Masthead Logo

The Open Journal of Occupational Therapy

Volume 2
Issue 2 *Spring 2014*

Article 3

4-1-2014

Promoting Client Goal Ownership in a Clinical Setting

Laura H. VanPuymbrouck
University of Illinois at Chicago, Laura_vanpuymbrouck@rush.edu

DOI: 10.15453/2168-6408.1087

Promoting Client Goal Ownership in a Clinical Setting

Abstract
Effective goal setting involves collaboration between the client and therapist and is an important component of occupational therapy practice. However, encouraging involvement and collaboration does not necessarily guarantee that client goals are incorporated into the treatment plan. The purpose of this innovative treatment program was to determine if providing a client with a venue for goal identification, documentation, and maintenance might impact participation and satisfaction in a day rehabilitation setting. Responses to a study satisfaction survey (Ss) were taken at baseline and immediately postintervention from the experimental (N = 11) and control (N = 10) groups and attendance rates were compared between groups. Semi-structured post-intervention interviews were used to obtain qualitative feedback of the intervention. Minimal differences between the control and experimental group were found on the quantitative measures. However, unanticipated results to components were identified. Qualitative findings suggested that both patients and therapists felt the intervention created positive outcomes. This innovative program approach outlines basic strategies therapists can employ to provide a venue for client goal ownership focusing on client goal identification, client goal documentation, and client goal maintenance. While results do not support increases in self-efficacy, further research to explore the role of client-owned goals is suggested.

Comments
To view a video about this article with the author, Laura VanPuymbrouck, visit our partner, MedBridge, at:
http://ojot.medbridgeeducation.com/breakouts/11-promoting-client-goal-ownership-in-a-clinical-setting

OJOT is excited to partner with MedBridge to offer online CEUs through Breakouts – short, evidence-based video interviews featuring OJOT authors. Click here to learn more about this unique opportunity for discussions on hot topics in OT by leading researchers.

Keywords
Goal setting, collaboration, occupational therapy, self-efficacy, client-centered

Cover Page Footnote
The authors would like to thank Dr. Marcia Finlayson and Dr. Miho Asano for their assistance in reviewing multiple drafts of this manuscript, staff and clients at the Rehabilitation Institute of Chicago Grand Day Rehab clinic, the Betts Innovation committee of The Rehabilitation Institute of Chicago for funding and support of this project, and students of the University of Illinois-Chicago who provided feedback on the initial stages of the manuscript. Portions of the material in this article were presented at the Illinois State Conference, 2011, and have been accepted for a poster session at the AOTA Annual Conference & Expo, Baltimore, April 2014.

Credentials Display
Laura H. VanPuymbrouck, OTR/L

DOI: 10.15453/2168-6408.1087

Effective goal setting involves collaboration between the client and therapist and is an important component of occupational therapy practice. According to Adams and Grieder, "there is perhaps no greater expression of respect, understanding, hope, and empathy by the provider than the ability to elicit, acknowledge, and accept the individual's and family's goals" (2005, p. 122). The Occupational Therapy Practice Framework (AOTA, 2002) emphasizes involvement of the client and their family in establishing rehabilitation goals. However, encouraging involvement and collaboration does not necessarily guarantee the incorporation of client goals into the treatment plan. There is evidence supporting the use and effectiveness of clients creating their own action plans or goals in mental health rehabilitation and chronic illness management (Lorig & Holman, 2003; Lorig, Sobel, Ritter, Laurent, & Hobbs, 2001). Yet, there is little literature in the area of physical rehabilitation that describes methods for providing clients with the opportunity to create their own goals or therapy plans.

The purpose of this paper is to describe an innovative pilot program that incorporates strategies to maximize opportunities for clients and their families to generate their own rehabilitation goals and manage their own goal documentation in an interdisciplinary rehabilitation setting. As other existing studies suggest, greater collaboration with and participation of clients in goal setting might increase satisfaction with the therapeutic experience (Holliday, Ballinger, & Playford, 2007; Doig, Fleming, Cornwell, & Kuipers, 2009). It is the guiding hypothesis of this innovative approach to therapy that clients, when given the opportunity to generate, document, and maintain their own goals, will have a greater positive response on discharge surveys compared to clients who did not have this opportunity, and that they will demonstrate on subjective reports that they perceive the process as having a positive impact on satisfaction during the rehabilitation experience. For this study, occupational, physical, and speech therapists, as well as psychologists, nurses, and the clinic physicians, are all part of the interdisciplinary team that join in this process with the client.

Literature Review

Goal setting in Occupational Therapy

Client-centered care is a prominent theme throughout the Occupational Therapy Practice Framework (AOTA, 2002). It is defined as an approach where "the client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation" (Sumsion, 2000, p. 308). Despite the near universal recognition that early goal setting is critical to successful therapy, Barnard, Cruice, and Playford (2010) have observed that attempts to facilitate client participation in goal setting is "rarely a straightforward translation of patient wishes into agreed-upon written goals" (p. 241). Indeed, in a study investigating occupational therapists' and clients' perceptions of practice, 75% of the therapists interviewed believed that their clients participated in setting their goals, while the majority of the clients reported little or no active involvement in goal setting (Maitra &

Erway, 2006). The researchers identify a "perceptual gap that exists between occupational therapists and their clients in relation to their stated use of and participation in client-centered practice" (p. 308). They suggest that occupational therapists establish a therapeutic environment that facilitates open communication with clients and develop a strategy to encourage their clients' participation in the rehabilitation process.

