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Clinical Utility of the Melville-Nelson Self-Identified Goals Assessment

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Abstract

The rationale for utilizing client-centered assessments is they may facilitate individualized occupational therapy interventions allowing therapists to consider and be sensitive to the unique needs and abilities of clients they are working with. The Melville-Nelson Self-Identified Goals Assessment is a client-centered assessment that has been designed to help patients identify meaningful goals for therapy and make judgments as to progress toward those goals in a time efficient way. This study investigated the clinical utility of the Melville-Nelson Self-Identified Goals Assessment from the point of view of 15 registered occupational therapists working in 13 skilled nursing facilities or transitional care units located in northern Ohio and southern Michigan. After training, therapists administered the Melville-Nelson Self-Identified Goals Assessment to 3 patients. After administration of the final assessment therapists responded to eight declarative statements eliciting their opinions on the clinical utility of the SIGA. Scores on all eight items were overwhelmingly positive, with only 2 of 90 ratings on the disagreement side of the scale. The eight mean scores were equal to or greater than 5.9 on the 7-point scales. Cronbach's standardized alpha was .73, indicating acceptable internal consistency. Most therapists agreed that the SIGA is effective in eliciting meaningful goals and in evaluating progress toward those goals, and agreement among therapists was even stronger that some kind of client-centered assessment is valuable. In future studies a larger sample size, expanded geographic representation of therapists, and examination of the clinical utility of repeated administration of this assessment are recommended.

Clinical Utility of the Melville-Nelson Self-Identified Goals Assessment

Occupational therapy is a unique field of rehabilitation in which the therapist and client collaborate to create a meaningful, purposeful, and stimulating therapeutic environment. Nelson (1997) stated during the Eleanor Clarke Slagle Lecture in 1996 “The profession of occupational therapy was founded for one reason: To use occupation as a therapeutic method” (p. 12). The profession of occupational therapy has since advanced; however, practitioners continue to abide by the original founders definition, utilizing occupations as a therapeutic method during treatment. According to Nelson & Thomas (2003), “a person must find personal meaning in the occupational form if therapeutic occupation is going to occur” (p. 132). Meaning is a unique individualized experience that a person engages in during therapy. For a person to find therapy meaningful treatment must be individualized and client-centered.

Client-centered therapy refers to focusing on what the client considers to be most important in the context of their own life (Law, 1998). Client-centered therapy is facilitated through a collaborative, interdependent partnership between the therapist and the client (Mew & Fossey, 1996). This type of therapy involves the therapist providing information, options, validation, facilitation, technical expertise, encouragement, and authentic respect for the integrity of the client (Stuber & Nelson, 2010). The client, or person receiving therapy, is the lead decision maker in assessment, methods for intervention, and goal-setting (Stuber & Nelson, 2010). “Client-centered models of practice emphasize personal success as the most important dynamic in occupational therapy” (Stuber & Nelson, 2010, p. 14). Utilizing a client-centered approach has value within the field of occupational therapy because it facilitates opportunities for rapport with clients, enhances the therapists understanding of the client’s perspective, and facilitates meaningful therapy (Mew & Fossey, 1996).

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Recognizing the importance of client participation in setting goals, the Occupational Therapy Code of Ethics and Ethics Standards (2010) states within Principle 3, “Occupational therapy personnel shall respect the right of the individual to self-determination,” (p. 20) that therapists should “establish a collaborative relationship with recipients of service including families, significant others, and caregivers in setting goals and priorities throughout the intervention process” (p. 21).

According to Pollock (1992), occupational therapists often use measurement tools that are not individualized to clients’ needs and situations. When performance is rated without clients’ input, passivity is reinforced; however when goals are set by the client, the potential for participation is enhanced (Pollock, 1992). Pollock (1992) hypothesized that there is more likely to be collaborative efforts between clients and therapists when clients are involved in the goal setting process. A study provides support to Pollock’s hypothesis indicating that occupational therapists may involve clients in the goal setting process, however not to the maximum extent (Northern, Rust, Nelson & Watts, 1995).

