The Problem of Functional Assessment: Political and Economic Perspectives

Industrialized countries have long accepted the need to provide various supports for people with disabilities. The common interest is to relate the benefits received by the person with a disability to a medical impairment and to the limitations the impairment places on function in the workplace. The purpose of this article is to discuss some of the international and American approaches to the evaluation of functional abilities and to the economic and political programs designed to meet the needs of people with disabilities, especially workers and their dependents.

It is clear that no universal agreement exists regarding the most valid and reliable approaches to functional assessment. Occupational therapists' understanding of this field and future input into functional assessment may help to advance, nationally and internationally, systems that will better match assessment of disabling conditions with service programs.

Disability Classification Systems

There are two major conceptual frameworks in the field of disability: the International Classification of Impairments, Disabilities, and Handicaps (ICIDH) and the functional limitation paradigm, which is not accompanied by a classification system. The ICIDH is an experimental addition to the World Health Organization's (WHO) International Classification of Diseases (1980). It has received mixed reviews but has broad international sponsorship and is used widely around the world. Several European countries have adopted the ICIDH and use it extensively in administrative systems and clinical settings.

The ICIDH is neither a classification nor a research tool. The original intent of the ICIDH was to provide a framework to organize information about the consequences of chronic disease and medical conditions. As such, it has been considered by some as an intrusion into the social aspects of life—a medicalization of disablement.

The ICIDH framework and the functional limitation paradigm each have four basic concepts. In the ICIDH, the four concepts are disease, impairment, disability, and handicap. In the functional limitation paradigm, the four concepts are pathology, impairment, functional limitation, and disability. Both frameworks recognize that whether a person performs a socially expected activity depends not simply on the characteristics of the person but also on the larger contexts of social and physical environments.

Recently the Institute of Medicine developed a conceptual framework derived from the functional limitation paradigm (see Table 1). This is a useful conceptualization because it places disability within the appropriate context of health and social issues. It depicts the interactive effects of biological, environmental (physical and social), lifestyle and behavioral risk factors that influence each stage of the disabling process. The relationship of the disabling process that often precedes disability is thereby brought into focus.

The functional measures that link disability to service programs and benefits are not well developed. Thus, the evaluation of partial versus total and temporary versus permanent disability remains an art.

International Programs

One of the most important reasons for assessing function is to ascertain which people are to be recipients of benefits and participants in disability programs. This is particularly important in countries with social insurance disability programs that have to deal with the dilemma of encouraging work and simultaneously providing for those who really cannot work. No one country seems to have the perfect disability program, but one issue warrants mention. Granting of a temporary disability benefit provides immediate opportunity for timely rehabilitation or habilitation intervention as well as establishing important links between the rehabilitation agency and the payer of benefits. This arrangement implies a mutual obligation on the part of the claimant and the agency to facilitate the person's ability to participate in the work force before any consideration is given to paying a permanent disability pension. Thus, in all countries, the following tasks occur:

- Identifying those who could benefit from rehabilitation;
- Monitoring rehabilitation to track achievement of the desired outcomes;
- Financing the services; and
- Providing incentives and supports to encourage persons with disabilities to work to the level of their capabilities.

None of these tasks is easy to perform.
Identification of those who could benefit is especially difficult because of the desire for early identification of claimants' incapacities, which may be very subtle. In all countries, viable links must exist between and among the providers of habilitation and rehabilitation services, the agency paying the benefits, and health care providers and former or potential employers. Few nations have as yet fully developed comprehensive integrated rehabilitation systems by establishing equally strong links between and among the systems.

Countries with sophisticated programs cope with programmatic disincentives, proper adjudication of cases, and linkage gaps between the different phases of the rehabilitation and reemployment process. In addition, certain types of disabilities are difficult to assess and pose problems in almost all countries. Virtually every industrialized country has seen its claims for disabling benefits for back problems and mental impairments increase greatly in the last 10 years. Finally, every country experiences increases in filings for disability benefits during times of economic downturn with the concurrent unemployment and poverty.