Another study investigating whether and how occupational therapists involved their clients in goal setting concluded that "although therapists do involve their patients and families in a goal-setting process, they are not consistently involving patients to the maximum extent" (Northen, Rust, Nelson, & Watts, 1995, p. 219). Although therapists seem to believe that they are engaging in client-centered goal setting, the evidence suggests that their clients do not share this view (Holliday, Ballinger et al., 2007; Maitra & Erway, 2006). This gap may be due to a lack of awareness of the methods identified for client collaboration or because of views that the process is too time consuming. Evidence obtained from literature reviews of patient-centered goal setting supports this conclusion (Rosewilliam, Roskell, & Pandyan, 2011; Sumsion & Law, 2006). Both of these reviews conclude that clear strategies and explicit frameworks for creating a process of patient-centered goal setting is lacking in physical rehabilitation programs.

Methods and measures do exist and are frequently cited for use in goal collaboration during occupational therapy. These include the Canadian Occupational Performance Measure (COPM) (Law et al., 2005) and the Interest Checklist (Klyczek, Bauer-Yox, & Fiedler, 1997; Rogers, Weinstein, & Figone, 1978). The COPM is an example of a tool used by occupational therapists that facilitates communication between the therapist and client and the opportunity for client choice (Sumsion & Law, 2006). While this tool has the potential to increase client-therapist collaboration, it does not define a process that allows clients to create their own documentation and maintenance of their own identified goals or therapy plans. The element of providing the environment for client control over defining and documenting treatment goals goes beyond the parameters of tools such as the Interest Checklist (Klyczek et al., 1997) and the COPM (Law et al., 2005). If therapists provide clients with a method for thinking about, selecting, and performing ongoing maintenance of their own rehabilitation goals, the process could facilitate power sharing in a more client-centered relationship, as suggested by Townsend, Galipeault, Glidon, & Little (2003). The current literature points to the need for research that documents strategies for engaging clients and families in goal setting that goes beyond collaboration and also provides a means for allowing optimal goal ownership during the physical rehabilitation phase of recovery (Playford et al., 2000; Holliday, Ballinger et al., 2007).

Background: Client-owned goals

While the literature clearly identifies the professions' commitment to collaboration with clients in the goal identification process, there are

DOI: 10.15453/2168-6408.1087

few studies that describe methods for supporting clients to generate, document, and maintain their goals in a physical rehabilitation setting. Okun and Karoly (2007) describe client-owned goals as those goals that are "self-set" or "self-created" by the client vs. "other set" by a team member or family member. Playford et al. (2000) described a workshop consisting of sixteen rehabilitation staff from three different settings that reviewed various methods of client collaboration during goal setting. The consensus of the participants was that the rehabilitation team, and not the patient, often set goals. Yet, they acknowledged that goals negotiated with the client were felt (by the clinicians) to be more successful. However, they did not report a unified method for consistently incorporating client-established goals into the rehabilitation plan.

Other studies expand on the complexities and difficulties perceived by rehabilitation teams in providing a format for clients to establish their own goals (Barnard et al., 2010; Holliday, Cano, Freeman, & Playford, 2007). The study by Holliday, Ballinger et al. (2007) examined the impact that establishing a goal-setting protocol had on an inpatient neuro-rehabilitation unit. This protocol provided clients with methods for defining and prioritizing their own goals. Through use of a "goal setting workbook," clients and therapists worked together to document client-identified long- and short-term goals. Results of this study were mixed with no functional outcome differences; however, clients did report greater perceived autonomy and greater perceived relevance of the goals that were addressed during the rehabilitation period. This literature suggests the importance of providing clients with the ability to identify, document, and manage their own rehabilitation goals. Holliday, Ballinger et al. (2007) suggested that future studies should focus on extending their methods to people with other disabilities working in different environments to investigate the impact that client goal setting would have on the participation in and promotion of client well being. This current innovative approach to therapy incorporates some of the Holliday methodology in a day rehabilitation clinic setting to identify whether providing an opportunity for client-generated goal selection, documentation, and maintenance would have an impact on their perceived satisfaction with and participation in their physical rehabilitation program.

Methods

Design

This is a quasi-experimental pilot study of an innovative approach to therapy using an intervention and control. The guiding hypothesis of this pilot program is that the participants in the experimental group, who have the opportunity to generate, document, and maintain their own goals, will show greater positive ratings on the discharge study satisfaction survey (Ss) and higher scores of satisfaction on the facility-wide discharge satisfaction survey (Fs) when compared to the control group. Quantitative measures included a Ss, given to all of the participants at the beginning and end of the intervention, and a Fs given to all

of the participants only at the completion of the intervention. The researchers used qualitative, semi-structured postintervention interviews to obtain feedback from the participants and the families of the experimental group on the perceived impact use that a Goal Log book had on the rehabilitation process. A questionnaire was also provided to therapy staff who had worked with the participants in the experimental group. This form consisted of seven open-ended questions asking the therapists to provide thoughts on the positive and negative impact of the Goal Log book on the rehabilitation process.

