Targeted applications of the Canadian Occupational Performance Measure

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Occupational therapy assessment • Outcome assessment • Canadian Occupational Performance Measure (COPM)

Abstract

Background. The Canadian Occupational Performance Measure (COPM) is an outcome measure designed to assess performance and satisfaction with occupation. It was developed to coincide with the occupation-focused, client-centred Canadian Model of Occupational Performance. Purpose. The COPM has been a feature of the occupational therapy landscape for approximately 15 years and has pervaded the consciousness of occupational therapists around the world. In this paper, we examine issues associated with application of the COPM in targeted clinical and non-clinical situations. Results. The paper suggests considerations required to ensure that the highest quality of information is derived from the COPM in all situations. Practice Implications. Although the paper emphasizes the centrality of the client-centred approach, it also demonstrates the flexibility and adaptability of the COPM to different situations, clients, settings and purposes.

Résumé

Description. La Mesure canadienne du rendement occupationnel (MCRO) est une mesure des résultats qui a été conçue dans le but d'évaluer le rendement et la satisfaction du client face à ses occupations. Elle a été élaborée de manière concurrente avec le Modèle canadien du rendement occupationnel, qui est centré sur l'occupation et le client. But. La MCRO est une caractéristique du milieu ergothérapique depuis environ 15 ans et elle s'est infiltrée dans la conscience des ergothérapeutes à travers le monde. Dans cet article, les auteurs examinent des questions relatives à l'application de la MCRO dans des situations cliniques ciblées et non cliniques. Résultats. L'article suggère des aspects à considérer pour veiller à ce que l'information découlant de la MCRO soit de la meilleure qualité possible et ce, dans toutes les situations. Conséquences pour la pratique. Bien que l'article mette l'accent sur l'importance de l'approche centrée sur le client, il démontre également la souplesse de la MCRO et la possibilité de l'adapter à différents buts, clientèles, situations et milieux.

The Canadian Occupational Performance Measure (COPM) has been a feature of the occupational therapy landscape in Canada for approximately 15 years, since it was originally published in 1990 (Law et al., 1990, 2005). Over the past decade, the measure has also pervaded the consciousness of occupational therapists around the world. It has now been officially translated into 24 different languages, and is used in over 35 countries.

The COPM is a semi-structured interview aimed at identifying problems in occupational performance, designed to correspond to the Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists [CAOT], 1997). The COPM has three sections: self-care (activities of daily living & instrumental activities of daily living), productivity (education & work), and leisure (play, leisure & social participation). It offers two scores: performance and satisfaction, both of which are self-rated by the client. Identified occupational performance problems may be weighted in terms of importance, in order to establish the client's priorities and provide information for goal setting and treatment planning.

The COPM was designed to apply equally to all types of clients, regardless of age, disability or background. The only stipulations to using the COPM were that the therapist practice in a client-centred fashion and that he or she be interested in assessing occupational performance and satisfaction with occupation (McCull, 2005; McColl & Pollock, 2005; Pollock & McColl, 1997; Pollock, McColl, & Carswell, 1998). It has become clear from a number of sources, however, that the application of the COPM is more complex in some situations than in others. Based on our experiences with workshops all over the world, with questions on the website, and with inquiries that reach us through our individual e-mails, there are several clinical and non-clinical situations where therapists repeatedly raise interesting and challenging issues with the application of the COPM.

In this paper, we will discuss the issues associated with using the COPM in:

(a) targeted clinical situations, such as with children, interpreters, proxy respondents, people with cognitive impairments, and people from non-Western cultures;
(b) non-clinical applications, such as administration, program evaluation and research.
Targeted clinical applications

The first issue that arises in a number of clinical situations is the legitimacy of the client's viewpoint if there is a question about his or her ability to be a reliable informant. Most readers will say to themselves that, of course, they always consider the client's perspective as legitimate. However, many challenges the ability of a child, or a person with a mental illness or a cognitive impairment to report reliably on the problems that will form the basis for the therapeutic agenda.

The client-centred approach, upon which the COPM is based, requires that the client's perspective carry the final authority in the therapeutic relationship. Thus, if a client states that he or she has a problem that the therapist does not observe or consider important, it must still appear on the therapeutic agenda. Perhaps even more challenging, if the client states that he or she does not have a problem, even though the therapist observes evidence of the problem, the problem does not appear on the therapeutic agenda.

It is easy to be client-centred when the therapist and client agree. Where the client-centred approach is truly tested is where there is disagreement. Typically, the institutional power structure favours the therapist, and his or her perspective wins out, since issues like discharge and access to other benefits and services hinge on the therapist's assessment. In contrast, the client-centred relationship overturns the power structure and systematically favours the client's perspective. It is a constant challenge to practice from a client-centred perspective in a system and in a world that honours medical-scientific credentials and expertise. It is particularly challenging when issues of client safety and risk come into play. In these cases, it is important that a reliable assessment of competency is undertaken, and that assumptions not simply be made about competence.

It may be important when using the COPM with people from non-Western cultures to consider the degree of comfort with client-centred practice, and the extent to which clients are willing to be decision-makers and active participants in their therapy. The client-centred approach to practice was developed with the North American and European health care environments in mind, and may require some interpretation for use in other systems or with people from other cultures.