Disability programs in the foreign industrialized countries have some common characteristics. Most countries have several income-maintenance programs to protect workers in the event that they are disabled. The three most common of these public income-maintenance programs are: (a) cash sickness benefits for short-term illness or injury; (b) disability pensions for long-term illness or injury and disability; and (c) work-injury compensation with a permanent disability that either occurs at the workplace or is a result of the work environment. Among the industrialized countries, most provide benefits under all three of these programs.

All of the industrialized countries have earnings-related disability programs that provide disability benefits or pension to workers and supplements to their dependents. All countries possess some form of comprehensive and universal health insurance.

Most of the foreign programs provide a range of supplementary benefits and allowances that recognize the additional costs of a disability. Although the nature of such benefits varies among the different countries, the effect of the disabling condition on the person's ability to function is assessed apart from the question of capacity to earn.

Countries commonly have cash sickness programs that pay benefits for short-term illness or injury, often providing an early opportunity for identification of candidates for rehabilitation. Long-term disability benefits begin only after the insured has been prevented from working for a prescribed period of temporary incapacity, such as the first 26 or 52 weeks of illness or until the claimant is cured, determined permanently disabled, or dies.

All countries require existence of a physical or mental impairment affecting the claimant's ability to work. Typically, the claimant's own physician initially certifies that a medical condition prevents the claimant from being able to perform work. The claimant then becomes eligible for a cash sickness benefit. However, in many countries, programs have some built in flexibility to continue cash sickness benefit status, if needed, to allow completion of rehabilitation or participation in a retraining program.

Foreign industrialized countries emphasize habilitation and rehabilitation, indicating a willingness to invest money up front on the claimant in hopes of preventing permanent disability status and, consequently, permanent disability pension expenditures. The philosophy holds that people with severe disabilities can be capable of meaningful work in the nation's economy. When people with disabilities are allowed to work and earn what they can, maximum independence essential to positive self-esteem is facilitated while the value of work to society is underscored. These countries acknowledge the often additional costs of a disability by paying auxiliary benefits based on the effect of a disabling condition on the person's ability to function.

In short, although certain problems plague all disability programs, there is much in foreign disability insurance programs that is worthy of further research and consideration. All countries are attempting to deal with determination of the severity of disability and the

<table>
<thead>
<tr>
<th>Pathology</th>
<th>Impairment</th>
<th>Functional Limitation</th>
<th>Disability</th>
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<tbody>
<tr>
<td>Interruption or interference of normal bodily processes or structures</td>
<td>Loss and/or abnormality of mental, emotional, physiological, or anatomical structure or function, includes all losses or abnormalities, not just those attributable to active pathology; also includes pain</td>
<td>Restriction or lack of ability to perform an action or activity in the manner or within the range considered normal that results from impairment</td>
<td>Inability or limitation in performing socially defined activities and roles expected of individuals within a social and physical environment</td>
</tr>
</tbody>
</table>

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length of award and benefits. Figure 1 depicts a schematic for understanding these relationships. The quotient derived from these segments usually determines the variety and level of benefits such as cash benefits, access to various medical and vocational rehabilitation and health services, and social services.

**U.S. Programs**

A large amount of data about populations with disabilities has been collected by the U.S. Census Bureau, by other government departments, by interest groups representing people with disabilities, and by professionals working on related issues. The problems with these data are that they are often incomplete and inconsistent, due in part to differences in definitions of disabilities used by different groups when collecting and interpreting data. In many instances, the available data are simply incomplete. This is illustrated by Table 2, which contains summary projected data for 1990 for the major types of disabilities used by the Census Bureau. The population with these disabilities is very large, amounting to more than one third of the total U.S. population, or about 92 million people. This is an overestimate because people with multiple disabilities are counted in multiple categories. Clearly, not all people reporting these disabilities are seriously impaired; for example, many with vision and hearing impairments get along well with simple prosthetic aids (glasses or hearing aids), or even manage without them. The same is true of the other categories, and it is important to look more deeply to find those impairments that represent a serious level of disability.

In Table 3 are listed data on persons with disabilities that have a substantial effect on their work.

