Work Potential Evaluation in Mental Health

(mental health services; services, occupational therapy; work)

Allegra Pressey Andersen

A survey was conducted to describe the methods and the degree to which occupational therapists in mental health settings were evaluating the work potential of patients. Of the 231 responses received from a population of 500 therapists, 157 were usable for this study. Results showed that 36% of the respondents performed work potential evaluations using interest inventories, crafts, and miscellaneous nonstandardized measures as their primary sources of information, and they cited observation as the most useful tool to obtain information about a patient. Most respondents identified the need to do more in this area and expressed an interest in expanding their skills and available resources. Implications for occupational therapy were discussed in relationship to new Medicare legislation.

Throughout the history of the profession, occupational therapists have been evaluating patients' capacity for work and developing the work potential of those with physical and mental disabilities. While work potential evaluation and treatment have received varying degrees of emphasis by occupational therapists over the years, during the past two decades federal legislation has mandated that the severely handicapped must be included in the services provided by the Rehabilitation Services Administration (RSA) and must represent a significant portion of those patients served. Among those cited in the legislation as "severely handicapped" are persons deemed to be "mentally ill" (1).

The focus of legislation has been to provide vocational evaluation and training to handicapped individuals whose vocational potential is realistic, and to ensure that subsequent discrimination does not occur in the hiring process. In 1923, the Vocational Training and Employment—Federal Industrial Rehabilitation Act was passed requiring all general hospitals dealing with industrial accidents or illness to provide occupational therapy for vocational training and employment. The RSA emerged from this act and today administers 80% of the money needed by state agencies for patients who need vocational programming and whose vocational potential is realistic. The RSA serves the mentally retarded, the mentally ill, and, to a more limited extent, the physically disabled (1).

In 1973, Public Law 93-112, or the Rehabilitation Act of 1973, replaced the Vocational Rehabilitation Act, and extended and revised grants to states for vocational rehabilitation services with special emphasis on services to those with severe handicaps. It provided funding for evaluating the rehabilitation potential of handicapped individuals, and for promoting and expanding their employment opportunities in the public and private sectors (2). Section 504 of the Rehabilitation Act mandates that industry cannot discriminate in hire.
ing the disabled, which means that effective job analysis, patient assessment, and work potential development are particularly important for the occupational therapist in making effective placements (1).

Some individual states have responded to Section 504 by implementing their own laws to include the following:

- Tests administered by a potential employer must reflect the applicant's aptitudes, skills, and strengths rather than impaired sensory, manual, or speaking skills, except when specifically tested for such.
- An employer must make reasonable accommodations by modifying a job and providing appropriate assistance to the employee unless this results in undue hardship to the employer.
- An employer must not terminate, subject to different terms of employment, or refuse to hire or promote an employee or applicant because of a present disability that is not job-related or because a previous job-related handicap may recur, provided that this does not impose undue hardship on the employer (3).

The impact of these pieces of legislation on the role of the occupational therapist is particularly important for the functions of work potential evaluation and job analysis. In 1959, Cromwell (4) was among the first to emphasize the importance of using standardized tests, job samples, and behavioral observations for assessing the realistic potential of handicapped individuals in order to improve their marketable skills and enhance their placement potential in jobs suited to their abilities. Wegg (5) also addressed the validity of available tests for evaluating work potential and proposed work samples as a means of simulating the actual work situation, thus providing better indicators of a patient's ability. She contended that the purposes of work evaluation are testing and evaluating work capacity, ability, and interest, and predicting future work performance (5).

Cromwell (4) and Wegg (5) focused primarily on work skills; several years later Ethridge (6) focused on work behaviors. Ethridge's study focused on the effectiveness of the Pre-vocational Evaluation of Rehabilitation Form, a behavioral rating tool, and his results complemented the tenets put forth by Cromwell and Wegg. As a checklist that rated work skills and tolerance, attitude toward others and socialization, personality characteristics, and general observations, the tool was used by the rehabilitation coordinator for evaluating mental health patients' work potential. Ethridge was able to conclude that work behaviors were as important as work skills in predicting a patient's work outcome. Patient follow-up studies by Distefano and Pryer (7), and by Solberg and Chueh (8), indicated that the use of behavioral ratings combined with performance evaluations were good predictors of vocational success.