Formal client-centered assessments have been developed in an effort to insure client involvement in the occupational therapy process. Kielhofner and his colleagues developed the Occupational Self Assessment (OSA) from the Model of Human Occupation (Kielhofner, 2008). This assessment is used in identifying clients’ perceptions of competence in self-identified occupations (Cassidy, 2000). The OSA consists a series of statements related to “occupational life” organized in two sections, Myself and Environment. The client is asked to rate his or her competence on each statement on a 3- point scale: strength, adequate functioning, or a weakness. The client then rates the level of importance of each statement using a 3- point scale: not so important, important, and extremely important. The final step in this assessment involves the client choosing 4 statements they would like to change, and ranking them in order of importance. Baron, Kielhofner,

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Goldhammer, and Wolenski (2006) stated, “The OSA assists in helping the client prioritize areas for change and serves as a foundation for collaborative goal setting between the client and the therapist ” (para. 1).

Another client-centered assessment is the Canadian Occupational Performance Measure (COPM) based on the Model of Occupational Performance. Law, Baptiste, Carswell, McColl, and Polatajko stated in 2005 “the COPM is an individualized measure designed for use by occupational therapists to detect change in a client’s self-perception of occupational performance” (p. 1). The first step in the assessment process consists of interviewing the client about his/her occupational performance. During this step it is important to identify occupations that the client needs, wants, or is expected to do in daily life (Law et al., 2005). Once problems have been identified the client is asked to rate the occupation in terms of importance (Law et al., 2005). During rating a 10-point scale is used, ranging from not important at all to extremely important (Law et al., 2005). Once the ratings of importance are completed the client is asked to choose up to five problems and rate them in terms of current performance and current satisfaction (Law et al., 2005). According to Law et al. (2005) “The COPM was developed to enable individuals to identify and prioritize everyday issues that restrict or otherwise impact their occupational performance” (p. 1).

Research has been conducted on the clinical utility of client-centered assessments. Clinical utility can be defined as “the value of a measure, relative to other measures, for a particular purpose” (Doig, Fleming, & Kuipers, 2010, p. 905). Toomey, Nichololson, and Carswell (1995) investigated the clinical utility of the COPM and found that therapists stated this assessment was valuable; however, they also stated it was time consuming and difficult to administer. McColl, Paterson, Davies, Doubt, and Law (2000) found during their study addressing the validity and community utility of the COPM, the assessment took on average 46 minutes to complete. A recent study by Stuber and Nelson (2010) found that the OSA took a median of 12.5 minutes to complete while the

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COPM took a median of 17.5 minutes to complete. Given the constraints of the regulatory framework governing sub-acute and long-term care, therapists and administrators have sometimes reported the COPM took too much time to administer (Melville et al., 2002). In a study conducted by Colquhoun and colleges (2010), results showed that the COPM was time consuming; the main reason provided by therapists for not continuing to use the COPM was related to the amount of time this assessment took to administer.

The Melville-Nelson Self-Identified Goals Assessment (SIGA) is part of the Melville-Nelson Occupational Therapy Evaluation System for Skilled Nursing Facilities and Subacute Rehabilitation. According to Melville, Baltic, Bettcher, and Nelson (2002) this assessment “depended on the groundbreaking work of the COPM and has extended the ideas of person-identified goals and self-ratings of progress to the particular constraints (time) of subacute rehabilitation” (p. 652). This assessment was developed to help patients identify meaningful goals for therapy and make judgments as to progress toward those goals in a time efficient way (Melville et al., 2002).

Administration of the SIGA involves asking information related to the patients prior functioning, home situation, life work, interests, and customary routines (Melville & Nelson, 2001). After information is given related to prior function, the therapist then uses interviewing skills to have the patient identify specific goals. Suggestions are made throughout the assessment protocol related to questions therapists should ask the patient. Once the patient identifies goals the therapist then records them on the evaluation and has the patient rate the goals using a 10 point scale. The patient is asked “How well can you do all of the things you want to do on a scale from 0 to 10, with 0 being that you can’t do them at all and with 10 being you can do them your very best” (Melville & Nelson, 2001, para. 7). The therapist then has the option, based on the

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patient's level of fatigue, to have the patient rate each goal individually using the same 10 point scale.

