website link to the survey was available to all occupational therapists across Australia), it is not possible to determine an overall response rate. Respondents from two of the surveys received worked with paediatric rather than adult populations and were therefore excluded from the study, leaving a total of 209 respondents. Participants’ demographic characteristics are shown in Table 1.

TABLE 1: Participant demographic information

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>All participants (n = 209)</th>
<th>Acute care (n = 77)</th>
<th>Inpatient rehabilitation (n = 81)</th>
<th>Community (n = 51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographical location</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>2 (1.0)</td>
<td>1 (1.3)</td>
<td>1 (1.2)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>NSW</td>
<td>27 (12.9)</td>
<td>10 (13.0)</td>
<td>12 (14.9)</td>
<td>5 (9.7)</td>
</tr>
<tr>
<td>NT</td>
<td>2 (1.0)</td>
<td>1 (1.3)</td>
<td>1 (1.2)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>QLD</td>
<td>19 (9.1)</td>
<td>8 (10.4)</td>
<td>10 (12.3)</td>
<td>1 (2.0)</td>
</tr>
<tr>
<td>SA</td>
<td>16 (7.7)</td>
<td>8 (10.4)</td>
<td>7 (8.6)</td>
<td>1 (2.0)</td>
</tr>
<tr>
<td>TAS</td>
<td>4 (1.9)</td>
<td>3 (3.9)</td>
<td>1 (1.2)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>VIC</td>
<td>104 (49.7)</td>
<td>34 (44.1)</td>
<td>37 (45.7)</td>
<td>33 (64.7)</td>
</tr>
<tr>
<td>WA</td>
<td>35 (16.7)</td>
<td>12 (15.6)</td>
<td>12 (14.9)</td>
<td>11 (21.6)</td>
</tr>
<tr>
<td>Years of practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–5</td>
<td>87 (41.6)</td>
<td>40 (51.9)</td>
<td>32 (39.5)</td>
<td>15 (29.4)</td>
</tr>
<tr>
<td>6–10</td>
<td>72 (33.5)</td>
<td>26 (33.8)</td>
<td>28 (34.6)</td>
<td>18 (35.5)</td>
</tr>
<tr>
<td>11–19</td>
<td>39 (18.2)</td>
<td>10 (13.0)</td>
<td>18 (22.2)</td>
<td>11 (21.6)</td>
</tr>
<tr>
<td>20+</td>
<td>11 (6.7)</td>
<td>1 (1.3)</td>
<td>3 (3.7)</td>
<td>7 (13.7)</td>
</tr>
</tbody>
</table>
Table 3 shows participants’ highest ranked reasons for selection of standardised assessment batteries. There was consistency among therapists across the continuum in the use of these assessments to ‘support findings of OP-based assessments’. The availability of standardised assessment batteries within acute and inpatient rehabilitation settings was also identified as a factor influencing selection of these assessments.

Table 4 shows participants’ highest ranked reasons for selection of OP-based assessments across the continuum of care. Therapists working in acute settings more frequently reported challenges with their ‘ability to articulate assessment findings’, and ‘level of confidence with administering and interpreting assessments’ than those working in inpatient rehabilitation or community settings. Whereas clinicians across all practice areas ranked using standardised assessment batteries to ‘assist with development of intervention strategies’ as the third most important reason for using these assessments, this same factor was also identified as one of the most frequently encountered challenges associated with their use.

Challenges with use of assessments

Challenges identified with the use of cognitive screens and standardised assessment batteries across the continuum of care are shown in Tables 2 and 3. In relation to cognitive screens, clinicians working in acute settings more frequently reported challenges with their ‘ability to articulate assessment findings’, and ‘level of confidence with administering and interpreting assessments’ than those working in inpatient rehabilitation or community settings. Whereas clinicians across all practice areas ranked using standardised assessment batteries to ‘assist with development of intervention strategies’ as the third most important reason for using these assessments, this same factor was also identified as one of the most frequently encountered challenges associated with their use.

Table 4 shows the highest ranked challenges with the use of OP-based assessments across the continuum of care. Almost 20% of participants across acute and inpatient rehabilitation settings identified ‘articulating...
assessments' to be one of the highest ranked challenges with use of OP-based assessments.

Utility and perceived importance of OP-based assessments

OP-based assessments were ranked as the most important method of information gathering by the participant group as a whole. In descending order participants then ranked collaborative history, initial interview, liaison with the multidisciplinary team, standardised assessment batteries, home assessment and cognitive screens as the most important methods of information gathering. Sixty-two per cent of participants reported using OP-based assessments in combination with cognitive screens, and 28% reported using OP-based assessments in combination with standardised assessment batteries for more than half of their clients presenting with cognitive impairment.