The purpose of the present study was to describe the methods being used by occupational therapists in mental health settings to assess the work potential of their patients.

Methods

Subjects

Subjects in the study consisted of 231 registered occupational therapists (OTRs). A random sample of 500 OTRs was generated from the membership list of the Mental Health Special Interest Section (MHSIS) of The American Occupational Therapy Association. The sample size was chosen with the expectation that a 50% return rate would yield an actual sample of 250 subjects or 10% of the total population of the MHSIS.

Instrument

A questionnaire was designed for the study based, in part, on a survey developed by Nadolsky (9). It consisted of 20 items requiring the respondents to indicate which standardized and nonstandardized tools were used in their settings to evaluate the work potential of mental health patients. Evaluation of work potential was defined in the questionnaire as a comprehensive process that focuses on the measurement and development of the evaluatee's potential for work. It includes evaluation of feasibility; physical and emotional work tolerance; assessment of attitudes, temperament, and behavior; and vocational interests. The evaluation process also provides services that are intended to improve the evaluatee's potential (10).

Procedures

A cover letter explaining the purpose of the study, the questionnaire, and a postage-free envelope were sent to the random sample. Therapists were asked to check any and all pertinent data (type of facility, age and type of patient), and whether or not they did work potential evaluations (WPEs). If they did, they were asked to list and name the tools and methods they incorporated into that evaluation. Two weeks after the initial mailing a second questionnaire was sent to nonrespondents.
Data Analysis

Descriptive data analysis was used in this study. Frequencies and cross-tabulation procedures were performed using the Statistical Package for the Social Sciences (SPSS).

Results

Of the 231 questionnaires returned, 157 were usable for the purposes of this study. One hundred-one responses (64%) were from OTRs who did not do WPEs because of inappropriateness for their setting, lack of time and funds, duplication of another department’s services, or because it was not a priority for treatment (e.g., short-term acute care). Twelve questionnaires were received from OTRs who were employed in facilities in which work potential is evaluated, but those functions were not in their specific job responsibilities.

Although 64% of the respondents did not do WPEs, 68% of these respondents said they saw a need for such evaluations within their facilities. Seventy-five percent said they would like to acquire work samples and other WPE tools to incorporate into their existing resources, and that they were beginning to move their occupational therapy departments in that direction.

The final number of questionnaires used and analyzed in this study was 56 (36%). These respondents were OTRs who indicated that they were members of the team that evaluated and treated patients with work dysfunction.

Objective of WPE Programs

The work settings of 52% of the 56 respondents used a formalized or structured evaluation program. Objectives of these programs included, but were not limited to, evaluating and developing work skill and potential; assessing patients’ strengths, weaknesses, aptitudes, and interests; determining present level of function; building work tolerance and strengthening work behaviors; and, where applicable, securing placement in a sheltered workshop or work setting. The amount of time a patient spent in the evaluation program varied from five or more weeks (42%) to less than one week (20%), with some patients spending three to four weeks (16%) or one to two weeks (14%).

Psychometric Evaluations

Respondents were asked to check and name all the psychometric and psychological tests normally used in the evaluation process. Interest inventories were used most commonly (48%), followed by dexterity tests (38%), and “other” instruments (34%), which tended to consist of evaluation tools designed for individual settings. Intelligence tests were used by 32% of the therapists, and aptitude tests and personality inventories by 21%.

Work Samples and Work Activities

Thirty-two percent of the 56 respondents used standardized work samples—9% used Valpar (Valpar International, 3801 E. 34th Street, Tucson, AZ 85713), 5% used Work Evaluation Systems Technology (WEST) (16400 Pacific Coast Highway, Suite 211, Huntington Beach, CA 92649), and 11% used “others.” Among nonstandardized measures, 9% reported using Stout Vocational Rehabilitation Worksamples, 75% used crafts, and 69% used “other” miscellaneous nonstandardized measures. The most frequent listings in the “other” category were industrial and clerical work tasks. When asked what tools they would add to their existing resources, 9% of the respondents stated “none,” and 7% said they would purchase Valpar work samples.