Recruitment and Sampling

Participants were eligible for inclusion in this innovative therapy approach if they were 18 years of age or older and were referred to the day rehabilitation unit for post acute rehabilitation. Day rehabilitation is intensive (at least three hours a day and up to five days a week, requiring at least two out of three of either occupational therapy [OT], physical therapy [PT], or speech and language pathology[SLP]) interdisciplinary care performed in an outpatient setting. Clients were referred by the same large acute rehabilitation hospital and referred to the day rehabilitation unit by their physiatrist, due to a need for continued therapy. Beginning with an established date, the participants were assigned to one of the two groups sequentially upon admission to the day rehabilitation unit. If the unit received two admissions in one day, the assignment was based on the time of day that the unit received the referral in order to maintain the sequential selection criteria. Participants were not eligible if they demonstrated a limitation in the ability to engage in therapy. This criterion excluded clients with low levels of alertness, arousal, severe cognitive deficits, or severe communication deficits determined upon the first day of the initial evaluation. Clients physically unable to write were included; however, either a family member or a therapist performed this task with instruction from the participant. Recruitment was completed after six weeks from the start of the allocation period.

The participant's liaison therapist introduced the study to the participant and his or her family to obtain consent, and the signed consent forms were placed into the participant's medical chart. In this clinical setting a liaison therapist is the case-managing clinician (OT, PT, or SLP) assigned the responsibility of facilitating communication among the interdisciplinary staff and the family, caregiver, and client. Eligible participants who consented were assigned to either the control group or the experimental group in a randomized alternating fashion based on their start date at the day rehabilitation unit (see Figure 1).

The researchers recruited participants from a variety of diagnostic groups in to the program. Four people with traumatic brain injury, two with acquired brain injury, three with either arthritis or orthopedic injuries, nine with cerebral vascular accidents, two with general deconditioning/cancer, one with multiple sclerosis, and one with Parkinson's disease. One client from the control group was excluded from the study due to

readmission to the hospital. This resulted in 11 participants in the experimental group (six women and five men) and 10 participants in the control (five women and five men) (see Figure 1). The participants all spoke English. No other demographic was collected for the study. At the time of the study all of the participants were living at home with assistance.

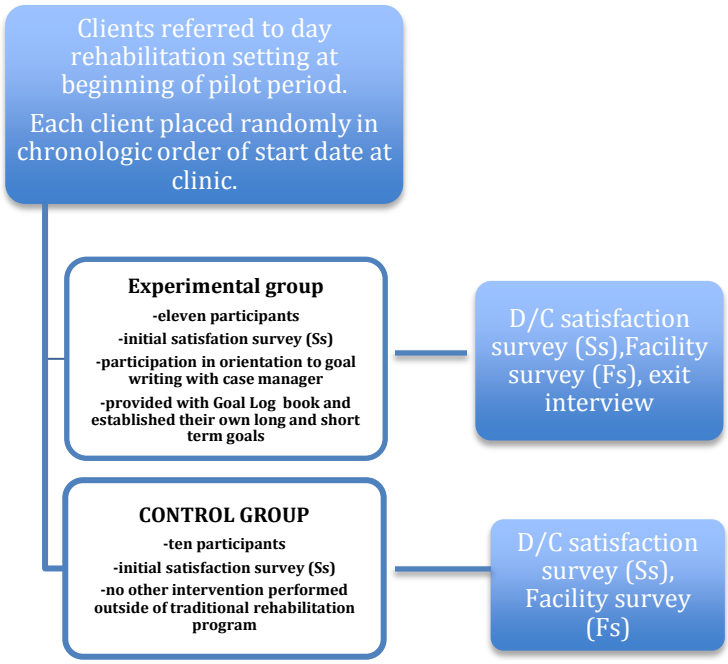

Figure 1. Study intervention pathway for experimental vs. control groups.

The hospital's innovation awards committee approved and funded this pilot program. The committee screens, selects, reviews, and supervises the use of proposed innovative interventions from hospital staff for use of new and "innovative therapeutic practice approaches designed solely to enhance the well-being of an individual client that have a reasonable expectation of success" (U.S. Department of Health and Human Services, 1979, "Part A," para. 2).

Measures. This treatment program used three data sources to assess differences between the experimental and control group:

- Quantitative
  - Study satisfaction survey (Ss)
  - Facility discharge survey (Fs)
- Qualitative
  - Informal exit interview of experimental group and feedback of treating therapists

The Ss is comprised of 14 questions and was created by a multi-disciplinary group from the clinic to identify perceived satisfaction in three areas: interaction with staff, psychosocial wellness, and self-advocacy (see Table 1). The survey development occurred over a one-month period, fielding questions from all multi-disciplinary staff, grouping the questions into thematic categories, and funneling the questions

down into the final 14 questions. The final survey was critically analyzed by all staff and field tested for "plain language" issues on all staff prior to use.

This Ss is a Likert-type survey that asked for responses ranging between five levels. The ranges of these were "strongly agree" to "strongly disagree." The initial admission component of this survey asked the participants to respond to questions regarding their most recent experiences with therapy. Each participant had been receiving therapy at the acute inpatient facility just prior to admission to the day rehabilitation unit. The questions asked at admission on the Ss would require the participant to reflect on interactions with therapy regarding goal setting and goal collaboration up to this point in time.

