The Participants' Experience of a Goals-based Community Rehabilitation Service: the impact of using a Goals Menu.

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

ABSTRACT

This study explored the participant experience of using a goals menu in community rehabilitation. A goals menu is a list of goal statements from which the participant selects their rehabilitation goals. These goal statements are then individualised for each participant, and are used to guide their rehabilitation.

A phenomenological approach was used to explore the participant's rehabilitation experience, with emphasis on the impact of using a goals menu to set goals. Six participants were purposefully recruited from one Victorian Community Rehabilitation Service. Semi-structured interviews were completed.

The interviews were audio-recorded, transcribed, and analysed. The following themes were identified relating to the impact of the goals menu: 1) the goals menu provides direction and the development of a rehabilitation plan, 2) hope about a new future, 3) awareness of self: knowing own capabilities and limitations, 4) a way of working together: a collaboration, 5) a process for engagement in rehabilitation: the participant role in rehabilitation, and 6) a means of returning to an 'adapted' normal life.

In addition, participants described their role in goal-based rehabilitation as including their active engagement in rehabilitation, sharing their goals, 'doing the work', asking questions, seeking information, receiving advice, sharing their experiences about their rehabilitation progress, and making their own decisions.

This study suggests that that a goals menu is a useful tool in facilitating participant goal setting, especially with its direct relationship to promoting hope for a new future. It suggests that models of service provision should be based on the participant's role in rehabilitation. It also highlights hope and self-efficacy as important inter-professional education topics. In summary it has been demonstrated

that team work which is centred around the participant is instrumental in a positive rehabilitation experience, and supports the practice of person centred care.

STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by The Alfred Ethics Committee (44/09) and by the Faculty Human Ethics Committee of the Faculty of Health Sciences, La Trobe University (FHEC09/211).

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Introduction

Rehabilitation is defined by Stucki, Cieza and Melvin (2007), as a major health strategy “to enable people with health conditions experiencing or likely to experience disability to achieve and maintain optimal functioning in interaction with their environment” (p. 282).. Rehabilitation is provided in settings on a continuum from acute hospitals to community services.

In Victoria, Australia, time–limited, individualised community rehabilitation services are provided to adults who live in the community. Frequently they are frail, disabled, chronically ill, or are recovering from a traumatic illness or injury and will have clearly identifiable goals. The majority of the case load in most community rehabilitation services is older people[1] (Department of Human Services, 2008). The aim of community rehabilitation is to improve client health outcomes, and to assist clients to achieve their maximum reintegration into their community (Department of Human Services, 2008). This is achieved through the efforts of interdisciplinary healthcare professionals focussing on the client’s needs and goals (Bloom et al., 2006; Leach, Cornwell, Fleming, & Haines, 2010).

Rehabilitation services comprise interdisciplinary teams and use a team approach in the delivery of their services. Interdisciplinary teams refer to a group of healthcare professionals from varied discipline backgrounds who use their professional skills and knowledge to propose solutions to the complex, multifactorial, problems commonly presented (Conneeley, 2004; D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005; Wade & de Jong, 2000). These complex problems require different interventions delivered by numerous people who work on a specific

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[1] An older person is defined as a person aged 65 years or over, an Aboriginal or Torres Strait Islander person aged 45 years and over, or a person with an age related illness (Department of Human Services, 2008, p. 88).

area of need, frequently in a set order to address the well-being of the client (Bovend'Eerdt, Botell, & Wade, 2009; Hurn, Kneebone, & Cropley, 2006). Occupational therapists are members of community rehabilitation teams, as are consultative medical services, dietetics, nursing, physiotherapy, podiatry, social work and speech pathology (Department of Human Services, 2007). Interdisciplinary teams deliver effective health care using collaborative practice (The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, 2005) and members of interdisciplinary teams may or may not include the client (Mickan, Hoffman, & Nasmith, 2010). The Healthy Teams Model described by Mickan and Rodger (2000) relates to the practice of team work within health environments, and provides ideas which will be drawn upon in this study.

Person centred practice is an important concept in occupational therapy. The principles of person centred practice define a therapy process that “respects, informs, and enables clients to become active partners in determining their own goals and strategies of therapy” (Kielhofner, 2002, p. 163), and which places the person centrally within the rehabilitation service with their needs and wishes being paramount (Dow, Haralambous, Bremner, & Fearn, 2006). Models of practice are useful in providing the concepts for determining the intervention approach required in person centred practice (Kielhofner, 2002). Occupational therapy theories have been developed which guide the practice of occupational therapists and which are consistent with person centred practice. Theories and models of practice guiding service delivery contribute to the experience of clients as they contribute to the cultural environment in which the service is provided (Townsend & Polatajko, 2007).

One commonly used theoretical model is the Canadian Model of Occupational Performance and Engagement (CMOP-E) which highlights three constructs: the person, the environment and the occupation (Townsend & Polatajko, 2007). People act on their environment through occupation (Townsend & Polatajko, 2007). In rehabilitation, clients express the occupations they need to, or wish to, return to as goals. That is, client goals are occupations. Occupational therapists enable occupation through the use of a range of enablement skills such as adapting, advocating, coaching, collaborating, consulting, coordinating, designing/building, educating, engaging and specialising (Townsend & Polatajko, 2007). Occupational therapists draw on these skills to address the client's personal or environmental factors, thus enabling goal attainment. The authors of the CMOP-E also developed a process framework, the Canadian Practice Process Framework (CPPF), for providing person centred occupational therapy (Townsend & Polatajko, 2007). The CPPF demonstrates the client's journey in an occupational therapy service, and includes eight steps through which a client progresses. These eight steps are: enter/initiate, set the stage, assess/evaluate, agree on objectives/plan, implement plan, monitor/modify, evaluate outcome, conclude / exit.

Another key person-centred occupational therapy theoretical model is the Model of Human Occupation (MOHO) (Kielhofner, 2002). This model proposes that a person's participation and performance in occupation occurs within physical and social environments, and results in development of occupational identity and competence, leading to occupational adaptation. The person's performance in occupation is due to their volition (that is, their competence and effectiveness [personal causation], their values and their interests), their habits, and their capacity for performance. Occupational therapists enable clients to change by working with the person, the environment, or their occupational performance through use of therapeutic strategies such as validating, identifying, giving feedback, advising, negotiating, structuring, coaching, encouraging and providing physical support (Kielhofner, 2002). Concepts which are related to personal causation and which are found in other fields of study is the concepts of self efficacy (Gage & Polatajko, 1994) and self awareness (Toglia & Kirk, 2000).

Beyond the practice of occupational therapy, community rehabilitation within Victoria uses the Health Independence Program (HIP) model, first presented in the HIP guidelines which were developed with the aim of meeting the needs of the client by improving their health outcomes and their community integration (Department of Human Services, 2008). The HIP model is a process model consisting of six discrete steps through which the client progresses: 1) access and initial contact; 2) initial needs identification whereby eligibility for the program is determined; 3) assessment; 4) care planning and implementation; 5) monitoring and review; and 6) transition and exit from the rehabilitation service. Embedded within steps 3 and 4 of the HIP model is the concept of the development and treatment of client goals. A focus on a client's own goals is viewed as a key component of program delivery and is centred in the practice of person centred care (Department of Human Services, 2008). Both the HIP and the CPPF assist in guiding the client's rehabilitation journey.

However, although the HIP guidelines recommend that goal setting is implemented with clients, the guidelines do not specifically inform the practice of goal setting, with individual community rehabilitation services having no guidance on how to set goals. The implementation of the HIP guidelines lay with each individual community rehabilitation service. To date, within the literature there is no identified best process for implementing goal setting with clients (Bloom et al., 2006). Furthermore, challenges have been identified with goal setting procedures and tools in rehabilitation setting, including the site of the current study. For example, all staff at the research site had previously participated in a study conducted by the National Ageing Research Institute to explore the possible use of the Canadian Occupational Performance Measure (COPM) in community rehabilitation services (Smith et al., 2001).

The COPM is a standardised person centred tool developed by Canadian occupational therapists to enhance the practice of goal setting in occupational therapy, including rehabilitation. The COPM assesses a client’s perceptions of their abilities in self-care, leisure and productivity (Smith et al., 2001). The COPM ensures the inclusion of client perspectives in setting goals, thereby ensuring that occupational therapy practice is person centred. Although the COPM is a useful tool in occupational therapy settings (Carswell et al., 2004; Wressle, Eeg-Olofsson, Marcusson, & Henriksson, 2002) it is more difficult to administer in multidisciplinary teams. It has been identified that the discipline involved in the actual setting of the client goals resulted in a bias toward the identification of goals from that discipline, and was therefore not truly enhancing multidisciplinary goal setting (Smith et al., 2001). It was also reported that the COPM is time consuming and difficult to administer (Donnelly & Carswell, 2002) and is difficult to use with clients who have cognitive or communication impairments (Chen, Rodger, & Polatajko, 2002). After participation in the study by Smith et al, the staff at the research site reported that the COPM took too long to administer thus preventing them from initiating the treatment that the client was expecting. As a result, there was a collective hesitancy by most staff to adopt the COPM methodology. Thus, different tools were sought to guide the practice of goal setting to promote person centred practice.