**Table 2**

**Incidence of Major Types of Disability (1990 Estimates)**

<table>
<thead>
<tr>
<th>Disability</th>
<th>Persons (thousands)</th>
<th>Percentage of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visually handicapped</td>
<td>8,600</td>
<td>3.4</td>
</tr>
<tr>
<td>Hearing handicapped</td>
<td>22,000</td>
<td>8.8</td>
</tr>
<tr>
<td>Motor</td>
<td>23,400</td>
<td>9.6</td>
</tr>
<tr>
<td>Orthopedic impairments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific learning disabilities</td>
<td>18,700</td>
<td>7.5</td>
</tr>
<tr>
<td>Speech impaired</td>
<td>2,000</td>
<td>0.9</td>
</tr>
<tr>
<td>Mentally retarded</td>
<td>3,000</td>
<td>1.2</td>
</tr>
<tr>
<td>Illiterate and semiliterate</td>
<td>14,000</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>51,700</td>
<td>36.4</td>
</tr>
</tbody>
</table>

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**U.S. Disability Programs**

In the United States, four major types of disability insurance exist: (a) private disability insurance, (b) Worker's Compensation Insurance (usually a state-regulated program with matched federal funds), (c) Veterans Compensation and Pension Benefits, and (d) Social Security's Disability Insurance and Supplemental Security Insurance.

**Private Disability Insurance**

Of the 50 companies that provide dis-
ability insurance, only 5 or 6 are major contributors; the remaining companies are either subsidiaries, reinsurers, or independent contractors. These few major companies generally dictate industry policy related to disability.

Disability insurance provides income-maintenance or protection, providing for partial replacement of lost wages as the result of accident, illness, or pregnancy. Two common types of income protection exist. The first is short-term sickness (STS), which provides limited term protection and benefits for up to 2 years. The second is long-term disability (LTD), which provides benefits for from 5 years to life. Usually, these benefits are integrated with Social Security or Worker's Compensation benefits, so that the level of income replacement does not exceed 60%.

Although there is a broad spectrum of definitions of disability, they are generally categorized as work-referenced or not work-referenced. Work-referenced refers to any occupation that, by education or training, the insured is capable of performing. For those occupations that are not work-referenced, when the insured is unable to perform the important duties of his or her own occupation, even if he or she is gainfully employed in another occupation, then he or she is considered disabled. The first definition parallels that of the Social Security's Disability Insurance (SSDI) program, whereas the latter is much stricter, and, although policy-specific for disability for the insured, would not meet SSA's requirements.

Once the definition of disability has been met, as stipulated in the insured's policy, an important question is the presence of any pre-existing limitations and exclusions. It is a generic rule that disability insurance policies have a clause which states that the insurer will meet SSA's requirements. When there is disagreement as to the existence of disability, an adjudication process begins. In many workers' compensation programs, the American Medical Association's Guides to the Evaluation of Permanent Impairment (1990) plays an important role in disability determinations.

The preface to the book states clearly that: (a) impairments are purely medical conditions; (b) disabilities are not purely medical; (c) physicians are competent at rating permanent impairments; and (d) disability rating is a fundamentally administrative responsibility. In practice, impairment ratings often carry the entire load of disability determination. Thus, workers' compensation programs often compensate for physical impairment rather than economic disability.

Essentially, the book provides a standardized physical examination, a recording of findings, and a conversion to a rating. Eleven of the chapters address impairments of different body systems. Some of the system-specific chapters present rules that can be used to develop

### Table 3

**Summary of Severe Impairments (1990 Estimates)**

<table>
<thead>
<tr>
<th>Disability</th>
<th>Persons (thousands)</th>
<th>Percentage of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual impairment</td>
<td>580</td>
<td>0.2</td>
</tr>
<tr>
<td>Legally blind</td>
<td>1,500</td>
<td>0.6</td>
</tr>
<tr>
<td>Severely impaired vision</td>
<td>2,400</td>
<td>1.0</td>
</tr>
<tr>
<td>Hearing impairments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe to profound bilateral hearing loss</td>
<td>2,400</td>
<td>1.0</td>
</tr>
<tr>
<td>Motor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability interfering with work</td>
<td>13,300</td>
<td>5.3</td>
</tr>
<tr>
<td>Orthopedic impairments interfering with work:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back or spine</td>
<td>3,300</td>
<td>1.3</td>
</tr>
<tr>
<td>Hips and lower limbs</td>
<td>4,100</td>
<td>1.6</td>
</tr>
<tr>
<td>Severed spinal cord</td>
<td>580</td>
<td>0.2</td>
</tr>
<tr>
<td>Cognitive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific learning disabilities</td>
<td>6,200</td>
<td>2.5</td>
</tr>
<tr>
<td>Impaired speech interfering with work</td>
<td>200</td>
<td>0.1</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>3,000</td>
<td>1.2</td>
</tr>
<tr>
<td>Adult illiterate (less than 4th grade)</td>
<td>14,000</td>
<td>7.0</td>
</tr>
<tr>
<td>Total</td>
<td>47,160</td>
<td>21.0</td>
</tr>
</tbody>
</table>