Table 1. *Study Survey Satisfaction Form (Ss)*

	strongly agree	**agree**	**uncertain**	**disagree**	**strongly disagree**
During therapy, I can bring up things that I think are important	A	B	C	D	E
Therapists listen carefully to what I have to say	A	B	C	D	E
Therapists explain test results and goals so that I understand them	A	B	C	D	E
Therapists are concerned about my emotional well-being	A	B	C	D	E
I am happy with my ability to do my daily routine at home	A	B	C	D	E
I am happy with my social life at this time	A	B	C	D	E
I do my homework/home exercises from therapy on a regular basis	A	B	C	D	E
I feel I am involved in making decisions about my therapy	A	B	C	D	E
I have goals for my future	A	B	C	D	E
I see improvement with my rehabilitation	A	B	C	D	E
It is easy to talk to my family about my progress in therapy	A	B	C	D	E
It is easy to talk to my therapists about my progress in therapy	A	B	C	D	E
It is easy to talk to my family about my goals	A	B	C	D	E
It is easy to talk to my therapists about my goals	A	B	C	D	E

DOI: 10.15453/2168-6408.1087

The inpatient facility protocol for client participation in goal setting requires therapists to identify and document client goals in the electronic medical record during the initial evaluation. Currently, no standard protocol exists for formalized collaboration of treatment goals beyond a prompt on the initial evaluation form. The discharge component of the Ss would again ask the participants to reflect on their most recent experiences with therapy pertaining to goal setting and goal collaboration at the day rehabilitation unit.

The Fs has been utilized by the hospital for quality assurance purposes for over 10 years. This Fs was filled out per the clinic's protocol, which is a discharge only, one time survey of satisfaction with the therapeutic experience. This form has four levels for reporting satisfaction, ranging between "excellent" and "poor." Daily attendance was tracked for each participant in the study; however, due to factors beyond the reach of this pilot program, it was not used as a dependent outcome measure. Psychometric properties of the Ss and the Fs have not been evaluated. A comparison was made between the responses on the admission and discharge Ss and rates of satisfaction as recorded on the Fs.

Experimental Intervention

The participants in the experimental group were responsible for generating, documenting, and maintaining their own therapy goals, eliminating the necessity for the therapists to translate or make presumptions about client goals. The participants were provided with a format for creation of goals that were self-set, or "owned goals," as described by Okun & Karoly (2007). The participants assigned to the experimental group were introduced to the program and oriented to all of the components of the goal-setting packet. When possible, the process included the participants and their family members. The goal-setting packet included a worksheet on how to identify potential goal areas, examples of long- and short-term goals, a *Declaration of Client Responsibility*, and the Goal Log book. The *Declaration of Client Responsibility* was signed by the participant, reinforcing his or her commitment to refer to and update the log book as necessary. The packet's Goal Log book provided space for multiple long-term goals with corresponding short-term goals or "stepping stones." Some participants required outside assistance with developing and maintaining their personalized Goal Log book. Therapists provided this, if necessary; however, they encouraged families to be the primary facilitator during the process. If possible, the participants performed all written documentation in the log book. When outside assistance was necessary, goals were documented verbatim for the participant in his or her own words. Throughout the duration of the program, the participants required varying amounts of outside cueing to use the log book. Some participants used the book daily with total independence, while others required daily cues to access the book and refer to it. Those who were less independent were reoriented to the purpose of the log book at least one session per week by their liaison therapist.

The participant and their family updated or modified the goals as they determined to be appropriate. Log books were used during family-therapist meeting sessions, as well as during clinical psychology sessions. The therapists were instructed to review the participant's goals and incorporate them in daily treatment plans and activities.

The participants from the experimental group took part in an informal exit interview administered by their liaison therapist. In this interview, they were asked to provide one or two statements on paper regarding their opinions about the impact that documenting their own goals had on their rehabilitation. The clinical staff that had clients in the experimental group were also provided with an informal feedback form requesting input on the impact of the client-managed goal setting program.

Control Condition

The process for goal setting for the control group followed the standard facility protocol. This protocol, as in the inpatient rehabilitation setting, requires therapists to ask clients to identify their therapy goals. The therapist then documents these goals in the medical record during the initial evaluation. Similar to the inpatient setting, there are no current standard protocols that exist for formal approaches to use for collaboration of treatment goals with clients beyond this prompt on the initial evaluation form. Similar to the study by Maitra & Erway (2006), the therapists' involvement in collaborating with the participants to identify goals generally resulted in a vague description of goal statements by the participant in the treatment plan. Therapists working with participants in the control group ask, "What are your goals for therapy?" This results in responses that are typically general and do not include specific long- term and short-term distinctions. Examples of these might be, "I want to walk", or "I would like to go back to work." Once client goals are documented in the initial evaluation, therapists create a treatment plan, identifying long- and short-term goals that focus on identified client deficits that demonstrate potential for improving functional levels of independence. The participants in the control group did not have their own Goal Log book.

Procedure

All disciplines at the day rehabilitation setting participated in the project, which included OT, PT and SLP; the clinic physician; and the clinical psychologist. Prior to the start of the project, all staff received a one-hour orientation and training session about the procedures and methods of the program. The orientation was lead by the programs' developer, an occupational therapist, and included the background, purpose, and methods of the program and a review of all documents. The documents included the Ss, which was created by a multi-disciplinary group from the clinic and given to both groups, and the goal-setting packet that was only given to the experimental group. The Ss was created to identify perceived satisfaction in three domains: interaction with staff, psychosocial wellness, and self-advocacy. The goal-setting packet included a

worksheet on how to identify potential goal areas, examples of short- and long-term goals, a *Declaration of Client Responsibility*, and the Goal Log book. An informal exit interview form for the participants in the experimental group was also reviewed. All of the therapists in the facility verbalized a good understanding of the program procedures and agreed to participate. No changes at the facility were made in the protocol for client assignment to therapy staff. Clients continued to be assigned to therapists based on caseload openings. All of the participants in the study were provided with a study introduction within the first two days of treatment. The participants from each group were asked to fill out the Ss at that time. This survey was created to assess perceived client satisfaction with the rehabilitation experience. The survey questions seek a comprehensive response to the participants' rehabilitation experience, and do not ask for discipline-specific feedback. The survey required the participants to reflect on their most recent experiences with therapy just prior to admission to the day rehabilitation unit. The participants in the control group then received therapy as prescribed by the referring physician with no further innovation program-based intervention. The participants in the experimental group were provided with the goal-setting information packet and oriented to its contents by a primary team therapist. The study was not blinded to staff, as clinicians were required to facilitate the use and incorporation of the client Goal Log book into daily treatment.