A goals menu is one version of a structured goal setting tool which uses categories or options to assist translating client concerns into goal statements (Kuipers, Carlson, Bailey, & Sharma, 2004). It is perceived to be useful in overcoming some of the difficulties associated with involving clients in the goal setting process (Kuipers et al., 2004). Staff at the research site considered a trial worthy, as a goals menu could accommodate the range of goals seen as important by various team members in a time-efficient way.

The goals menu used in this study consists of 56 statements which were generated by the community rehabilitation therapists at the research site based on their clinical experience of previous types of goals addressed in rehabilitation. In using the goals menu, the client identifies from the goals menu activities which they currently find difficult to do and which they would like to do better. The goal statements selected by each client become the focus of their rehabilitation program. [See Figure 1: Goals Menu].

FIGURE 1

Goals Menu

- This is a list of activities / goals that might help you to determine what you want to work on during your rehabilitation.
- Please read through this list and tick the activities / goals that you are finding difficult, and would like to do better, following your recent change in health.
- If you have ticked a lot of activities / goals, please circle your five most important ones and this will be discussed further with your therapist.

Out & About

☐ Get into/out of a car
☐ Use public transport
☐ Do my own banking/pay bills
☐ Return to driving
☐ Go shopping by myself/with others
☐ Manage climbing steps / stairs

Socialisation/Leisure

☐ Meet people and socialise with them
☐ Return to my previous leisure activities
☐ Get to my local community
☐ Find a new leisure activity

Work & Study

☐ Return to work/study
☐ Caring for others (children/partner)

Emotions and Feelings

☐ Make decisions for myself
☐ Cope with/express my feelings better
☐ Deal with family issues
☐ Feel less anxious
☐ Learn how to relax

Communication & Memory

☐ Speak more clearly
☐ Communicate better over the phone
☐ Educate my family on best ways to help
☐ Make handwriting better
☐ Be more confident with my communication
☐ Understand other speakers better
☐ Read better
☐ Planning my day/week
☐ Develop memory strategies

My Body

☐ Have better balance/stop falling
☐ Have stronger legs
☐ Have stronger arms & hands
☐ Learn how to better control my pain
☐ Lose weight
☐ Walk better/further
☐ Manage/reduce my dizziness
☐ Manage/reduce tiredness/fatigue
☐ Learn more about healthy eating
☐ Gain weight

☐ Learn more about my special diet

Please turn over

At Home

☐ Get into/out of chair/bed
☐ Cook/heat meals
☐ Do my own gardening/home maintenance
☐ Get up from the floor (eg, after a fall)
☐ Clean my house
☐ Do my own laundry
☐ Make my home easier to get around (e.g. rails, ramps)

Personal Care

☐ Be able to use cutlery
☐ Control my bladder/bowels better
☐ Get into/out of the shower/bath
☐ Be able to wash and dry myself
☐ Groom myself better (e.g. brush teeth & hair, shave)
☐ Eat/drink without coughing/choking
☐ Get on/off the toilet more easily
☐ Dress with more ease

Medical

☐ Manage/reduce pressure wounds
☐ Better manage my medication

Education

☐ Learn more about my condition
☐ Learn about community supports

Other

☐ ……………………………………………………………………………………………
☐ ……………………………………………………………………………………………

Additionally, a process for administering the goals menu was developed with the aim of enabling interdisciplinary goal setting. This process is described as:

1. The goals menu is completed by the client, with or without assistance from family, carers or rehabilitation staff, within the first two contacts with the community rehabilitation service, for each new episode of care.

2. The therapist and client prioritise the goals to be addressed, and the therapist individualises the goal statement by writing a clear and specific goal which has meaning for the client. The written goal aims to be **s**pecific, **m**easurable, **a**chievable, **r**ealistic and **t**ime-limited, as per best practice in goal setting (Playford, Siegert, Levack, & Freeman, 2009). These characteristics are termed SMART.
3. A written copy of these personalised goals is provided to the client and is reviewed during the rehabilitation program. Each goal may be addressed by any of the disciplines involved in the client's rehabilitation program or may be represented by only a single discipline. An example of a single disciplinary goal is:

Client goal:	*to purchase own groceries.*
Physiotherapist input:	Client to be able to independently walk 100m around the shops, using a 4 wheel walker in 8 weeks
Occupational therapist input:	Client to be able identify the items on shopping list and place in a basket balanced on her 4 wheel walker.
Speech pathologist input:	Client to be able to clearly ask for assistance when required.

The individual discipline goals can be grouped in one interdisciplinary goal to ensure that all rehabilitation staff is addressing the same client goal:

> Client will be able to ask for assistance as required to independently purchase her own groceries using a shopping basket whilst ambulating with a 4 wheel walker in 8 weeks.

Each client goal becomes the focus of the rehabilitation program and the goal provides the basis of discussion at the regular client review meetings. Communication to the general practitioner and other relevant health professionals is also based on the client goals and their achievement of those goals, as identified by the rehabilitation therapists.

The perspective of the client (commonly termed consumer in mental health services) is paramount in the planning, delivery and evaluation of mental health services, and includes Governmental policies aimed at ensuring consumer participation (Department of Human Services, 2009). However, within rehabilitation there is limited discussion regarding the importance of the client's voice in service delivery, planning and evaluation. A leading researcher in the area of person centred care, Cheryl Cott, recommends that it is important that the clients' perspective of their rehabilitation is ascertained so that the care provided reflects their needs (Toronto Rehab, 2012).

Based on occupational therapists' understanding of occupation, defined by Townsend and Polatajko as "any activity or set of activities that is performed with some consistency and regularity, that brings structure, and is given value and meaning by individuals and a culture" (2007, p. 19), each client's experience of community rehabilitation will be different due to the dynamic interaction between the person, their environment, and their occupation. Therefore, understanding the client's experience of goals-based rehabilitation using a goals menu is useful in determining the value of the goals menu in addressing client need. The premise of individual experiences in rehabilitation provided a rationale for conducting this study.

Since the implementation of the goals menu in 2004, the clients' experience of using the goals menu in community rehabilitation has not been investigated. This study will explore the client experience of engaging in a goal based community rehabilitation service, using a goals menu. It will identify the impact of using a goals menu on the clients' rehabilitation.

The impact of using a goals menu is identified as an important element which contributes to a positive rehabilitation experience. These findings can inform the practice of occupational therapists and other health professionals in interdisciplinary rehabilitation teams in relation to setting goals with clients, and the impact and expected benefits of this process.

This thesis will explore the literature relating to clients' experience in rehabilitation and the elements of rehabilitation which contribute to that experience: person centred care, hope and self-efficacy. It will also explore the current understanding of the rehabilitation team and how this influences the client experience of rehabilitation. The evidence supporting the use of the goals menu within the broader context of goal setting in rehabilitation will be discussed. The methodological approach used in this study, phenomenology, will be discussed and details of how the methodology was applied will be outlined. The study results will be described in the findings chapter, followed by consideration of the results in relation to the literature in the discussion chapter. Implications for practice and further research will be considered in the conclusion. Each of these implications will be discussed in detail to aid understanding of the participants' experience of a goals-based community rehabilitation service, and the contribution of the goals menu to that experience.

Literature Review

The clients' experience of rehabilitation and the elements contributing to that experience

This chapter explores the literature relating to clients' experiences of community rehabilitation. This will include literature covering the elements of rehabilitation which contribute to the experience, namely: models of service provision, person centred practice, self efficacy, hope, goals and goal setting processes, and working in a health team. The perspectives and influence of occupational therapy in these elements will be a particular focus. This chapter will identify current knowledge about participant experience with a view to understanding gaps in the research to position this study in the context of participant experiences in goal based rehabilitation.

In this chapter, the user of the rehabilitation service will be referred to as a client, as that denotes their relationship with that service at that point in time. However, when describing the major underlying philosophy of rehabilitation, the term person centred care shall be used rather than client centred care. This terminology is deliberately applied as it supports the wishes of clients to be treated as people (d'Cruz, personal communication, February 2011). In the methodology and findings chapter, the term client is replaced by participant to highlight that the findings are related to the clients who participated in *this* research, and not to all clients of the rehabilitation service. In the discussion chapter, the term participant refers to clients in *this* research, whereas the term clients relates to the findings of other studies.

A database search was conducted in August 2010 using CINAHL, PsychInfo and Medline to find relevant literature. The search was restricted to articles published between January 2000 and August 2010, published in English in peer reviewed journals. Databases were searched using the search terms “goal setting”, “goal framework”, “goal checklist”, goal identification”, “goal$”, “client centred”, “client perspective”, “client experience”. The symbol $ is a truncation term used in the databases. Boolean operators were used to restrict the search parameters to rehabilitation. The reference list of significant articles were reviewed for other publications.

Understanding service provision.

Models and frameworks are useful in directing the client’s pathway through rehabilitation, and hence influence the clients’ experience in a rehabilitation service. Two models that assist in guiding the client journey in rehabilitation are the Health Independence Program (HIP) model of care (Department of Human Services, 2008) and the Canadian Process Practice Framework (CPPF) (Townsend & Polatajko, 2007). The HIP model details the client journey from first involvement with the service through to discharge, and was described in the introduction. The model is from the perspective of the service and states the actions to be undertaken by a service to ensure that the client’s rehabilitation best meets their needs. However, the model does not indicate the client’s own involvement in their rehabilitation, other than assuming their ongoing attendance to progress through the separate steps.