In a pilot study Hodge (1999) utilized focused group interviewing as a method to obtain information examining therapists opinions related to the content validity of the SIGA. During the focus groups therapists were asked a series of prewritten questions addressing the content validity of the Resident Identified Goals section and the appropriate methods for addressing the clinical utility of patient identified goals (Hodge, 1999, p. 9). Hodge (1999), summarized therapists' comments as follows: "This part of the occupational therapy assessment was the only place where clients have input into and control of their recovery process" (p. 15). The author also stated that "The self-identified goals process could contribute to rapport building through open communication" (Hodge, 1999, p. 15). In a related study conducted by Cassidy (2000) examining the clinical utility of the SIGA the author stated, "Therapists overwhelmingly agreed that the assessment is beneficial to clients and themselves" (p. 18).

The purpose of the current study is similar to the study conducted by Cassidy (2000) examining the clinical utility of the SIGA. The current study will utilize formal in-person interviews of practicing occupational therapists. The main question examined in the current study will focus on the clinical utility of the Self-Identified Goals Assessment.

Method

Participants

The final sample included 15 certified occupational therapists practicing in 13 sub-acute facilities located in northern Ohio and southern Michigan., including both skilled nursing facilities and transitional care units. Therapists were required to have one year of full-time experience working in a sub-acute rehabilitation facility. Therapists were also required to

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currently practice at least 25 % of their time in a sub-acute rehabilitation facility. This sample is appropriate because the SIGA was developed for sub-acute rehabilitation facilities and nursing homes (Melville & Nelson, 2001).

Recruitment of therapists employed The University of Toledo's Occupational Therapy Doctorate Program Fieldwork Site List and an internet search using the keywords SKILLED NURSING FACILITIES AND TOLEDO OHIO. Therapists were then contacted via email and telephone calls. During the email or telephone call the study was described briefly, and therapists were asked for their participation.

Therapists participating in this study ranged in age from 26 to 57 years, with a mean age of 39.6 years ($SD = 11.6$). Total occupational therapy experience ranged from 1 to 32 years with a mean of 14.5 years of experience ($SD = 12.1$), with a mean of 7.7 years ($SD = 8.1$) working at the current facility.

Therapists received training on the SIGA less than one month prior to the beginning of data collection on the main instrument in this study. Training was provided at each facility in person or through a telephone call by the student investigator. After providing each therapist with copies of the SIGA protocol, the student investigator reviewed each aspect of the protocol. Therapists were encouraged to ask questions. After the initial training, the occupational therapists were required to administer the SIGA on a minimum of 3 patients at admission. Administration of the SIGA at other times (e.g., discharge) was encouraged. Therapists were encouraged to telephone or email the student investigator after the first or second SIGA administrations, and all did so except one who telephoned after the third administration. The purpose of this telephone call was to provide training as needed. In these telephone conversations, the therapist provided information concerning the types of goals and scores

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elicited by the SIGA. Therapists frequently stated that it was difficult to elicit specific occupational goals from some patients (e.g., the patient simply said he or she wanted to go home). In response, the student investigator re-read the section of the SIGA protocol providing instructions for dealing with vague or non-occupational goals. Since the SIGA is an instrument used in routine clinical practice, and since patient data were used by the therapists but remained masked to the researchers, informed consent was unnecessary in this study of therapists' judgments about practice.

Instrument and Procedure

Administration of the SIGA involves the therapists asking clients questions related to prior functioning home situation, life work, interests, and customary routines (Melville & Nelson, 2001). The SIGA also involves the therapists asking the patient to identify specific goals, then rate the goals on a scale from 0-10 (Melville & Nelson, 2001).

Data collection involved a formal in-person or telephone interview of the therapist. This interview consisted of the student investigator stating eight pre-planned declarative statements, similar to the statements given in a pilot study conducted by Cassidy (2000), to the clinician (see Figure 1). The statements elicited the opinions of the occupational therapists on the clinical utility of the SIGA. The statements were based on the therapists professional opinions related to the meaning and usefulness of client self-identification of goals. The original research plan included two statements regarding administration of the SIGA at discharge; however, these two items proved to be impractical.