Both the experimental and control groups were asked to fill out a second copy of the Ss on the day of their individual discharge from the day rehabilitation program. The client's liaison therapist administered the Ss. They were not provided with their original copy for reference. The survey again required the participants to reflect on their most recent experiences with the interdisciplinary therapy occurring at the day rehabilitation unit. The participants from each group were also asked to complete the Fs, which is a standard, ongoing procedure at the facility.

Data Analysis

The data collected from the participants using the two surveys were first summarized descriptively (see Table 2 and 3). Fisher's Exact test was then used to compare the proportion of people reporting strongly agree/agree in the Ss upon discharge from therapy between the experimental and control group at the beginning and the end of the program intervention (see Table 4). Due to the small sample size, the response categories of "agree" and "strongly agree" each were combined, as were "strongly disagree", "disagree", and "uncertain" for the statistical analysis. The qualitative data included responses from the participants' semi-structured exit interviews and the therapist feedback forms. The same multi-disciplinary clinician group that had created the Ss reviewed and coded the participants' responses. In a formal meeting, this group identified three main themes that emerged across the responses. These were: (a) providing structure to therapy, (b) setting goal priorities, and

(c) strong goal ownership. The primary program investigator separated responses from the therapists' feedback into "positive" vs. "negative" categories referring to the intervention. Member checking followed the siloing of these responses with no contradictions found.

Table 2. *Mean Scores for Satisfaction Survey (Ss) Responses (average rating on 1-5 scale)*

Question		Experimental	Control
1. During tx, I can bring up things that I think are important	Admission	4.5	4.2
	Discharge	4.8	4.7
2. Therapists listen carefully to what I have to say	Admission	4.8	4.5
	Discharge	4.7	4.9
3.Therapists explain test results/goals so I understand them	Admission	4.4	4.3
	Discharge	4.4	4.7
4. Therapists are concerned about my emotional well-being	Admission	4.4	4.4
	Discharge	4.9	4.8
5. I am happy with my ability to do my daily routine at home	Admission	3.4	3.4
	Discharge	4.1	4.5
6. I am happy with my social life at this time	Admission	3.5	3.8
	Discharge	4.2	4.5
7. I do my home exercise from tx on a regular basis	Admission	3.8	3.4
	Discharge	3.9	4.0
8. I feel I am involved in making decisions about my therapy	Admission	4.1	3.8
	Discharge	4.5	4.5
9. I have goals for my future	Admission	4.7	4.0
	Discharge	4.6	4.6
10. I see improvement with my rehabilitation	Admission	4.4	4.0
	Discharge	4.7	4.7
11. It's easy to talk to my family about my progress in tx	Admission	4.7	3.7
	Discharge	4.6	4.3
12. It's easy to talk to my therapists about my progress in tx	Admission	4.2	4.3
	Discharge	4.5	4.7
13. It's easy to talk to my family about my goals	Admission	4.6	4.1
	Discharge	4.5	4.1
14. It's easy to talk to my therapists about my goals	Admission	4.5	4.3
	Discharge	4.5	4.6

Table 3. *Facility-wide Discharge survey (Fs); Excellent responses only*.

	Experimental N = 9	Control N = 8
I felt staff were courteous and respectful	7	6
I was satisfied with any treatment of pain	8	8
I participated in goal setting	9	6
I was satisfied with the skills of staff	8	8
I was satisfied with communication with staff	9	7
I felt staff satisfactorily explained procedures	9	6
I am satisfied with my discharge planning	9	4
I participated in patient/family teaching	5	6
I was always informed of progress	9	7
I am satisfied with my overall care	9	7

DOI: 10.15453/2168-6408.1087

Results

Quantitative results

The guiding hypothesis of this pilot program was that the participants in the experimental group would show greater positive ratings on the discharge Ss and higher scores of satisfaction on the Fs when compared to the control group. The quantitative findings did not support this hypothesis. On the Fs, more participants in the experimental group reported excellent in discharge planning than those in the control group (100% vs. 50%, P = 0.03) (see Table 3). However, the proportion of participants reporting excellent were statistically identical between the two groups for the other nine questions of this survey (Fs). It is interesting that the results of the Ss demonstrated no statistically significant differences in the proportions of participants reporting satisfaction between the two groups for all 14 questions, both at admission and discharge (see Table 4).