Townsend and Polatajko (2007) introduced the CPPF as an occupational therapy client centred model which demonstrates the journey undertaken by a client in any occupational therapy service. The CPPF goes further than the HIP model in outlining the client journey in a health service. Firstly the CPPF identifies that alternate routes are possible and does not assume that the client progresses through each stage. For example, discharge may occur without the provision of treatment by the occupational therapist. Secondly, the CPPF briefly mentions the role of the client at each stage, by the inclusion of “with client participation and power sharing as much as possible or desired” (Townsend & Polatajko, 2007, p. 251). However, like the HIP model, the focus is from the perspective of the service and does not view the client’s experience in rehabilitation from the perspective of the client. The focus is on therapist “doing to” the client, rather than “doing with”. That is, neither the HIP nor CPPF situate the client within the model.

In summary, the HIP and CPPF models detailing the client journey have not fully incorporated the perspective of the client, although the models themselves influence the client’s rehabilitation experience. Lack of inclusion of a client’s perspective misses an opportunity for services to ensure that service provision reflects client’s needs, and does not inform clients about their role in their rehabilitation to achieve desired change. Understanding the client’s experience in rehabilitation may contribute to models of care which reflect their needs and which inform clients of the opportunity to enhance their outcomes.

Client Experience in Rehabilitation.

The experience of each client in rehabilitation is unique. This is as a result of the influences of the societal and practice contexts in which the rehabilitation occurs including the physical, social, cultural and institutional influences on the rehabilitation environment (Townsend & Polatajko, 2007). Personal factors and characteristics, such as the resources, knowledge, skills, abilities, habits and beliefs, of each client and their team of therapists, combine with environmental factors to produce a unique experience of rehabilitation for each client (Townsend & Polatajko, 2007). Table 1 outlines societal and practice contexts relevant to this study, highlighting the range of environmental factors, as part of the CMOP-E, contributing to each person's experience of community rehabilitation.

TABLE 1

Societal and Practice Contexts Relevant to this Study

Environmental factors	Societal contexts	Practice contexts
Physical	The built environment such as cities	Treatment location: home or at a community centre
Social	The client's own family and social networks	Health professionals involved in the client's health care, and the practice of collaborative team work
Cultural	Client's age, race, ethnicity and gender	The philosophy of person centred care, as practised by the team members
Institutional	Health system policies, e.g. HIP guidelines	The policies and procedures of a service, such as the use of a goals menu to facilitate goal setting

Understanding the client's experience in rehabilitation has more recently been discussed in the research literature. Researchers have conducted interviews with clients who have participated in different types of rehabilitation, including inpatient rehabilitation (Dixon, Thornton, & Young, 2007), neurological rehabilitation (Wain, Kneebone, & Billings, 2008) and in-patient occupational therapy (Palmadottir, 2003, 2006). The application of person centred care (Palmadottir, 2006; Wain et al., 2008) and the attributes of self-efficacy (Dixon et al., 2007) emerged as key factors contributing to a client's experience in rehabilitation. Person centred care, self-efficacy, and the related concept, hope, will be discussed to provide a context of current thinking in this area.

Person centred care.

Person centred care is an important concept in occupational therapy, with this being reflected by the application of two person-centred models, Canadian Model of Occupational Performance and Engagement (CMOP-E), and Model of Human Occupation (MOHO) within the profession. Person-centred care is considered to be a philosophy or approach that “reflects the needs of individuals and groups of clients” (Cott, 2008, p. 89). It encompasses a focus on the client (Dow et al., 2006; Rebeiro, 2000), and on their goals (Cott, 2004; Sumsion & Law, 2006), which together facilitate successful rehabilitation (Bloom et al., 2006; Leach et al., 2010).

Person centred care refers to a client’s “active involvement in managing their health care and their rehabilitation process in partnership with service providers who understand and respect their individual needs” (Cott, 2004, p. 1418). Person centred practice is a respectful and collaborative partnership between clients and service providers who are responsive to client’s needs, wishes and values (Australian Commission on Safety and Quality in Healthcare, 2010; Dow et al., 2006). The premise of person centred care implies user involvement in the rehabilitation service, and collaboration between the client and healthcare professionals (Palmadottir, 2003).

Other important dimensions in the practice of person centred care include: the health environment’s contribution to the physical comfort of the client (Cott, 2008); the provision of support to the client in their preparation to return to living back into the community (Cott, 2004); the provision of care needs to be coordinated and integrated (Dow et al., 2006), and tailored to the client’s own needs which requires that the client is involved in determining their goals (Cott, 2004; Sumsion & Law, 2006); the provision of support to address the client and their family needs; and, ensuring that the service is accessible and easy to navigate for the client (Dow et al., 2006). The focus of person centred care is broader than is commonly discussed in the literature, as person centred rehabilitation encompasses more than goal setting and shared decision making (Cott, 2004).

The practice of person-centred care requires that the focus of care is on the person and not their illness or disability (Rebeiro, 2000) and that the therapist maintains their role as expert on the health condition and in subsequent treatment (Sumsion & Law, 2006). Demonstrating this respect requires the health professionals to believe in their client's potential, to value their client's life experiences, and to recognise the client as the expert in relation to themselves (Corring & Cook, 1999) and their disability (Law, Baptiste, & Mills, 1995). This requires service providers to get to know their clients as people (Dow et al., 2006).

Respect for the client is also demonstrated through the provision of choices during a client's engagement with health services. The choices provided to the client are influenced by the client's capabilities and stage of illness or disability (Sumsion & Law, 2006). Choices must be meaningful to the individual client (Rebeiro, 2000). The provision of choice at each stage of the client's health journey requires a collaborative working relationship between the client and therapist. A collaborative relationship accommodates client experiences prior to and during their engagement with the health service. Therapists need to be flexible in order to deliver choice at each stage of the health journey (Dow et al., 2006; Sumsion & Law, 2006).

Communication is an important element in the practice of person centred care. Health service providers are required to effectively and efficiently work together in order to maximise health outcomes (The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, 2005). Effective communication can address issues of power by aiming to shift the power toward the client so that they can set their own goals, achieve their objectives and effect outcomes (Sumsion & Law, 2006). This is supported by the work of Cott (2004) where clients identified that being educated by health care providers facilitated their self direction and their decision making.

Central to communication and the client's experience of rehabilitation is the client-therapist relationship. This relationship is one element contributing to the client experience through the personal factors of both the client and the therapist: knowledge, skills abilities, habits and beliefs (Townsend & Polatajko, 2007). The client – therapist relationship is an important determinant of the success of rehabilitation (Palmadottir, 2006). The manner in which therapists practise their role, share their power and build connections contributes to the client and therapist relationship (Palmadottir, 2006). Townsend and Polatajko (2007) recommend the concept of enablement as what occupational therapists do, that is, the way in which they practise. The Canadian Model of Client-Centred Enablement (CMCE) portrays occupational therapists core competency within the boundaries of a client-therapist relationship (Townsend & Polatajko, 2007). Enablement is at the core of person centred practice (Townsend & Polatajko, 2007). Person centred enablement occurs through occupational therapists use of enablement skills in a collaborative relationship with clients (Townsend & Polatajko, 2007).

Person centred care: the client's perspective.

Understanding person centred care is best ascertained from the client's own perspective (Corring, 1999). Occupational therapists' interpretation of person centred care is that the client is the expert in their own occupations, and the client must be an active partner in the occupational therapy process (Townsend & Polatajko, 2007). The overarching need expressed by clients with regard to the philosophy of person centred care is that they are valued as a human being (Corring & Cook, 1999), are listened to with dignity and respect and are treated as a person (D'Cruz, personal communication, February 5, 2011).

Rehabilitation clients have indicated that the practice of person centred care is critical to optimising their experience of rehabilitation (Wain et al., 2008). Wain et al sought to understand the client experience in rehabilitation through identifying the ways in which clients' perceived rehabilitation. She interviewed eight clients who had received neurologic rehabilitation in order to understand their experiences. It was found that positive client experiences were related to the application of person centred care, perceived by the clients as the extent to which they directed and lead their rehabilitation, and by the extent in which they received individual and holistic care. This qualitative study was comprehensively reported with strong evidence of client voices being accurately represented in the findings. Rehabilitation was perceived to be positive when the clients owned their rehabilitation and it held value to them. Wain et al (2008) found that the provision of a therapeutic atmosphere, such as a friendly and relaxed environment, facilitated the person centred approach. A positive perception of rehabilitation was related to the application of person centred care. This study highlights how person centred practice is instrumental in the delivery of successful rehabilitation. Consistent with these findings, the person-centred approach has been identified as important in Victorian Government policy in the HIP guidelines however, in the HIP guidelines, the person is not situated at the centre of care.

In 2004, Cott, a physiotherapist, conducted comprehensive qualitative research to identify what was important for clients with long-term physical disabilities who had received rehabilitation. She identified that clients wanted: service providers to understand their specific needs as individuals as well as their health conditions; active involvement in setting their goals and in decision making; to be educated in order to be self-directed and make decisions; to be prepared for a return to community living; to receive emotional support from staff in the form of advice; to receive encouragement and direction; to have coordination of services and to have ongoing access to rehabilitation after discharge.