Work Behavior Evaluations

Behavioral checklists were the most commonly used tools to measure behavior (46%), followed by anecdotal summary (38%), behavioral rating scales (29%), counting/timing (25%), and the Comprehensive Occupational Therapy Evaluation (COTE) and interval recording (16% each). Twenty-one percent reported using other means to measure behavior.

Observation was also listed most frequently as the tool respondents thought to be the most valid (18%) and as providing the most useful information (30%). Thirteen percent also believed observation yielded the most accurate information for predicting patients’ performance.

Decision-Making Process

In addition to psychometric tools, work samples and work activ-
ities, and work behavior evaluations, the decision-making process in this sample’s WPE incorporated several other tools and sources of data. An interview to uncover new information was used most frequently (by 77%), followed by an interview to verify referral information (71%), and formal (70%) and informal (54%) case conferences. The most commonly listed staff members providing input for decision making at the case conferences were OTRs, social workers, psychologists, nurses, physicians, and recreational therapists. Other printed sources of occupational information were used by 23% of the respondents, with 16% using job analysis data and 13% using the Dictionary of Occupational Titles. Regular follow-up of patients was performed by 38% of the respondents. Follow-up was reported to occur within one month by 22%, “other times” by 35%, and 41% of the respondents did not do regular follow-up procedures.

Discussion

Work has been a part of the basis for treatment throughout the history of the occupational therapy profession. The ability to observe, analyze, and relate information to an individual’s condition is part of the education and training that occupational therapists receive. They are also taught to maximize a patient’s assets and compensate for disabilities, and to teach and motivate patients who exhibit behaviors that make them difficult to work with (11).

Work potential is a major element of the productivity performance component that occupational therapists are taught to evaluate and treat. Work potential evaluation is essential in order to provide potential employers with information about a patient’s strengths and weaknesses, and to make appropriate work placements. It also gives the patient feedback about where skills are best put to use and in what areas improvement is needed. This information is necessary for therapists, patients, and third party payers to make reasonable and realistic decisions and choices about work potential and work placement.

Despite the historical emphasis and the need for WPE, only 56 of the 231 mental health occupational therapists sampled performed it. Work potential evaluation will become increasingly important as the prospective payment system for reimbursing health services is implemented in psychiatric settings.

Work potential evaluation can enhance assessment and identification of problems and can provide data necessary to substantiate occupational therapy treatment. Strengths and weaknesses are identified by WPE using behaviorally anchored and measurable data. In this study 75% of the 56 OTRs performing WPE used crafts, 65% used miscellaneous nonstandardized instruments, and only 23% used standardized measures. Therapists’ observations and opinions of patients’ work potential may be accurate for predicting future performance, but more and more these observations will need to be substantiated with measurable data because such data will be imperative for reimbursement of services.

Recommendations

This study indicates a need for more information about WPE and continuing education programs in this area. More research about the types of patients appropriate for WPE, along with appropriate evaluations, is also needed. Other areas needing study are the worker’s compensation arena and forensic medicine. Occupational therapists need to become more aware of what tools are available so they can make choices that complement their existing resources. Continuing education could address the need to represent observational data in measurable terms that are consistent with reimbursement requirements. Occupational therapists may also benefit from input on how to market their skills in order to increase physician referrals and decrease WPE referrals out of the mental health occupational therapy department.

Summary

This study provided information about the use of work capacity evaluation in mental health settings by occupational therapists and the methods currently being used. Occupational therapists in general hospitals and community mental health centers are more likely to perform work evaluations than those in other types of facilities. Patients served typically ranged in age from 18 to 50 years. Thirty-six percent of mental health therapists do WPE and most commonly use crafts, interest inventories, and other nonstandardized measures as evaluation tools. Therapists identified the need to increase their awareness of WPE and the resources available for use in their settings.

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RELATED READINGS