Table 4. *Study Satisfaction survey (Ss) strongly agree/agree versus disagree/uncertain: control and experimental*

Admission	**Experimental group (N = 11)**		**Control group (N = 10)**		**Fisher's Exact Test**
Question	**Strongly Agree/ Agree**	**Disagree or Uncertain**	**Strongly Agree/ Agree**	**Disagree or Uncertain**	**P**
1. During tx, I can bring up things that I think are important	11	0	9	1	0.48
2. Therapists listen carefully to what I have to say	11	0	9	1	0.48
3.Therapists explain test results/goals so I understand them	9	2	8	2	1.00
4. Therapists are concerned about my emotional well-being	10	1	9	1	1.00
5. I am happy with my ability to do my daily routine at home	6	5	6	4	1.00
6. I am happy with my social life at this time	5	6	6	4	0.67
7. I do my home exercise from tx on a regular basis	7	4	6	4	1.00
8. I feel involved in making decisions about my therapy	9	2	7	3	0.63
9. I have goals for my future	9	2	8	2	1.00
10. I see improvement with my rehabilitation	10	1	9	1	1.00
11. It's easy to talk to my family about my progress in tx	10	1	7	3	1.00
12. It's easy to talk to my therapists about my progress in tx	9	2	10	0	0.48
13. It's easy to talk to my family about my goals	10	1	6	4	1.00
14. It's easy to talk to my therapists about my goals	11	0	10	0	0.15

Discharge	**Experimental group (N=11)**		**Control group (N=10)**		**Fisher's Exact Test**
Question	**Strongly Agree/ Agree**	**Disagree or Uncertain**	**Strongly Agree/ Agree**	**Disagree or Uncertain**	**P**
1. During tx, I can bring up things that I think are important	11	0	10	0	1.00
2. Therapists listen carefully to what I have to say	10	1	10	0	0.48
3. Therapists explain test results/goals so I understand them	9	2	10	0	0.21
4. Therapists are concerned about my emotional well-being	11	0	9	1	1.00
5. I am happy with my ability to do my daily routine at home	9	2	8	2	1.00
6. I am happy with my social life at this time	10	1	8	2	1.00

7. I do my home exercise from tx on a regular basis	9	2	9	1	0.59
8. I feel involved in making decisions about my therapy	11	0	8	2	0.59
9. I have goals for my future	11	0	8	2	1.00
10. I see improvement with my rehabilitation	11	0	9	1	1.00
11. It's easy to talk to my family about my progress in tx	10	1	10	0	0.48
12. It's easy to talk to my therapists about my progress in tx	10	1	8	2	1.00
13. It's easy to talk to my family about my goals	9	2	7	3	1.00
14. It's easy to talk to my therapists about my goals	10	1	9	1	1.00

Qualitative results

Review of the exit interview statements from the experimental group provide insight into client perceptions of self-generated and maintained goal documentation during the therapy process. Participant feedback expressed overall high levels of satisfaction with use of the Goal Log book. The responses generally fall into three categories: (a) providing structure to therapy, (b) setting priorities, and (c) goal ownership. The overall theme in the comments appeared to be one of increased conceptualization for the participants on what they were working toward in the rehabilitation process. The following are representative examples of the participants' comments:

- "The log book helped me see how far I have come."
- "The log book keeps me focused" and "setting the goals initially helped me to crystalize what I wanted to accomplish."
- "The log book changed my way of thinking from 'I want to get stronger' to 'I want to be able to do *this* or I want to be able to do *that.*'"
- "The log book helped me in my sessions with the psychologist to focus on specifics versus the uncontrollable."

The control group received no exit interview and therefore insight into their perspective on the standard methods used for goal collaboration is unavailable.

Responses from the therapist feedback form were generally positive. The themes that emerged in these responses were:

- Goal ownership: "Instead of talking about how the therapist can get them better the conversation changed to what the client can and needs to do to get better."
- Provision of structure: "This process helped me to pinpoint what activity was most important to clients."
- Engagement: "The clients seem more proactive and focused on the activity when they know what they are working toward."

The negative feedback from the therapists focused primarily on the difficulty in working with the participants who had greater cognitive deficits, specifically memory. The therapists expressed concerns and difficulties with adhering to the procedures of the program when the participants

DOI: 10.15453/2168-6408.1087

required more than minimal cueing for use of the log book.

Discussion

The purpose of this innovative program was to explore the impact of providing clients with the opportunity to generate, document, and maintain their own goals. This paper describes a pilot program that incorporated strategies to maximize opportunities for clients and their families to participate in rehabilitation goal identification and documentation in a clinical setting and reports the results in context of occurrence. It was anticipated that through greater involvement in the goal setting process and using a Goal Log book for personalized documentation, the participants would have greater satisfaction with the rehabilitation process (Holliday, Cano et al., 2007).

The results of this program's quantitative measures showed statistical difference in satisfaction between the participants assigned to the experimental vs. the control group for only one question on the Fs, the question concerning discharge planning. No differences were found between the two groups on the Ss. Similarly, in the study by Holliday, Cano et al. (2007), no significant differences were reported on functional measures between the two participant groups.

In this program, qualitative results were obtained through semi-structured informal exit interviews of the experimental group. The participants' responses provide greater insight into how the daily use of the log books impacted therapy. The responses of the participants from this program were categorized into three themes: (a) providing structure to therapy, (b) setting priorities, and (c) goal ownership. In the study by Doig et al. (2009), a client-centered approach to goal identification was used to direct the content of the occupational therapy program with clients consisting largely of people with moderate to severe TBI. The qualitative results of this program fell into four themes: "(1) provision of structure, (2) goals and motivation, (3) goal ownership, and (4) impact of awareness on participation" (Doig et al., 2009, p. 563). The similar themes of structure and ownership suggest that through an increased involvement of clients in the process of goal development and management, clients are able to better conceptualize the ongoing experiences of rehabilitation.