Qualitative research in rehabilitation literature suggests that in addition to the application of person centred care as a key factor contributing to the client's experience in rehabilitation, the attribute of self efficacy, and its related concept hope, are important factors.

Self efficacy and hope.

Self efficacy and hope are positive psychological constructs. Snyder, Lehman, Kluck and Monsson (2006) assert that both are goal focussed and are based on what a person can do as opposed to what they can't do: they each have a client asset focus. However their differences lie in their key focus with respect to goal achievement. Self-efficacy consists of outcome expectancies, that is, what is the likelihood of an outcome occurring, as well as efficacy expectancies, that is, how can I achieve the goal described by the outcome. Together, these expectancies focus on the thinking undertaken by individuals with respect to goal directedness for a specific situation (Snyder et al., 2006). Likewise, hope is also concerned with thinking about goals, but it assumes a global process, that is, hope is developed from all goal pursuits and is not related to the person's perception of performance for each activity.

Self Efficacy.

Self-efficacy is a person's belief about their capabilities to perform an activity that influences the events affecting their lives (Dixon et al., 2007; Toglia & Kirk, 2000) and it relates to their confidence to achieve a desired goal (Scobbie, Wyke, & Dixon, 2009). It relies on a client's recognition of their own progress (Dixon et al., 2007). Self-efficacy is a belief in personal ability to perform a specific task, and is generated from four interrelated experiences: 1) performance accomplishments, that is the degree of accomplishment, such as success or failure ; 2) vicarious experience which is a process of comparison between self and someone else; 3) social persuasion, such as encouragement or discouragement; and 4) emotional arousal, that is, an individual's perception of negative emotional response in unfamiliar tasks which may result in a perceived ability of success in that situation (Dixon et al., 2007; Nieuwenhuijsen, Zemper, Miner, & Epstein, 2006). Self-efficacy can differ in terms of magnitude and strength (Gage & Polatajko, 1994). The magnitude of self-efficacy refers to the relative difficulty of the task that is being rated, and strength refers to the degree of belief that a person has about their ability to succeed (Gage & Polatajko, 1994). Although self-efficacy is not a global construct, and is dependent on each individual activity (Nieuwenhuijsen et al., 2006; Snyder et al., 2006), the degree of self-efficacy can be generalised to other activities (Gage & Polatajko, 1994).

Self-efficacy is believed to be a fundamental requirement in health, especially in health services delivering person centred care (Nieuwenhuijsen et al., 2006). Self efficacy is similar to the concept of personal causation in the Model of Human Occupation, and is therefore important in the practice of occupational therapy.

Self-efficacy is an important component of the delivery of person centred care, as the development of self-efficacy by clients enables them to retain responsibility, which is the foundation principle of person centred care (Sumsion, Craik, & Glossop, 2006). Self-efficacy was identified by Scobbie, Wyke and Dixon (2009) as a theory of behaviour change relevant to the practice of goal setting. It is believed to influence client motivation and participation in rehabilitation (Dixon et al., 2007). Self efficacy has been attributed to positive health outcomes (Snyder et al., 2006).

In a comprehensive study presenting client voices in the findings, Dixon (2007) demonstrated that a client's engagement in the rehabilitation process contributed to the development of their self efficacy. The clients identified the importance of relying of themselves in rehabilitation, using attributes and skills such as having self reliance and determination, and being able to recognise their own improvement, thus facilitating the development of self-efficacy. Clients also highlighted the importance of others during rehabilitation, including staff, and other clients, and that the ability to compare their own performance was as important as receiving external reassurance. The process elements of rehabilitation, such as using a goal setting system, approaching rehabilitation as a routine, and seeking advice and guidance from staff were all sources for self-efficacy.

Hope.

Snyder's theory of hope is based on positive psychology, which aims to make normal life more fulfilling. Snyder et al. (2006) stated that hope is a goal directed cognitive motivational process which influences a person's emotions in response to the consequence of their goal pursuit. Hope is the "person's perceived ability or internalised belief that they can produce goals" (Snyder et al., 2006, p. 89).

It consists of two interactive thinking processes: pathway thinking, which is the planning to meet a goal, and agency thinking which is, the goal directed energy.

Hope can be expressed along a continuum from high hope to low hope. Positive benefits are identified by having high hope, which incorporates the ability to identify more goals and more pathways to achieving each goal, the ability to stay focussed on goals, and the ability to set ‘stretch’ goals which are realistic but require considerable effort. People with high hope are more likely than people with low hope to abandon unreachable goals. Hope needs to be nourished and can be taught by using specific strategies (Snyder et al., 2006).

The idea of hope is discussed in many areas of health, especially in mental health, but less so in rehabilitation. In a well conducted qualitative study where people who had experienced a stroke discussed a) the patterns of hope they manifested after the stroke, and b) the factors associated with their patterns of hope, it was suggested that hope is a concept that positively affects rehabilitation clients, and that inspiring hope in individuals is an emerging philosophy of rehabilitation (Bays, 2001). Bays, found that for people who had experienced a stroke, hope consisted of positive anticipation, involved active participation, was a forward moving process, was an inner sense of self that change and improvement would result, or was a faith in God. In addition, when clients continued to hope, hope was life sustaining, was based on realistic possibilities, and was derived from relative comparison and connectedness. Finally, Bays suggested that hope was a desire for previous abilities, and that functional mobility was important. No studies were identified that explored hope or self-efficacy in community rehabilitation services.

Team approach.

Community rehabilitation services consist of interdisciplinary teams. Interdisciplinary teams require a degree of collaboration as they share a common goal, a common decision making process (D'Amour et al., 2005) and have group responsibility for the final product (Conneeley, 2004). Relationship between the health care professionals and the client, and between each of the health care professionals are important factors relevant to interdisciplinary rehabilitation teams which can impact on the clients' experience of rehabilitation.

A recent approach regrading the effective delivery of health care is interdisciplinary collaborative practice, a term which is related to interdisciplinary teams however focussing on process rather than structure (Petri, 2010). Occupational therapists in Canada have been key stakeholders in driving the development of principles and framework of interdisciplinary collaboration (The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, 2005). Interdisciplinary collaboration, in the context of health is defined as "an interpersonal process characterized by healthcare professionals from multiple disciplines with shared objectives, decision making, responsibility, and power working together to solve patient care problems" (Petri, 2010, p. 80). Collaboration is enhanced when a team's communication structures and internal processes enable health professionals to work together in the most effective and efficient way to produce the best health outcomes for individuals and families (The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, 2005).

Interdisciplinary collaboration commonly refers to the staff involved in the delivery of healthcare, however, Mickan, Hofman and Nasmith (2010) suggest that the concept of interdisciplinary collaboration can be extended to include the client as a member of the health care team. The notion of the client as a member of the healthcare team is in keeping with person centred practice whereby the person is at the centre of their own care. A person can only be central if there is a team which surrounds that person, and this team functions effectively. It is therefore recommended that the client is included as a team member in an effective health care team. Mickan and Rodger, (2005) suggest that including the client as a member of the healthcare team may enable the relationship to be overtly explored for the duration of the rehabilitation program.

In support of practising effective teamwork, occupational therapists Mickan and Rodger (2005) developed a framework based on a large numbers of surveys with health managers and health practitioners, the Healthy Teams Model. In this model, Mickan and Rodger suggest that team members need to develop a forward looking purpose relevant to both the client and the organisation. The goals are a link between the team purpose and its outcomes and focus on achieving client outcomes. The goals need to be agreed on by members of the team (including the client), set collaboratively, and described clearly. The team needs to develop processes for leadership as this influences goal achievement. This includes structures for decision making, managing conflict, sharing ideas and information, coordinating tasks and providing feedback. Communication needs to be regular and thus facilitate the easy sharing of information between members. Sufficient time needs to be allowed for reflection. Cohesion is important as a sense of camaraderie and involvement and is generated over time. Cohesion arises from participation in tasks, and from communication networks. The aim is for team members to want to work together. Mutual respect of each others professional and personal skills is also essential from each team member. Each team has embedded structures and processes which focus on the team purpose, goals, leadership, communication, cohesion and mutual respect.

The characteristics of team work included in this model represent elements within person centred care. This crossover between operating as an effective team, and the practice of person centred care further supports the premise that the client should be included within the health team.

A focus on client goals.

Goal setting is considered a fundamental component of rehabilitation (Bovend'Eerdt et al., 2009; Kuipers, Foster, Carlson, & Moy, 2003; Levack, Dean, Siegert, & McPherson, 2006; Playford et al., 2009; Scobbie et al., 2009; Siegert, McPherson, & Taylor, 2004; Wade, 2009) as it is an effective way of achieving change in people (Bovend'Eerdt et al., 2009). While occupational therapy aims to enable change, the profession acknowledges it is only the clients who can accomplish their own change (Kielhofner, 2002).