In a study conducted to investigate patients' perspectives of the validity of the SIGA, authors state, "Results demonstrate that the SIGA was effective in helping therapists identify personally meaningful goals" (Melville et al., 2002, p. 656). The authors also stated that this

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study confirms that the SIGA can be useful in sub-acute rehabilitation care within skilled nursing facilities and transitional care units of hospitals (Melville et al., 2002). The authors suggested that future studies on the SIGA should focus on test-retest reliability and clinical use from therapists' perspectives (Melville et al., 2002).

The scale used by the therapists to rate their opinions on the statements was similar to the scale used by Cassidy (2000). Therapist opinions were scored using a 7-point Likert type scale. The range of this scale included: strongly agree, agree, slightly agree, neither agree nor disagree, slightly disagree, disagree, and strongly disagree. Therapists were asked to respond to each statement to the best of their professional knowledge, and the student investigator circled the response indicated by the therapist.

Data Analysis

Data analysis involved counting responses, computing the means, and identifying the standard deviations of the interview responses. The internal consistency of multiple interview items designed to measure a single variable, utility, was measured alpha, based on the inter-correlations among items.

Results

Responses from therapists to the eight declarative statements are given in Figure 1. Scores on all eight items were overwhelmingly positive, with only 2 of 90 ratings on the disagreement side of the scale. Cronbach's standardized alpha was .73, indicating acceptable internal consistency. Alpha was probably depressed because of the lack of variance, with a definite ceiling effect resulting from the therapists' positive ratings. For example, on item 6, 13 of the 15 respondents gave the highest possible rating of strongly agree (7), and on items 1 and 4, 12 of 15 provided the highest possible rating.

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Scores on the other five items were not as high as on items 1, 4, and 6; however, they were still high in absolute terms, with all mean scores equal to or greater than 5.9 on the 7-point scale. The only two disagreements were in response to the following two items: “Repeated administration of the SIGA provides useful ways for clients to reflect on progress,” and “Given the time demands faced by occupational therapists, the SIGA can be administered in a reasonable amount of time.”

Comments given by the occupational therapists within the optional comment section included: “This assessment provides useful information”; “This is a practical way to obtain information”; “This is a good tool to use upon evaluation it is quick and to the point”; and “Overall this assessment allows therapists to get client-centered goals”. One therapist stated “This assessment can be depressing for acute patients who are cognitively aware; there are shorter, more effective ways to obtain data”.

Discussion

The main purpose of this study was to examine the clinical utility of the Melville-Nelson Self-Identified Goals Assessment from the point of view of occupational therapists. Results indicated therapists responded with overwhelmingly strong agreement to statements regarding the utilization of client-centered assessments. Therapists’ responses towards the SIGA were in agreement however not as strong as towards general client-centered assessments. For example in response to the client centered statement “When designing occupational therapy interventions, therapists should consider clients personal goals” 13 of the 15 therapists strongly agreed (a mean score of 6.9, SD = 0.4). When responding to the following statement regarding the SIGA “When administering the SIGA adult clients without severe cognitive disabilities are able to formulate

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goals.” 5 of the 15 therapists strongly agreed while 8 of the 15 therapists agreed (a mean score of 6.2, $SD = 0.7$).

The findings of this study were similar to the study conducted by Cassidy (2000). In the study conducted by Cassidy (2000) results indicated that clinicians believed they were able to build rapport with their clients by asking what they wanted to work on. In the current study when responding to the statement “When designing occupational therapy interventions, therapists should consider clients personal goals,” 13 of the 15 therapists strongly agreed (a mean score of 6.9, $SD = 0.4$).

Results from the study conducted by Cassidy (2000) also indicated clients identified unique goals that the therapist may not have thought of which in turn allowed therapists to know their clients better. In the current study when responding to the statement “When adult clients without severe cognitive disabilities are participating in occupational therapy, it is appropriate to identify their personal goals” 12 of the 15 therapists strongly agreed with a mean score of 6.7 ($SD = 0.6$).