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op organ-level ratings (e.g., for an elbow) and whole person impairment ratings that take into account the effect of the impairment on the whole person. Sometimes activities of daily living are considered in constructing the rating.

Disability Programs of the Department of Veterans Affairs

The Department of Veterans Affairs (VA) administers a system of benefits for veterans and their dependents. The Veterans Benefits Administration administers two main assistance programs for veterans with disabilities: the Disability Compensation Program and the Disability Pension Program. The Disability Compensation Program provides benefits to veterans who suffer from disabling injuries or diseases incurred or aggravated while in military service (not necessarily during active combat).

In addition to these two main compensation and pension programs for disabled veterans, the VA administers a variety of smaller programs offering vocational rehabilitation, employment services, housing assistance, and prosthetic and sensory aids to disabled veterans. The purpose of the Disability Compensation Program is to provide financial assistance to veterans with service-connected disabilities, whereas the purpose of the Disability Pension Program is to provide financial assistance to veterans who have non-service-connected disabilities, who served during a designated wartime period, and who meet income and net worth criteria.

Veterans are eligible for disability pension benefits if the disability is non-service-connected, if the veteran is either permanently or totally disabled, and if the veteran meets specific income and net worth criteria. Veterans who are at least 65 years of age are automatically considered permanently and totally disabled. In contrast, veterans under the age of 55 years must be rated as 100% disabled and be unable to engage in substantial gainful activity to be defined as permanently and totally disabled. Veterans between the ages of 56 and 64 years must be rated as at least 50% disabled to be considered permanently and totally disabled.

To establish eligibility for a pension, a veteran must file a claim with the VA. If the veteran is under 65, the veteran is referred to a VA hospital for a medical examination to determine whether the disability is permanent and total. The results of the medical examination are reviewed by a VA rating board, which certifies that the veteran is permanently and totally disabled and may then grant the veteran a disability pension.

To determine an appropriate level of compensation and pension relative to the severity of veteran’s mental and physical impairments, the VA uses an instrument known as the Disability Rating Schedule. This schedule was originally compiled in 1945 through the process of converting medical information into criteria for nearly 720 medical conditions.

The VA is authorized by law to periodically adjust the rating schedule “in accordance with experience”; however, few revisions have been made since 1945. Further, the U.S. General Accounting Office has recently reviewed the schedule and determined that the medical criteria are outdated and require revision. The VA concurred with this conclusion and is currently reviewing the criteria.

Several problems with the current rating schedule need to be addressed. First, much of the medical terminology is outdated and not in accord with current professional knowledge, so it does not match the language used by physicians. The need to translate current terminology into the terminology contained in the schedule increases the potential for errors in classification. Second, some of the impairments in the schedule are ambiguous and not clearly defined, making consistent classification difficult. Third, the schedule contains gaps in the form of missing medical conditions. For cases where the schedule does not include a diagnosis for the medical condition, rating specialists need to use analogous categories as the basis for assigning disabilities; this is less reliable than using specific diagnoses for assigning disability ratings. A final point about the rating schedule is that the description of the veteran’s disability and the corresponding benefit levels, as stated in the disability rating manual, are related to the determined employability of the veteran. This underscores the need for updating the schedule, because employability today is markedly different from employability at the end of World War II when the United States was heavily oriented towards agriculture and heavy industry. Additionally, there is an increased understanding of the importance of psychosocial elements related to employability, as well as the importance of these elements for adaptability in general. Therefore, the rating boards today are recognizing the whole person when considering employability and assignment of disabilities.