Simply stated, a goal is something which a client wants to achieve (Leach et al., 2010). A goal expresses a future end state, and in rehabilitation, it also commonly includes the effort by which the end state is achieved, expressed as a SMART goal (Playford et al., 2009; Wade, 2009). For the purposes of this research, a goal is “a destination…with steps towards achieving it, with a plan towards achieving it” (Barclay, 2002, p. 9).

It is generally believed that the ongoing future of goal setting in rehabilitation is considered secure, due to both its effectiveness for influencing behaviour, and because of its intuitive sense to both clinicians and clients (Siegert et al., 2004). Goal setting is considered to be an innate behaviour of a rehabilitation clinician (Levack, Taylor, et al., 2006). As stated by a clinician discussing the value of goal setting in an informative and well conducted study, “you can’t really have rehab without goals because you are always working towards something, towards some improvement” (Levack, Dean, McPherson, & Siegert, 2006, p. 1442).

The ideal method of setting rehabilitation goals should involve the goal being identified by the client, or by their family, (Doig, Fleming, Cornwell, & Kuipers, 2009; Glazier, Schuman, Keltz, Vally, & Glazier, 2004), and then set collaboratively with rehabilitation staff (Barnard, Cruice, & Playford, 2010). Barnard et al. (2010) identified that collaborative goal setting served to increase discussion about the goal and required that the treating team explain their clinical reasoning when negotiating realistic and achievable goals. Playford et al. (2009) suggest that more productive goals are those which are ambitious rather than achievable. Collaborative goal setting with clients is therefore the aim of goal setting in rehabilitation, however, best strategies to facilitate collaborative goal setting are not well established (Bloom et al., 2006).

Client involvement in goal setting is highly regarded at a policy level (Barnard et al., 2010), as evidenced through the inclusion of goal setting with clients in the HIP guidelines (Department of Human Services, 2008). Studies exploring the impact of client involvement in goal setting have revealed that clients had an increased sense of control over their rehabilitation (MacLeod & Macleod, 1996), were positive about the process but less so about the substance of that process, (McAndrew, McDermott, Vitzakovitch, Warunek, & Holm, 2000), perceived the process as beneficial, which increased their motivation and fostered realistic expectations (Young, Manmathan, & Ward, 2008), and were encouraged to increase their active participation in rehabilitation (Leach et al., 2010). Overall, the client’s perspective of goal setting suggests that it was a positive experience contributing both realistic expectations and enhanced participation.

At the research site for this study, the goals menu was implemented to involve the client in the identification of their own goals. Structured goal setting tools can assist in: identifying the clients goals (Barclay, 2000, Glazier, Schuman et al, 2004); providing a shared framework for discussion between the therapist and client and can provide structure and guidance to the goal setting process (Barclay, 2000); improving the communication between a client and their rehabilitation team to help define the treatment plan (Bloom, Lapierre et al, 2006); and supporting an effective partnership between client and therapist (Holliday, et al, 2007).

Summary of Literature Review

The research and evidence reviewed highlights the importance of team work and effective communication within teams, and person centred practice within the rehabilitation process. Rehabilitation clients have indicated that a positive experience of the rehabilitation process relates to the attributes of hope, self-efficacy, and to the application of person centred care. Person centred care is a method of working with clients that focuses on the client and actively includes them in the rehabilitation process. This is achieved by addressing a client’s goals, and by including the client as a member of the healthcare team. Client goals are a client statement of their end point, and are used to better practise client centred practice and provide a framework for better team work. Goals need to be set collaboratively with the client as this provides motivation to participate in rehabilitation, and thus maximise functional outcomes. Goal setting can be challenging to implement with clients, however, using a goals menu is one strategy to facilitate client goal setting. The other key strategy is client-therapist and interdisciplinary communication. Communication needs to occur between all members of the team, with the client viewed as a central player within the team. The Healthy Teams Model provides a useful framework for working as an effective healthcare team.

Aim of this Study

Two years after the introduction of goal setting using the goals menu at the community rehabilitation service, it was suggested that it would be valuable to understand the client's experience of engaging in this goal based rehabilitation program. Thus the research could then be used to guide future goal setting practices within the service. The aim of this study was:

1. To explore the participant's experience in a goal-based community rehabilitation service.
2. To identify the impact of using a goals menu on the participant's community rehabilitation experience.

Thus, in this study, the participants' perspective of the goals menu was sought to understand their experience of using the goals menu in a community rehabilitation setting, and to understand the impact of the goals menu on their experience.

Methodology

This chapter describes the methodology used to explore the participants' experience of participating in a goal-based community rehabilitation service. Contextual background information regarding the chosen methodology is provided through a brief discussion on both qualitative research and phenomenology. Information is provided regarding the rehabilitation setting and participant details. The data analysis process is described in detail, including the methodology undertaken for a second level of data analysis. Issues of trustworthiness and ethical implications are highlighted. When direct quotes from the participant interviews are provided they are identified by two numbers. The first number relates to the participant number, and the second number identifies the page number of the transcript.

Qualitative research is an umbrella term for research methodologies that study participants in their natural settings (Denzin & Lincoln, 1994). This methodology is valued because participants are viewed "as inseparable from their social, cultural, physical, economic, political, historical and legal environments" (Hammell, 2001 p. 231). The aim of qualitative research is to make sense of the phenomena being researched in terms of the meanings people attribute to them, and as such it is a research approach which aims to understand how people look at the world, and how this motivates them to act in particular ways (Andrews, Sullivan, & Minichiello, 2004; Holstein & Gubrium, 1994; Liamputtong, 2009). This form of research draws on a "social constructivist view of society and the way people interact" (Andrews et al., 2004. p. 62) which considers that our view of ourselves and our reality is developed over time as a result of interactions with others. Qualitative methods are commonly used to investigate the interactions between individuals and the health care environment (Fossey, Harvey, McDermott, & Davidson, 2002).

This research project utilised phenomenology, which is an interpretive methodology. An interpretative methodology is one form of qualitative research that aims to describe and explain an individual's experiences, behaviours, interactions and social context (Fossey et al., 2002) with an emphasis placed on the participant's perspective of the phenomena being studied (Hammell, 2001) "regardless of their individual or collective origin" (Fossey et al., , p. 720).

Phenomenologists view the individual and their world as co-constituting one another, that is, it is via the world that the meaning of the person's existence emerges, and it is the individual's existence that gives the world its meaning (Valle & King, 1978). Phenomenological research enables an understanding of the participant's experience, such as their thoughts, emotions and sensations (Valle & King, 1978), and the meanings they attribute to that experience (Andrews et al., 2004) with an overarching aim to identify what the phenomenon is concerned with (Colaizzi, 1978). Tesch, (1990, as cited in Fossey et. al., 2002) suggests that phenomenologists are "interested in the way people experience the world, what it is like for them" (p. 720).

Colaizzi, an important early author in phenomenology, stated that the identification of the phenomenon is based on a description of the experience from the people who had the experience (1978). This is revealed through a process of dialogue (Colaizzi; Valle & King, 1978) whereby social dialogue between participant and researcher both constructs and conveys meaning (Holstein & Gubrium, 1994). This dialogue occurs in a situation of trust and without the presence of power relationships, that is, the researcher and subject act as co-researchers (Colaizzi).

Overall, phenomenology aims to elicit “the common elements of subjective experience as described by separate individuals” (Fossey et al., 2002, p. 720.). Therefore the phenomenology research methodology used in this study enabled a detailed examination of each participant’s subjective experience of participating in a goal-based community rehabilitation service, followed by the development of an understanding of the common elements of this practice. Colaizzi’s method (1978), a commonly used method in phenomenology and widely cited in health sciences literature, was utilised in this research and shall be discussed further.

In 1978, Colaizzi suggested that human experience could be viewed and described objectively. He believed that people act out to the world all that they are experiencing in the world, so a person’s experience is observable, through their actions, by people standing separate to that experience. For example, being angry is not only an internal state but is directed to objects and people in the world. The objectivity resides in the notion that the person with the experience is able to faithfully describe what occurred.

In order to accurately understand and account the meanings of experience requires that the researcher remains with the experience as it is experienced, (Colaizzi, 1978). Colaizzi identified that preconceived meanings of an event regulate all subsequent involvement in that event, thus the researcher’s preconceived meaning of the research topic is scrutinised. To address this, a detailed discussion of the researcher’s reflections on this topic is presented. Refer to [Figure 2: Researcher’s preconception regarding the phenomenon studied] for the researcher’s prior notions of goal setting in community based rehabilitation.

FIGURE 2

Researcher's Preconception Regarding the Phenomenon Studied

March 2006.

As an occupational therapist, I need to know my clients to work with them. The work undertaken by occupational therapists in community rehabilitation is to assist clients to overcome their difficulties in re-engaging in their chosen occupations after they have an acquired brain injury or other neurological or orthopaedic problem which usually, but not always, requires inpatient hospital admission. My practice as an occupational therapist is guided by the teachings of person centred care. I use goal setting with clients as a means of knowing the client and to provide the rehabilitation they require.

However, my colleagues (dietitian, physiotherapist, social workers, and speech therapists) are not working on the same things. Although I have independently worked with the client to identify their goals, which were framed as occupations they wished to improve their performance in, I failed to share this with my colleagues. There was no process in place for this communication to occur. Furthermore, the actual goal setting process was ad hoc and was driven by therapist identification of client problems. This lack of connection with client-set goals, and lack of team procedure for client goals to drive the rehabilitation process felt like a dismal failure in the delivery of person centred practice.