A second issue in using the COPM in some clinical situations is the potential for inclusion of other key stakeholders as informants in the assessment process. For example, parents, teachers, caregivers, employers, and other members of the support system are often pivotal players in the therapeutic process, and will undoubtedly have issues that they wish to have considered. They may also have important information to contribute to our understanding of the client's context. At the root of this issue is the definition of client. For the COPM, the client is the person who seeks to change his or her occupational performance.

A third issue in using the COPM is the possible need to modify the interviewing approach, the language of the assessment or the scoring system to accommodate the client's developmental level and ability to deal with abstract concepts. With clients with diminished language or cognitive capacity, it may be important to think through strategies for communicating more effectively. Careful attention to the language used in the questions, the addition of concrete stimuli such as pictures, the clarity of response options and the context for the assessment can improve the validity of the results. There may also be difficulties dealing with abstract scoring procedures, such as rating from 1 to 10. Some clients may require the therapist to be more creative in how he or she derives baseline and progress values for the performance and satisfaction with occupation. The numerical rating scale is something that has become an inherent part of Western culture; however, the idea of assigning an abstract number to occupational performance may be quite foreign to someone from another culture or from a less numerate way of life. Therefore, alternative symbolic ways to illustrate the intent of the scale should be considered to facilitate clients' understanding and engagement.

A fourth issue to be considered is the situation where a third party is needed in order to be able to communicate with the client. The ideal interpreter is someone who can communicate fluently with both therapist and client, is impartial to the outcome of the assessment, has no pre-conceived notions about the client, and is a good listener. Furthermore, he or she is someone in front of whom the client can tell the whole truth. Assessing the degree to which someone can act as an interpreter, knowing his or her relationship to the client, and ensuring that the interpreter is not editorializing are all important issues in obtaining the best possible information on the COPM. Further, it may be useful to try to discover and take account of the interpreter’s bias, if one is suspected.

A somewhat more complex situation arises when the client is non-communicative, and requires a proxy respondent rather than an interpreter. In this case, it is impossible to assess fluency, and it is almost impossible to find a proxy who is impartial or disinterested. Perhaps most important in the case of proxy respondents is to be clear that they are expected to place their own wishes and impressions to one side, and attempt to answer as though they were the client. From their privileged position of knowing the client, they are asked to tell us how they think the client would answer the question if he or she were able.

A fifth issue in using the COPM is the ability of some clients to readily identify problems. In some instances, individuals may not be able to enumerate or express specific problems. The future may look so threatening and overwhelming that a therapeutic process may be necessary in order to help an individual get to the stage where he or she is able to identify problems. Occupational therapy may offer activities, simulations, discussions or outings that assist the individual to begin to conceptualize the demands of his or her life, together with the potential pitfalls and obstacles.

A sixth challenge arises out of attention and memory problems which make it doubly important to conduct the COPM in an area that is free from distractions and minimally stimulating. In order to obtain useful information from the interview, it may be necessary to complete the interview in multiple sittings if fatigue or distractibility becomes apparent.

Finally, although the COPM is designed to take account of culture (by asking about expectations and requirements for occupational performance within the socio-cultural environment), it is important when using the measure with clients from different cultures to be aware of views of disability and illness held by the client, and by other members of his or her community. Other considerations in administering the COPM with people from
non-Western cultures include: cultural assumptions and expectations about therapy, roles in society, family obligations and duties, relationships with professionals and comfort in expressing needs, setting goals and accepting help.

**Non-clinical applications of the COPM**

In addition to clinical applications of the COPM, we have also become aware of a number of non-clinical applications that may be of interest to readers. Administrators may find that it is possible to use the COPM as the basis for individual therapist performance evaluations, to give an individual therapist feedback and supervision about his or her performance relative to peers and relative to expectations by practice leaders. By extension, the COPM can be applied to departmental audits and workload monitoring. Routine data collection on COPM issues, instead of simply tracking direct and indirect patient contact, would make it possible for a manager to give both payers and staff more occupationally relevant information about the activities and successes of occupational therapy services.

One of the primary purposes for which the COPM was designed was program evaluation, as an outcome measure. However, this requires that we think in terms of program goals rather than individual therapy goals. Program goals set out targets and expectations for a group of clients who typically share a particular diagnosis or problem. Clients are referred to the program on the expectation that they can more effectively and efficiently address their problems together with other like clients, than in individual therapy. The programmatic approach requires that success be measured on the basis of average change for all participants in the program. If the average change is positive, then the program may be deemed a success. Finally, the COPM can be used as a measure of occupational performance in research (Carswell et al., in press). To date, the COPM has been used in descriptive studies that enhance our knowledge and understanding of the depth and breadth of occupation, and explanatory studies that show relationships between occupation and other variables (McColl et al., in press).

**Conclusion**

In summary, the paper reviews issues and considerations required to ensure the highest quality of information derived from the COPM in each of these targeted situations. Although the paper emphasizes the centrality of the client-centred approach with the COPM, it also demonstrates the flexibility and adaptability of the COPM to different situations, clients, settings and purposes. The only limiting factor to the use of the COPM is an interest in occupation, and arguably, this should not be an untenable constraint for most occupational therapists.

**References**


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