Overall, 69% of participants reported using OP-based assessments for more than 75% of their clients, compared with clinicians in community (67%) and acute (58%) settings. Only 5% of participants that used OP-based assessments reported using standardised measures, with the PRPP system of task analysis and the Assessment of Motor and Process Skills cited as the measures of choice in these instances. Seventy-two per cent of clinicians in inpatient rehabilitation and community settings reported conducting OP-based assessments within the client’s own home environment for more than half of their clients presenting with cognitive impairment, whereas only 14% of those in acute settings reported doing the same.

Discussion

This study surveyed occupational therapists’ use and selection of cognitive assessment methods, along with the challenges associated with their use when working with individuals with cognitive impairment post-stroke and TBI. The main findings of this study highlight the importance of applying a combination of approaches throughout the cognitive assessment process, along with the value that clinicians place on OP-based assessment in occupational therapy practice.
In contrast with previous research, findings indicated that OP-based assessments were the most frequently used and considered the most important method of cognitive assessment by participants across the continuum of care (Alotaibi et al., 2009; Koh et al., 2009; Wheatley, 1994). One of the key strengths identified with these assessments was their provision of valuable information regarding the impact of cognitive impairment on a client’s occupational performance capacity. This is of particular relevance to clinicians in hospital settings who are often expected to make predictions and recommendations about a client’s safety, independence and efficiency in ADL performance. In acute hospital settings, clinicians are often required to make rapid decisions regarding a client’s readiness for discharge home, or alternatively advocate the need for ongoing therapy in an inpatient rehabilitation setting (Groves et al., 2010). It is therefore not surprising that clinicians working in acute settings ranked using OP-based assessments for the purpose of predicting clients’ safety for return home to be more important in their practice than those working in inpatient rehabilitation or community settings. Clinicians’ use of OP-based assessments for predictive purposes also highlights the need to use ecologically valid methods of cognitive assessment in practice that are able to identify the real-life manifestation of the impact of the client’s cognitive impairment on their ability to engage in daily tasks and fulfill important life roles (Aubin, Chapparo, Gelinas, Stip & Rainville, 2009; Giles, 1998; Lewis et al., 2011).

Similar to findings of Douglas et al. (2007), results of the present survey indicated that when using OP-based assessments, participants tend to use non-standardised methods. The main challenge identified by participants when using OP-based assessments was the lack of quantitative data provided by this method. This may further explain some of the challenges identified by clinicians; in knowing the level of prompts to provide throughout OP-based assessments, and articulating assessment findings. Along with providing quantitative data, standardised OP-based assessments, such as the PRPP system of task analysis, hold the benefit of providing a format for structuring both the task and observations. This structure can assist with interpretation and articulation of assessment findings. Issues surrounding the use of non-standardised OP-based assessments have been highlighted throughout the literature, with the suggestion that the subjective nature of observations made within these assessments may be influenced by the clinician’s view of what constitutes ‘normal’ behaviour (Vining-Radomski, 2008). The limited use of standardised OP-based assessments may also be indicative of a lack of formal training by therapists in the use of such tools, highlighting the need for promotion of training in this area.

### Table 4: Participants’ rankings of reasons for selection of and challenges with using occupational performance-based assessments

<table>
<thead>
<tr>
<th>Reasons for selection</th>
<th>All participants ranking (%)</th>
<th>Acute care ranking (%)</th>
<th>Inpatient rehabilitation ranking (%)</th>
<th>Community ranking (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides valuable information re: impact of cognitive impairment on occupational performance (OP)</td>
<td>1 (81.4)</td>
<td>1 (74.6)</td>
<td>1 (83.5)</td>
<td>1 (83.3)</td>
</tr>
<tr>
<td>To identify the level of independence within OP</td>
<td>2 (60.6)</td>
<td>3 (54.9)</td>
<td>2 (68.4)</td>
<td>3 (60.4)</td>
</tr>
<tr>
<td>Results are easily linked to OP</td>
<td>3 (54.3)</td>
<td>4 (53.5)</td>
<td>3 (56.9)</td>
<td>2 (62.5)</td>
</tr>
<tr>
<td>To predict safety for client’s return home</td>
<td>4 (52.1)</td>
<td>2 (67.6)</td>
<td>4 (51.9)</td>
<td>11 (22.9)</td>
</tr>
<tr>
<td>To identify cognitive deficits</td>
<td>5 (47.3)</td>
<td>6 (46.5)</td>
<td>6 (44.3)</td>
<td>4 (54.2)</td>
</tr>
<tr>
<td>To simultaneously trial intervention strategies</td>
<td>6 (38.8)</td>
<td>8 (25.4)</td>
<td>5 (46.8)</td>
<td>7 (41.7)</td>
</tr>
<tr>
<td>Assist with development of intervention strategies</td>
<td>7 (31.4)</td>
<td>9 (23.9)</td>
<td>8 (17.7)</td>
<td>6 (35.4)</td>
</tr>
<tr>
<td>To identify strengths in cognitive functioning</td>
<td>8 (30.8)</td>
<td>7 (32.4)</td>
<td>9 (22.8)</td>
<td>5 (39.5)</td>
</tr>
<tr>
<td>Predict the need for services following discharge</td>
<td>9 (19.5)</td>
<td>5 (24.5)</td>
<td>7 (21.5)</td>
<td>8 (13.5)</td>
</tr>
</tbody>
</table>