The rehabilitation team is aware that Department of Health is to implement guidelines for client care which includes client goal setting as part of their practice of person centred care. Change needs to occur. The rehabilitation service needs to implement a process to be used across the team. But why focus on setting goals?

I believe that setting goals with clients will allow me to address what a client wants to work on in rehabilitation. By addressing what clients want, they will improve more than if I set the rehabilitation schedule. The client's goals will make it easier for me to develop a pathway towards their chosen direction. This will result in a more satisfying experience for both me and for the client, and this increased satisfaction should be reflected in reporting a more favourable experience of rehabilitation. Goal setting with clients will enable me to be a more person-centred practitioner.

Goal setting may be most effective if the process includes the whole treatment team who all adhere to the pre-set procedure. This will ensure the whole team is on the same page. This requires overt discussion of client goals at the start of and during rehabilitation. Goal focussed discussion facilitates clients to recognise their own improvement, and thus be motivated to continue with engaging in rehabilitation. The goal setting needs to be implemented as a service-wide model of practice. I am instrumental in the development of the goal setting process utilised at the time of this study.

The researcher preconceptions presented above, namely the importance of client centred goal setting driving the rehabilitation process, contributed to the development of research questions that were discussed with the participants in this study.

Research Methods

Recruitment procedure.

In phenomenological research, any person with an experience of the phenomena being studied is considered appropriate for selection for that study (Colaizzi, 1978). In this study, the phenomena was participating in a goals-based community rehabilitation service, so participants were recruited from a Community Rehabilitation Service, in Melbourne. Six people with experience of the phenomenon were recruited. Sample size was based on the general rule provided by Morse (1994) as cited in Llewellyn et. al., (2004) who suggested that six participants in phenomenological studies would meet the primary aim of understanding the experience of the phenomena being studied.

The researcher aimed to interview people who represented the clients who attended the community rehabilitation service with regard to age, gender, treatment location (home or centre-based), and diagnosis so a stratified purposeful sampling method (Llewellyn et al., 2004) was used. The advantage of this method is that it allows for some degree of comparison between the experiences of those who are regarded as meeting the categories (Llewellyn et al., 2004). Ranges were set for the number of clients to be interviewed within each category, assuming that between six and ten participants were recruited to the study. The client profile of the community rehabilitation service was used to identify the ranges, as described in Table 2. The participants recruited to the study reflected the clients who attended the rehabilitation service in 12 out of 16 of the identified categories. The following variance from the service profile are noted and acknowledged as a limitation of this study: one male participant less, one centre based participant less, one participant less with a musculoskeletal/ rheumatology diagnosis, and one too many participants with a neurological issues which was not a stroke.

TABLE 2

Stratified Client Categories at the Rehabilitation Service: Target and Actual Numbers for Sample Inclusion

Categories	Sub-categories	% of clients in the community rehab service	Target number of clients aimed to be interviewed within each category[2]	Actual number interviewed	Status of Target aim
Gender	M	37	2-4	1	-1
	F	63	3-6	5	In range
Age	Under 60	14	0-1	1	In range
	60-69	14	0-1	0	In range
	70-79	32	1-3	1	In range
	89+	42	2-6	4	In range
Health condition[3]	Orthopaedic -elective	9	0-1	1	In range
	Orthopaedic -fracture	8	0-1	1	In range
	Orthopaedic musculoskeletal-rheumatology	17	1-2	0	-1
	Stroke	12	0-1	1	In range
	Other neurology	12	0-1	2	+1
	Debility	19	1-2	1	In range
	Other	12	0-1	1	In range
	Unknown	11	0-1	0	In range
Treatment location	Centre-based	45	2-5	1	-1
	Home-based	55	3-6	5	In range

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[2] The study aimed to interview between 6 and 10 clients, so these ranges relate to the total number of clients to be interviewed in each category if a minimum of 6 participants were recruited, up to a maximum of 10 participants.

[3] Victorian Integrated Non-Admitted Health (VINAH) Minimum Dataset (REF: http://www.health.vic.gov.au/hdss/vinah/2007-08/index.htm - refer to section 9)

The participants were identified by rehabilitation staff during the face-to-face discharge session. They were selected according to the inclusion and exclusion criteria. [Refer to Table 3].

TABLE 3

Criteria for Inclusion and Exclusion in the Study

Inclusion criteria	Exclusion criteria
Eligible to receive Community Rehabilitation as either a home-based, or centre-based client	Not eligible to receive Community Rehabilitation as either as home-based or centre-based client
English speaking	Individuals who need an interpreter for therapy sessions
Receiving therapy from two or more disciplines in community rehabilitation. This criterion has been included to ensure that the goal setting process is relevant for interdisciplinary application, rather than single discipline service delivery	Individuals who are receiving rehabilitation from an external service whilst a client at community rehabilitation service
Are able to independently provide informed consent.	Individuals who are unable to provide consent
Had used the goals menu	Had not used the goals menu
	Clients who accessed the community rehabilitation service via either the falls and balance clinic or the graduated discharge program, as clients in these programmes within the community rehabilitation service experience a different assessment approach which does not include a goal approach
Meets the client profile	Does not meet the client profile

A one page summary of the study [Appendix A: Study information sheet] was used to inform the potential participants about the study purpose. Rehabilitation staff sought the potential participant's permission to be contacted by the researcher. Prior to conducting the interviews, written consent was obtained using the Participant Information and Consent Form [Appendix B]. This form was completed prior to the recorded interview starting, with an opportunity provided for clarification of the research project aim and process. The participants were informed that their withdrawal from the study could occur at anytime, without impact on subsequent involvement with the community rehabilitation programme. The details of participants' names and diagnoses were stored separately from the data. The data was de-identified, with participants referred to as a number, based on the order that the interview was conducted.

Ethics approval to conduct this research was obtained from the Alfred Human Research Ethics Committee [Appendix C] and La Trobe University Faculty Human Ethics Committee (Appendix D). A memorandum re the ethics application (revised) is included in Appendix E.

Sample.

Six participants were recruited to this study. The research participants were all attending a community rehabilitation service that provided home-based and centre-based rehabilitation. All participants had used the goals menu. They all lived in the community (defined as: at home, in a hostel or in a supported residential service) at the time of their treatment. All participants had the capacity to benefit from rehabilitation, as assessed by both the referrer and intake officer.

One participant was male. He was the youngest participant in this study, and he was the only participant who had attended the centre-based program. The five other participants were females who had all been involved in the home-based program. Basic demographic information of study participants is presented in Table 4.

TABLE 4

Participant Demographic Details

Client number	Gender	Treatment location	Age	Health condition[4]	Disciplines which provided treatment
1	F	Home	82	Other	Physiotherapy Occupational therapy
2	M	Centre	42	Other neurology	Physiotherapy Occupational therapy
3	F	Home	83	Other neurology	Nursing Physiotherapy Occupational therapy
4	F	Home	84	Orthopaedic fracture	Physiotherapy Occupational therapy
5	F	Home	75	Orthopaedic elective	Physiotherapy Occupational therapy
6	F	Home	84	Debility / stroke	Occupational therapy Social work

Data collection.

Semi-structured interviews.

Interviews are the main choice of data collection techniques in phenomenological research as they provide an opportunity for dialogue describing experience in the first-person (Fossey et al., 2002). In-depth interviews are a conversation that permits a richness and depth of data (Crabtree & Miller, 1992) as they invite the participant to "recall, reveal, and construct aspects of subjective

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[4] Victorian Integrated Non-Admitted Health (VINAH) Minimum Dataset (REF: http://www.health.vic.gov.au/hdss/vinah/2007-08/index.htm - refer to section 9).

experiences and interpretations and to make that discussion coherent and meaningful" (Minichiello, Madison, Hays, & Parmenter, 2004, p. 413). Essentially, the interview is a conversation whereby the interviewer establishes the direction of the conversation and the respondent does most of the talking (Babbie, 1998).

Semi-structured interviews provide a more-focussed discussion than an unstructured interview which is conversational in nature (Fossey et al., 2002). Semi-structured interviews use an interview guide that provides a general plan of inquiry rather than a specific set of questions asked in a specific order (Minichiello et al., 2004). The guide provides opportunity for dialogue with participants about their experience. The guide used in this study is provided in Appendix F.

In semi-structured interviews, researchers use open questions to elicit the thoughts and feelings of the participants (Polkinghorne, 1989) and probing comments/questions to gain further description of experiences. In this study, the questions aimed to elicit vivid descriptions of the experience of participating in a goal-based community rehabilitation program.

Each interview was conducted by the researcher and interviews lasted about 60 minutes. The interviews were audio recorded and transcribed verbatim for analysis in order to ensure that the participants' voices were present in the analysis of the data (Fossey et al., 2002). Six interviews were completed between March 2007 and July 2007.

Data analysis.

Thematic analysis of the data was undertaken to make sense of the data and to identify the repeated patterns of meaning, termed themes, within the data (Liamputtong, 2009). The transcripts were analysed by the researcher using Colaizzi's (1978) approach to phenomenological data analysis. Colaizzi's methodology consists of seven thematically separate steps, which although reported linearly, are conducted concurrently throughout the period of investigation. The seven steps are outlined below, and the description includes examples of the data analysis process to provide a thick description of this process.