In the study conducted by Cassidy (2000) clinicians stated through utilizing the SIGA the therapist is able to address the unique needs of the clients which leads to increased client participation. In comparison, when asked if clients feel more involved in the therapy process when asked to identify personal goals for occupational therapy in the current study 12 of the 15 therapists strongly agreed with a mean score of 6.7 ($SD = 0.6$).

In a study examining the clinical utility of the COPM (Toomey et al., 1995) therapists indicated “the COPM took too long to administer (i.e. over one hour). In the current study 14 of the 15 therapists responded with a degree of agreement when given the statement “Given the time demands faced by occupational therapists, the SIGA can be administered in a reasonable

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amount of time”. In a study conducted by Cassidy (2000) therapists indicated the SIGA takes “five to ten minutes to administer to clients without cognitive deficits.”

In a study examining the clinical utility of the COPM (Toomey et al., 1995) therapists also indicated the semi-structured interview inhibited spontaneity and limited the creativity of clients. In the current study 9 of the 15 therapists strongly agreed (a mean score of 6.5, SD = 0.6) with the statement “Upon asking clients to identify their own goals, therapists are able to expand the types of goals set in therapy.” Therapists also stated that this assessment “provides useful information”, “helps the therapist to get client-centered goals”, and “it provides practical information”.

In a study conducted by Hodge (1999) therapists stated when identifying goals clients may say what they think the therapist wants to hear. However in the current study when given the statement “When asked to state personal therapy goals clients will answer honestly” 7 out of the 15 therapists strongly agreed with a mean score of 6.1 (SD= 1.0).

In the current study one therapist stated “This assessment can be depressing for acute patients who are cognitively aware; there are shorter, more effective ways to obtain data”. In comparison Hodge (1999) indicated therapists stated clients may feel “bombarded” and overwhelmed with questions upon admission leading to difficulties with identifying goals. In the study conducted by Cassidy (2000) therapists indicated some clients “did not understand the concept of goals or desired outcomes”.

In future studies a larger sample size would yield more significant data. A drawback to the current study included the small selected region of therapists. Including other geographic regions in future studies would broaden the sample of occupational therapy practitioners and further signify data. Further exploration of the clinical utility of repeated administration of the

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SIGA is recommended, including administration at discharge. Another idea for future study would be the use of an interview that clearly distinguishes between a) the therapist's commitment to client-centered assessment and b) the therapist's evaluation of the SIGA as one of several possible ways of conducting client-centered assessment.

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Figure 1.

Responses from occupational therapists to interview concerning clinical utility ($N = 15$).

	Strongly Agree (7)	Agree (6)	Slightly Agree (5)	Neither Agree/ Disagree (4)	Slightly Disagree (3)	Disagree (2)	Strongly Disagree (1)	<i>M</i> (<i>SD</i>)
When adult clients without severe cognitive disabilities are participating in occupational therapy, it is appropriate to identify their personal goals.	12	2	1	0	0	0	0	6.7 (0.6)
When administering the SIGA adult clients without severe cognitive disabilities are able to formulate goals.	5	8	2	0	0	0	0	6.2 (0.7)
When asked to state personal therapy goals clients will answer honestly.	7	4	3	1	0	0	0	6.1 (1.0)
Clients feel more involved in the therapy process when asked to identify personal goals for occupational therapy.	12	2	1	0	0	0	0	6.7 (0.6)
Upon asking clients to identify their own goals, therapists are able to expand the types of goals set in therapy.	9	5	1	0	0	0	0	6.5 (0.6)
When designing occupational therapy interventions, therapists should consider clients personal goals.	13	2	0	0	0	0	0	6.9 (0.4)
Repeated administration of the SIGA provides useful ways for clients to reflect on progress.	5	7	2	0	0	1	0	5.9 (1.3)
Given the time demands faced by occupational therapists, the SIGA can be administered in a reasonable amount of time.	7	4	3	0	0	1	0	6.0 (1.4)