Social Security Disability Programs

There are two programs administered by SSA, the SSDI (Title II) and the SSI (Title XVI) programs. For both, the statutory definition of disability is inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. The rules used to determine disability are prescribed by federal regulation to ensure uniform application of the law and consistency.

To facilitate the disability decision-making process, clinical guidelines describe severity levels in terms of clinical findings for most impairments. They include specific medical evaluation criteria, commonly known as the Listing of Medical Impairments. For each of the 12 major body systems, the listing describes impairments presumed to be severe enough to prevent a person who is not working from performing any gainful activity. A person who is not engaging in substantial gainful activity is generally considered unable to work by reason of the impairment alone. The use of the Listing of Medical Impairments does not in any way eliminate the
requirement that the person be unable to engage in substantial gainful activity. It is an administrative expedient designed to facilitate the processing of claims of the most severely disabled applicants whose diagnosed impairment meets or is equal to the level of severity reflected in the clinical findings shown for that impairment in the Listing of Medical Impairments.

The evaluation of vocational potential requires a sophisticated medical evaluation of the person's residual functional capacity (RFC), physical or mental, and careful vocational consideration as to how this RFC translates into the ability to engage in specific jobs. In judging the capacities of a person who may have functional limitations as a result of physical illness or injury, there are some gross measures of ability to stand, walk, lift, carry, use arms and hands in pushing, pulling, manipulating, and so on. Additionally, a separate functional assessment of mental capacities can be made that includes understanding and memory, sustained concentration and persistence, social interaction, and adaptation. These capacities are quantified to correspond with various job requirements as described in the Department of Labor's Dictionary of Occupational Titles (1991), which provides specifications for all the jobs in the economy and lays out all the factors in those particular occupations or jobs. These measures are judgmental because there are few scientifically validated guidelines relating medical examination findings with the required quantification of these residual physical and mental functions.

Furthermore, there is a requirement at the state level to refer beneficiaries for vocational rehabilitation, which is not done for people denied benefits. The irony is that those denied have potentially more capability to be rehabilitated and recover, but they are not referred for vocational rehabilitation because they are not beneficiaries of the SSDI program. Congress has been made aware of this internal irony over the years. But, considering the numbers that are denied—about 60% of the 2 million that apply in any 1 year—the numbers that would be referred for state-sponsored vocational rehabilitation mount very quickly. Consideration of these vocational factors requires extensive training in vocational assessment and full knowledge of the job market.

Recently, Social Security issued regulations that make far-reaching changes in the way the Social Security Administration (SSA) evaluates disability in children applying for Supplemental Security Income (SSI) payments. One of the regulations greatly modifies the process and standard used to evaluate childhood disability cases. A child under age 18 years will be considered disabled for purposes of eligibility for SSI, if he or she suffers from any medically determinable physical or mental impairment of comparable severity to that which would make an adult disabled.

Comparable severity, as defined in the regulations, means that a child's physical or mental impairment so limits his or her ability to function independently, appropriately, and effectively in an age-appropriate manner that the impairment and limitations resulting from it are comparable to those that would disable an adult. Specifically, the impairment must substantially reduce (or, if the child is under 1 year of age, be reasonably expected to substantially reduce) the child's ability to:

- grow, develop, or mature physically, mentally, or emotionally and thus to attain developmental milestones at an age-appropriate rate;
- grow, develop, or mature physically, mentally, or emotionally and thus to engage in age-appropriate activities of daily living in self-care; play, recreation, and sports: school and academics; vocational settings; peer and family relationships; or
- acquire the skills needed to assume roles reasonably expected of adults.

These additional individualized functional reviews in children focus on developmental and functional domains where there is a lag in achieving age-appropriate activities and expected developmental milestones. The domains of development and functioning are broad areas of activity (developmental or functioning) that can be identified in infancy and traced throughout children's growth and maturation into adulthood, such as motor, cognitive, communicative, social, and personal behavioral activities.