Step 1. The accuracy of the transcribed interviews was checked by the researcher who listened to each recorded interview and compared this with the written data. This served to familiarise the researcher with the transcripts.

Step 2. Significant statements (phrases or sentences) were extracted from each transcript, and attached to index cards

Step 3. A meaning for each significant statement was formulated by writing notes on each of the index cards. The meanings identified what the participants meant rather than what they said. For example:

> *Quote 1:* I hop on the tram, just sometimes for the outing, to go into Coles or go to the bank or go for a walk there [3-8].
> *Meaning 1:* Just get back to doing things.
>
> *Quote 2:* I made all these squares long before I fell over and when I was in hospital… I was busy thinking when I get home I'm going to do that or that. So the first job I've done is this (sew the quilt squares together and put the backing on) [4-7].
> *Meaning 2:* returning home and doing the things I love to do.
>
> *Quote 3:* I did some needlepoint. I usually, I don't know, just went for a walk, did more exercises, and then it was a case of … but I do

still try to watch the 12 o'clock news and take that break, have some lunch.

Meaning 3: Getting on and doing things.

Step 4. The above procedure was repeated for each transcript, and the meanings were grouped across all the transcripts to form an aggregated cluster of themes. This allows for the emergence of themes to be common across all of the transcripts. The themes were checked against the transcripts to ensure that they were representative of the written data. For a description of the themes identified, refer to Figure 3 in the findings chapter.

Step 5. An exhaustive description was developed for each theme and sub-theme to describe the participant's experience. For example;

Getting on and doing things: Back at home, just did things randomly, without too much hassle, [5-6] throughout the day. Some structure built in, (hot drink, have a shower, daily rest, watch the news and have lunch [5-6]. Just kept busy and helped out as possible [5-6] – small jobs create the day. Activity positively influenced emotions [5-6], and is preferable to watching TV. Taking each day as it comes [5-5], and getting on and doing things. Found meaning in doing things by 'trying to give my daughter a break' [5-5]. Completing activity that was uncompleted prior to going to hospital gave a focus on what to do [4-7]. Spent time in hospital thinking about things to be done on return home, which directed what was first done. Activities range from things at home to being out and about on tram, shops and outings, or for a walk. It is important to not always be at home [3-8]. Being able to engage in home life requires a reduction in pain [5-7]. Participants are able to resume doing occupations which were *previously too difficult to do [3-9].*

Step 6. The participant's experience was refined and resulted in the development of a fundamental structure of each theme and sub-theme within this study. For example:

Getting on and doing things: This theme was identified by three of the participants. For these participants, they had returned home from hospital with a plan of what they wanted to do upon returning home, and had focussed on taking each day as it comes by just randomly doing things in order to keep busy. One participant identified the importance of engaging in activities both in their home and in their broader community. They found that they had been able to resume doing activities which had previously been too hard.

Participant: Well first and foremost, taking each day as it comes, and seeing what I can do each day. Not necessarily setting an actual goal for the day; it's just simply doing things as I see they need to be done, and getting on and doing it. And that's what I did down at my daughter's. I tried to give her a bit of a break in some respects, because that's why I took on the washing, a bit of the ironing, not a lot, there's not a lot to do and cleaning the house, cleaning the floors. [5-5]

Step 7. Colaizzi’s (1978) last step consists of validating the findings by returning to each participant and asking for their comment to be subsequently incorporated into the findings. This step however was unable to be completed due to personal circumstances in which an 18 month delay resulted between the data collection and completion of the above step. This was deemed to be too distant in time to be beneficial for the participants, so this step was not carried out.

The findings obtained from completing the steps above are outlined in the findings chapter, which describes the participants’ journey in community rehabilitation. Although the intention of phenomenological research is to describe the phenomena rather than to develop a theory about it, the research question provided a framework for a second level of data analysis. That data was reconsidered through the lens of the impact of the goals menu in the participants’ rehabilitation experience. Therefore, additional thematic analysis was conducted on the fundamental structures in order to closely examine the influence of utilising a structured goal setting tool in a multidisciplinary community rehabilitation setting. This resulted in a different conceptualisation of the findings whereby the impact of the goals menu on the participants’ experience was central.

The steps undertaken in the re-conceptualisation of the data (second level of data analysis) were as follows:

1. The key concept for each theme and sub-theme was identified. This consisted of highlighting the key ideas within each fundamental structure and listing them in a table under the headings: theme, sub

theme, key concepts. [Refer to Appendix G: Themes, subthemes and key concepts from the fundamental structures].

2. Each key concept was mapped based on the fundamental structure, dated 6th March, 2011. See below.

   Fundamental structure: A focus on goals also contributes to clients trying to achieve. Participant 3 stated: “I would have to do the exercise, and I did them religiously, every morning and every afternoon, because I wanted to help myself, I knew nobody can help me, only myself. So I continued. I did the work” [3-12].

   Participant 4 stated: “Well whatever it is, I’ll work on it really hard as best I can to get it right.” Because at the back of my mind always was the goal of getting back to normal as near as possible. I can’t be a dud.” [4-7].

3. Two key pathways were identified and typed in bold typeface. These pathways consisted of convergence points of multiple concepts, or of single steps in a linear progression. This is illustrated in Appendix H: Concept map: relationship of the key concepts.
4. A simplified diagram based on participant experience was developed identifying the key concepts of participating in a structured goal setting community rehabilitation program. This is presented in the findings chapter, 5. The discussion chapter is based around this second level of analysis that uses the data to specifically understand the second part of

the research question: to understand the impact of using a goals menu on the participants community rehabilitation experience.

Trustworthiness

Trustworthiness is the “extent to which the findings are an authentic reflection of the personal or lived experiences of the phenomena under investigation” (Curtin & Fossey, 2007, p. 89). Strategies to enhance trustworthiness in this study are discussed below. Fossey et al. (2002) presented criteria by which qualitative research should be assessed to ensure good practice in the conduct of the research, termed methodological rigour, and of the interpretations made, termed interpretative rigour. Issues pertaining to each of these two elements of rigour will be presented.

Methodological rigour.

Congruence relates to the ‘fit’ between the research issue and chosen research methodology, as well as the ‘fit’ between the application of the research methodology in the design utilised (Fossey et al., 2002). This study used a phenomenological framework to explore the participants’ experience of community rehabilitation. The data analysis employed a commonly used analysis methodology to interpret and understand the participants’ experience. This is in keeping with the study design.

Responsiveness to social context requires the researcher to engage with the participants and become familiar with the study context (Fossey et al., 2002). The researcher was a former staff member in the rehabilitation service and had developed the in-house goal setting processes which were in place at the time of the data collection phase of the study. Therefore, the researcher was familiar with the study context. The inclusion of the researcher pre-conceptions provides a context for the starting point. Engagement with the participants occurred initially over the phone in order to arrange the interview time and location, and again during the interview. All participants were afforded an opportunity to discuss themselves in the context of rehabilitation.

A study is considered appropriate when the sampling and data collection methods are suitable to the research question (Fossey et al., 2002). Semi structured interviews, a commonly used data collection in phenomenology, were used to collect data. Participants were purposefully selected to be representative of the rehabilitation service, and details of the demographic characteristics are provided to allow transferability.

The adequacy of a study occurs at three levels: sampling, data gathering and analysis, and in the written report (Fossey et al., 2002). The provision of detailed description of the participants and sampling method contributes to the adequacy of the study. The detailed description of the data gathering and analysis methodology provided a rich description of the processes undertaken. The written description was enhanced by the inclusion of the examples of the data analysis process (termed audit trail) which aids understanding of the process.

Transparency of the data collection and analysis is enhanced when privilege is given to the participant’s voice, competing views are accounted for, and the processes described are rendered transparent (Fossey et al., 2002). The detailed description of the methodology, and the inclusion of verbatim quotations from the participants, including the range of views expressed by the six individual participants, enhances the transparency of the study.

Interpretative rigour.

Authenticity occurs when the participants’ perspectives have been authentically represented in the research process and in the interpretations made from the information gathered (Fossey et al., 2002). In reporting this study verbatim quotes directly represent the participants' voices. The description of the analytic process, that incorporates examples of how meanings were interpreted from the data, provides a detailed understanding of the how interpretations were made by the researcher. Evidence of conflicting views is found in sub-themes that seem to be opposed, but are actually representing the range of perspectives expressed by participants. Member checking (Curtin & Fossey, 2007) would have enhanced the authenticity of the study but did not occur due to the extended time between data collection and analysis making it impractical.

Coherence relates to how the findings are presented and is attained when the links between the data and the findings are credible (Fossey et al., 2002). An extensive description of the participants' experience is presented in the findings chapter, and includes quotes to illustrate the meanings identified.

Typicality relates to the comments made regarding the applicability of the findings in relation to similar services (Fossey et al., 2002). Sufficient detail has been provided in the methodological, findings and discussion chapters to allow readers to determine the applicability to their own settings.