The therapists who had worked with the participants in the experimental group had generally positive reports; however, they did identify some barriers to effective use of the log book with some participants. The therapists verbalized difficulty in working with participants who were more dependent in their daily use of the log book, due to decreased insight or recall. The therapists in the study by Doig et al. (2009) reported similar responses. Suggestions were made that use of traditional memory books for clients with cognitive deficits could occur initially in treatment with a "graduation" to use of a Goal Log book. Therapists felt that increased insight was required to use the Goal Log effectively. Therapists did feel that the Goal Log was effective and beneficial for participants who were able to

use the Goal Log with minimal outside cueing. The increased perception of therapists in the usefulness of client collaboration in goal setting is potentially an area for future analysis. Investigating whether this program influenced the therapists' future goal setting collaboration strategies would be of interest.

In the study by Holliday, Cano et al. (2007), the client priorities resulted in changes in the focus of rehabilitation interventions. Holliday reported, "this change appears to support individuals in maintaining both activity and participation, and may be important in promoting self-management and well being" (p. 579). It is unknown whether therapists in this program adjusted or changed the treatment to focus on client goals vs. therapist- or team-developed goals. In some of the responses by treating therapists, statements regarding activity focus and client goal prioritization suggest that this may have occurred.

Implications for Occupational Therapy Practice

Introducing a program similar to the one discussed in this innovative approach provides a pathway for client-centered treatment, but will it make a difference in outcomes? This study does not specifically answer that larger question, but it does provide some insight into methods for addressing client autonomy within a traditional rehabilitation setting. Cardol, De Jong, and Ward (2002) suggested that "autonomy, as the fundamental pre-requisite for participation, is a key concept for client-centered rehabilitation" (p. 970). Client-centered goal setting becomes more meaningful, as noted in the comments by this current study's participants, when the clients write the goals in a document that they can refer to as needed to identify the short-term and long-term reasons for the treatment that they are participating in at the moment. This moves beyond simply collaborating with a client to establish pertinent goals, to providing the opportunity for clients to participate throughout the rehabilitation process in goal generation, documentation, monitoring, and re-evaluation. Use of the Goal Log book required the participants to make personal decisions regarding on which areas to focus in therapy, and to engage in an ongoing reevaluation of the relevance of their goals. Life skills that are necessary for long term management of conditions, such as those seen by the participants in this pilot study, are problem solving, decision making, resource use, patient or health care provider partnership formation, and action taking (Lorig & Holman, 2003). The process of generating, documenting, and maintaining a personalized Goal Log book may reinforce these skills by providing a formalized method of monitoring their own progress in therapy. The qualitative information that was obtained from the experimental group and staff interviews suggest that both groups felt the experience was generally beneficial to the therapy process.

Limitations

Several limitations are evident in this pilot program. The results of this program were evaluated using quantitative and qualitative data.

DOI: 10.15453/2168-6408.1087

Due to the small sample size, the quantitative results demonstrate minimal to no differences in both surveys when they were compared, which may have been the result of a Type II error. The only statistically significant finding could be explained as a chance occurrence. In addition to the small sample size, the measures used to evaluate the results may not have been sensitive or accurate in measuring the changes between groups.

Neither survey in this pilot study has been evaluated for its psychometric properties. The Fs may not have been sensitive in addressing issues pertinent to the experiences of the population in the day rehabilitation setting. The Ss may also not be a sensitive measure for identifying the changes in a client's perceptions. As this survey was staff-generated, construct validity and internal consistency issues should be tested in future studies prior to commencing use in any future studies. The Ss may also not have accurately identified a client's perceptions of therapeutic experiences and relationships as the admission component of the Ss asked for reflection on experiences that occurred outside the day rehabiliation unit.

Including an exit interview component for the control group to obtain the groups' insights and perceptions on the goal-setting process could have provided invaluable qualitative comparisons. In addition, while attendance for both groups was tracked, no formalized means of determining why participants missed a session was included, and therefore this quantitative data was of little use. This eliminated a potential means to determine a client's commitment to the rehabilitation program and would be an area to address in a future study. Lastly, the informal exit interviews of the participants were often performed by a treating therapist, which may have influenced attitudes and responses. For example, participants may have responded positively to avoid conflict with the treating therapists. Not addressing the potential impact of having a treating therapist administer this interview compromises the responses. While evaluation of this pilot program demonstrates its limitations, addressing these could provide a guide for future clinical research projects on this topic area. In addition, defining key concepts, such as goal decision-making and goal management, could guide future study more specifically.

Conclusion

Client-centered practice requires clients and therapists to have the desire and ability to take part in shared decision making (Maitra and Erway, 2006). This would include providing the client with an opportunity for autonomy in goal establishment. This pilot program outlines an innovative approach that maximizes opportunities for the clients and their families to participate in the decision-making process through use of a goal generation and documentation process. The program identifies steps that go beyond collaboration between therapists and clients in goal setting. Instead, it encourages clients to manage their own therapy goals and plans while simultaneously developing a client-therapist partnership.

Of interest to the outcome of this program is that the intervention was incorporated in context, during true clinical encounters with clients while engaging in a dynamic multi-team rehabilitation experience. Scobbie, Wyke, and Dixon (2009) conducted a literature review for studies that "proposed a specific theory of behaviour change relevant to setting and/or achieving goals in a clinical context" (p. 321). Twenty-four papers were included in the review, and of those, only one of the interventions was "implemented by a standard multi-disciplinary team and incorporated within their routine rehabilitation practice" (p. 328). These authors suggest that studies must be incorporated into real-life settings to best assess feasibility and acceptability for optimizing implementation. While this current program was not addressing behavior change, the methods and process of implementing client-goal setting into a day rehabilitation experience can guide future study. One of the most significant lessons of this innovative program is the complexity of planning and the rigor required in thorough analysis of all components of performing any type of pilot study within that of a real life clinical setting.