In fiscal year 1990, SSA paid $10.3 billion in SSI (Title XVI) benefits to 4.8 million persons with disabilities each year. This amounts to an average of $339 a month which may be supplemented by a state program. This is not an insurance-based program and requires an examination of income and net worth before a claim is reviewed for disability for those under age 65 years. SSI recipients are also generally automatically eligible for Medicaid. In addition, the SSI program provides cash assistance totalling $121 million each month to about 312,000 children with disabilities from families with limited income and resources. The new regulations do not change the way Social Security figures income and resources.

Assessment and Research Opportunities

Several initiatives for assessing function exist within national agencies such as the Public Health Service and the National Institute of Disability and Rehabilitation Research of the Department of Education. The Public Health Service has recently established a Task Force on Improving Medical Criteria for Disability Determinations.

The Task Force has developed a strategy to improve the scientific accuracy of determination of ability, through biomedical and biopsychosocial research that will identify and quantify residual functional capacity, evaluate effectiveness of treatment, and improve accuracy of prognoses. The report was completed in April 1992 and has been adopted by the Public Health Service, which allows for the preparation of implementation strategies. It will constitute a plan for how to improve functional and medical criteria for making disability determinations.

Further, a National Center for Medical Rehabilitation Research (NCMRR) has been established in the Public Health Service at the National Institutes of Health. One of the key provisions and requirements of the authorizing legislation for National Institutes of Health Amendments of 1990, Public Law 101-613, was the establishment of the NCMRR. The legislation authorizing the NCMRR requires that a coordinating committee for medical rehabilitation research be established. The first task of this NCMRR's Advisory Board is to de-
velop a research plan.

The NCMRR will provide a focus for scientists who are interested in research on restoring, replacing, or enhancing the function of children and adults with physical disabilities. New medical and behavioral treatments for the care of persons with physical disabilities will be developed that will affect multiple body systems, consider the person's capabilities, and be implemented in the environment in which the person with a disability lives. Recent advances in bioengineering, computer assisted design and manufacturing, microsurgery, neuroimaging, human performance evaluation tools, and use of recombinant DNA technology will provide a basis for developing new and improved rehabilitation therapies and devices. The legislation creating the NCMRR specifically cites improved prosthetic and orthotic devices as a target for NCMRR efforts. In addition, attention will be paid to other areas including wheelchair and other mobility-enhancing equipment; cognitive retraining, memory enhancement, and speech restoration or substitution.

NIDRR is charged with developing a long range plan that will include reviews of vocational potential, discriminating people who are disabled from those who are not, and coordinating research related to assessing function and disabilities.

Conclusion

Many assessment plans and functional evaluation techniques exist. In general, they seem to work, but there is suspicion that more valid and reliable means and mechanisms need to be developed. Studies need to be designed and conducted correlating more precisely the severity of physical and mental impairments with functions required for performance of work-related activities. Such studies need to be completed in a systematic fashion to improve the rigor and robustness of the presently available and limited knowledge base.

Given the rationale and international classifications discussed here, it is obvious that many areas for inquiry and evaluation exist and there is no dearth of data and information for analysis. Much needs to be done to organize, correlate, and synthesize data and to carefully compare programs. In addition to this type of synthesis, a more fundamental issue arises. With the advent of the Americans with Disabilities Act, there is a grave need to determine functional characteristics of people with disabilities that prevent employment. This becomes an issue of assessment where relating capabilities to expectations of the workplace need to be more clearly understood and refined. Current global scales of functioning have an essential weakness in that they generally lack specificity. Yet focused functional assessments for particular tasks, although very useful, lack the characteristics needed for universal application. Clearly, occupational therapists and others are needed in the area of functional assessment to organize, integrate, and continue to pursue this important work.

Acknowledgments

This manuscript is based on a paper presented at the Symposium on Measurement and Assessment: Directions for Research in Occupational Therapy at the University of Illinois at Chicago, October 16–18, 1991. The symposium was jointly sponsored by the American Occupational Therapy Association, the American Occupational Therapy Association Foundation, and the Occupational Therapy Center for Research and Measurement at the University of Illinois at Chicago.

The views expressed in this paper are solely the author's and should in no way be interpreted as official federal policy.

Suggested Readings