†Percentage of respondents that selected this option.
The second most frequent challenge associated with OP-based assessments was the attempt to use results from these assessments completed in the clinical environment to predict the client’s performance in their home environment. This is not surprising considering the varying demands that different environmental contexts may place on the client, possibly creating differences in performance across environments (Nygard, Bernspang, Fisher & Winblad, 1994; Toglia, Golisz & Goverover, 2009). In order to ensure greater ecological validity, it is recommended that OP-based assessments are completed in conditions simulating the client’s natural environment (Giles, 1998).

The lack of ecological validity of cognitive screens and some standardised assessment batteries was cited by participants as the most frequent challenge in using these tools. Difficulties were also reported when using these assessments for linking results to occupational performance and predicting performance in the home environment. It is important to note that most cognitive screens are not designed to predict an individual’s capacity within occupational performance, with their purpose being to highlight an individual’s strengths and weaknesses in cognitive domains, and to measure change at the ‘body structure and function’ level (Douglas et al., 2008; Hartman-Maeir et al., 2009b; Salter, Jutai, Teasall, Foley & Bitensky, 2005; Sohlberg & Mateer, 2001). When considering that the second highest ranked reason for using cognitive screens was their speed and ease of administration, it is not surprising that despite their limitations, these tools were reported to be regularly used across the continuum of care. The lack of established predictive validity of cognitive screens and some standardised assessment batteries, along with the complexity of occupational performance activities, highlights the importance of using results from these tools in combination with OP-based assessments when attempting to estimate occupational performance capacity (Hartman-Maeir et al.).

Whereas this study has provided further insight into the cognitive assessment practices of occupational therapists, there remains a gap in the literature promoting the multifaceted utility of standardised OP-based assessment as: an information gathering approach, a means of generating intervention strategies, and a method for evaluating effectiveness of interventions in practice. With the cognitive rehabilitation literature placing increasing emphasis on the need to measure effectiveness of cognitive rehabilitation through investigating change at the ‘activity and participation’ level (Wilson, Evans & Gracey, 2009), future research efforts that focus on using OP-based assessments to demonstrate this will be important.

Limitations
Limitations of this study include the low response rate, and that the majority of participants were from Victoria, Western Australia, and New South Wales. The results of this study may not be reflective of practice in all areas of Australia. There is also potential for response bias, with those clinicians that were more knowledgeable or with particular interest in the area of cognitive assessment participating. Clinicians may have responded in a way that they feel constitutes ‘best practice’ rather than actual practice. The fixed-choice format of the survey did not allow for further exploration of participants’ responses for some items, which may have also resulted in omission of some information.

Conclusion
This study highlights the depth of knowledge and skill required by occupational therapists in order to utilise a broad range of cognitive assessment methods when working with individuals with cognitive impairment post-stroke and TBI. The recognition of the utility and importance of OP-based assessments in occupational therapy practice demonstrates the unique role of occupational therapists in cognitive rehabilitation. It is recommended that a range of assessment tools be used throughout the cognitive rehabilitation process, in collaboration with the multidisciplinary team, to provide a thorough cognitive evaluation that considers both the client’s underlying cognitive capacities and occupational performance abilities. Focussed efforts to further incorporate standardised OP-based assessments into clinical practice, research and ongoing professional development are required to enhance occupational therapy services when working with individuals with cognitive impairment. Standardised OP-based assessments should also be promoted at an undergraduate level and access to, training in and use of them enabled by employers of practicing clinicians. Future research efforts should also be directed towards demonstrating the utility of standardised OP-based assessments in generating targeted cognitive rehabilitation programs that are focussed towards affecting change in client performance at an ‘activity and participation’ level.

References