The quantifiable impact of allowing clients to manage their own goals in therapy is not known based on the results of this pilot program. Future studies using a more robust design, with adequate power and measurement strategies, are necessary to better understand the impact this approach to client-centered care might have on satisfaction outcomes. The qualitative information from the participants' narratives provides some insight that goal ownership might impact the ability of clients to better conceptualize and understand their path through the therapeutic process. Incorporating this level of collaboration and client-provider partnerships may help further define the next generation of client-centered treatment.

DOI: 10.15453/2168-6408.1087

References

Adams, N., & Grieder, D. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery*. Burlington, MA: Elsevier Academic Press.

American Occupational Therapy Association. (2002). Occupational therapy practice framework: Domain and Process. *American Journal of Occupational Therapy*, *56*(6), 609-639.

Baker, S., Marshak, H., Rice, G., & Zimmerman, G. (2001). Patient participation in physical therapy goal setting. *Physical Therapy*, *81*(5), 1118-1126.

Barnard, R., Cruice, M., & Playford, E. (2010). Strategies used in the pursuit of achievability during goal setting in rehabilitation. *Qualitative Health Research*, *20*(2), 239-250.

Cardol, M., De Jong, B., & Ward, C. (2002). On autonomy and participation in rehabilitation. *Disability and Rehabilitation*, *24*(18), 970-974.

Doig, E., Fleming, J., Cornwell, P., & Kuipers, P. (2009). Qualitative exploration of a client-centered, goal-directed approach to community-based occupational therapy for adults with traumatic brain injury. *The American Journal of Occupational Therapy*, *63*(5), 559-568.

Holliday, R., Ballinger, C., & Playford, E. D. (2007). Goal setting in neurological rehabilitation: Patients' perspectives. *Disability and Rehabilitation*, *29*(5), 389-394.

Holliday, R., Cano, S., Freeman, J., & Playford, E. D. (2007). Should patients participate in clinical decision-making? An optimised balance block design controlled study of goal setting in a rehabilitation unit. *Journal of Neurologic Neurosurgical Psychiatry*, *78*(6), 576-580.

Klyczek, J., Bauer-Yox, N., & Fiedler, R. (1997). The Interest Checklist: A factor analysis. *American Journal of Occupational Therapy*, *51*(10), 815-823.

Law, M., Baptiste, S., Carswell, A., McColl, M., Polatajko, H., & Pollock, N. (2005). *The Canadian Occupational Performance Measure*, (4th ed.). Ottawa, ON: CAOT Publications ACE.

Lorig, K. R., & Holman, H. (2003). Self-management education: History, definition, outcomes, and mechanisms. *Annals of Behavioral Medicine*, *26*(1), 1-7.

Lorig, K. R., Sobel, D. S., Ritter, P. L., Laurent D., & Hobbs, M. (2001). Effect of a self-management program on patients with chronic disease. *Effective Clinical Practice*, *4*(6),

256-262.

Maitra, K., & Erway, F. (2006). Perception of client-centered practice in occupational therapists and their clients. *American Journal of Occupational Therapy*, *60*(3), 298-310.

Northen, J., Rust, D., Nelson, C., & Watts, J. (1995). Involvement of adult rehabilitation patients in setting occupational therapy goals. *American Journal of Occupational Therapy*, *49*(3), 214-220.

Okun, M. A., & Karoly, P. (2007). Perceived goal ownership, regulatory goal cognition, and health behavior change. *American Journal of Health Behavior*, *31*(1), 98-109.

Playford, E. D., Dawson, L., Limbert, V., Smith, M., Ward, C. D., & Wells, R. (2000). Goal-setting in rehabilitation: Report of a workshop to explore professionals' perceptions of goal-setting. *Clinical Rehabilitation*, *14*(5), 491-496.

Rogers, J. C., Weinstein, J. M., & Figone, J. J. (1978). The Interest Checklist: An empirical assessment. *American Journal of Occupational Therapy*, *32*(10), 628-630.

Rosewilliam, S., Roskell, C. A., & Pandyan, A. (2011). A systematic review and synthesis of the quantitative and qualitative evidence behind patient-centred goal setting in stroke rehabilitation. *Clinical Rehabilitation*, *25*(6), 501-514.

Scobbie, L., Wyke, S., & Dixon, D. (2009). Identifying and applying psychological theory to setting and achieving rehabilitation goals. *Clinical Rehabilitation*, *23*(4), 321-333.

Sumsion, T. (2000). A revised occupational therapy definition of client-centered practice. *British Journal of Occupational Therapy*, *63*(7), 304-309.

Sumsion, T., & Law, M. (2006). A review of evidence on the conceptual elements informing client-centred practice. *Canadian Journal of Occupational Therapy*, *73*(3), 153-162.

Townsend, E., Galipeault, J. P., Glidon, K., & Little, S. (2003). Reflections on power and justice in enabling occupation. *Canadian Journal of Occupational Therapy*, *70*(2), 74-88.

U.S. Department of Health and Human Services, The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979). *Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (The Belmont Report). Retrieved on Dec. 21, 2013 from http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html

DOI: 10.15453/2168-6408.1087