Permeability relates to the transparency of the researcher's intentions, engagement and interpretations. Reflexive reporting enhances the permeability (Fossey et al., 2002). The aim is to ensure that the findings are informed by the data rather than the researcher's preconceptions. The inclusion of the researcher's preconceptions contributes to the permeability of the study as it demonstrates an awareness of their prior thinking. Ongoing thinking regarding the findings in the context of existing literature occurred throughout the duration of the study and was discussed in supervision.

Overall, the trustworthiness of this study is demonstrated through presentation of a thick description of the research process and findings, thus the study demonstrates both transferability and reflexivity. Data triangulation over time, researcher triangulation, and member checking are elements of trustworthiness which could have been included to enhance the trustworthiness of the research design.

Ethical Issues

Ethical conduct involves acting in a manner which shows respect and concern for the human participants in research, including interview-based research with people (National Health and Medical Research Council, 2007) (NHMRC) as per this research study. Ethical issues were considered in the design and implementation of this study

Summary of Methodology

This chapter has provided a description of phenomenology research, and has provided a detailed description of the research methodology used: recruitment procedure, sample, data collection, and data analysis methods applied. The trustworthiness and ethical issues are discussed. The next chapter will discuss the findings which emerged from the six semi-structured interviews conducted in this research study.

Findings

This chapter describes the main themes identified from the qualitative data analysis of the six interviews conducted with participants of the community rehabilitation service. The data aimed to elicit information on their experience of setting goals at the start of rehabilitation.

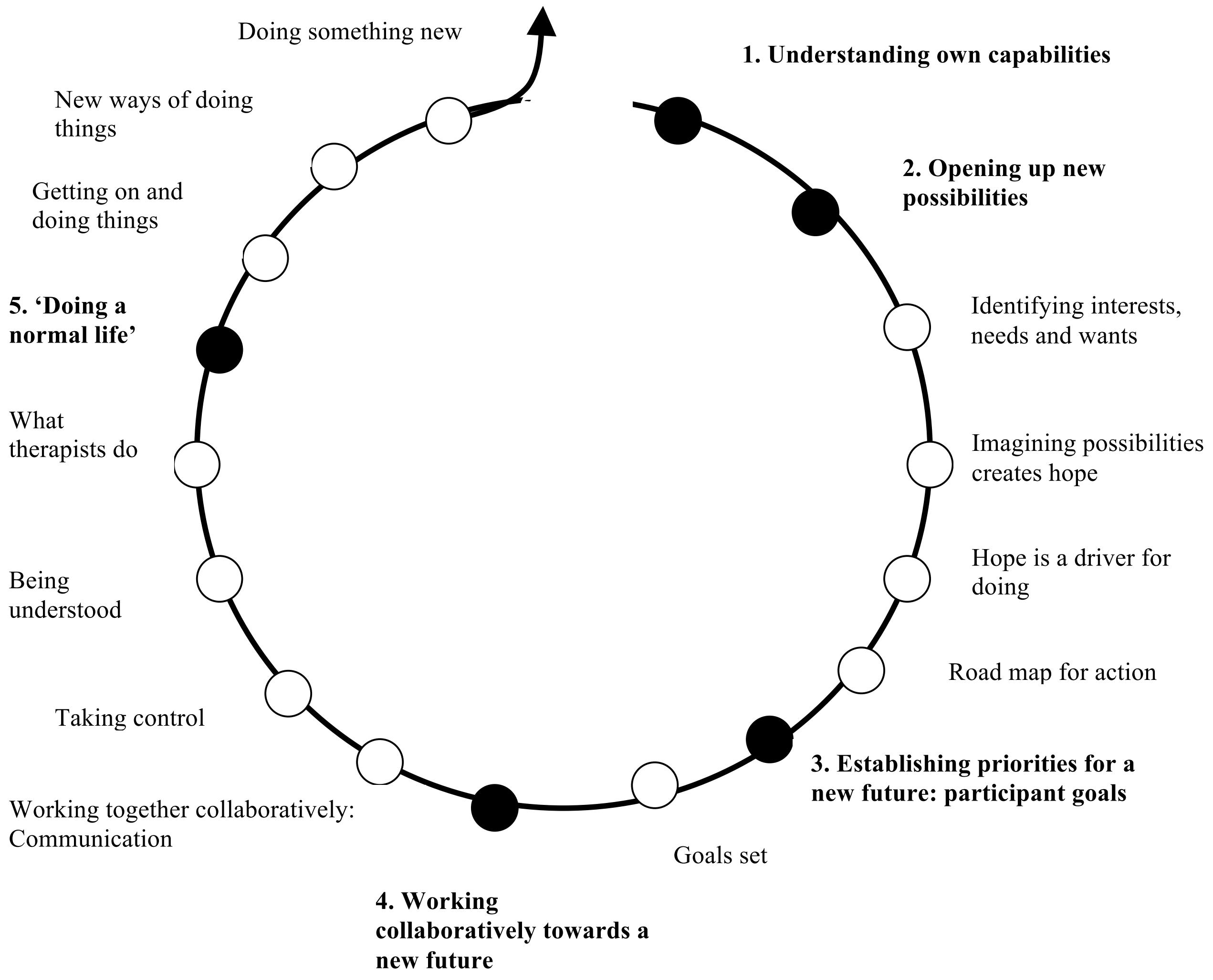
Five themes were identified:

1. Understanding own capabilities
2. Opening up new possibilities
3. Establishing priorities for a new future: participant goals
4. Working collaboratively towards a new future
5. ‘Doing a normal life’

The five themes, and a set of subthemes within each theme make up the participants’ journey in rehabilitation and are illustrated in Figure 3: The participant’s journey in goal-based community rehabilitation: themes and subthemes. These themes and subthemes were developed from data analysis. Each of the themes and subthemes are described in detail with quotes from the participants included to convey their meanings in their own words. When direct quotes from the participant interviews are provided they are identified by two numbers. The first number relates to the participant number, and the second number identifies the page number of the transcript.

FIGURE 3

The Participant's Journey in Goal-based Community Rehabilitation: Themes and Subthemes from data analysis



1. Understanding Own Capabilities

This theme was discussed by five out of six participants, and was mostly achieved by the participants drawing comparisons. Comparisons were made with respect to:

a. Their prior abilities compared with their abilities after their health condition changed.
b. Their own capabilities compared with the capabilities of others.
c. Expectation of self and others versus their actual experience.

Each of these points of comparison is discussed below:

a. Their prior abilities compared with their abilities after their changed health condition.

Participants gained an awareness of their own activity limitations through comparison with their prior activities by stating things they were currently unable to do: “I couldn’t lift anything anyway” [2-9]. “I couldn’t read, I couldn’t comprehend” [3-11]. “I didn’t remember anything” [6-6]. “I didn’t remember his (son’s) house number” [3-8]. “I could neither talk nor walk” [6-3]. “I can’t do shoelaces no way, neither the bra” [6-6].

The participants were thus aware of their health changes, as experienced through changes in their ability to do activities. Some of the participants suggested that the changes in activity related to changes in their own function, such as: “But I knew that my memory is a problem, because even in hospital I couldn’t ring up my son, I couldn’t dial the number” [3-4].

Participant 3 linked her impairment to limitations imposed by others on her occupations: “How my memory was, that’s why they stopped me from driving a car” [3-2]. This participant was not aware of the impact that her memory impairment had on her ability to engage in driving, as by virtue of having impaired memory it was difficult for her to draw that conclusion herself.

b. Their own capabilities compared with the capabilities of others.

One participant identified that she was recovering very well by observing the performance of those around her: “And I used to think that lady is still just doing that and I’m past that and I used to get an idea that I was going along OK” [4-13]. This same participant also sought validation from therapists to support her conclusions: “I used to ask the instructor “Am I gaining? How am I doing?” He said I was doing OK.” [4-13]. One participant acknowledged that the problems experienced by others highlighted their own capabilities, and led them to frame their health journey as ‘lucky’.

> Because what I saw in hospital brought it home to me as to how lucky I was, because when you look at this, you see some of the patients, and what they’re struggling to do, I didn’t have that struggle. [5-11]

c. Expectation of self and others, versus their actual experience.

One participant experienced a change in their abilities which resulted in ceasing their former paid employment role. The disappointment of the loss of their ‘work’ role was exacerbated by the lack of support which they had expected to receive from their employer. The mismatch between the expected support from a person and their actual support provided may influence the development of negative emotions:

> The thing is, like I said, I had the disappointment of my boss, that he didn’t look after me after ten years that I was there. And you think, wait a minute, I give you everything, even my back, and you didn’t support me back then. And I felt everything collapse on top of me. So I was really disappointed about that.

> So that's when I started to go – I was a bit depressed before but now even more because I thought, my god, physically I can't stand up. [2-10]

2. Opening up New Possibilities

Four sub themes contribute to the theme that a goal based rehabilitation process using a structured goal setting tool facilitates the opening up of new possibilities for participants.

a. Identifying interests, needs, wants.
b. Imagining possibilities creates hope
c. Hope is a driver for doing
d. A road map for action

Each of these sub themes is discussed separately below.

a. Identifying interests, needs, wants.

Four participants identified that utilisation of the goals menu facilitated a focus on each participant's interests, needs and wants with respect to what they wanted to achieve and what was deemed to be important. The goals menu served to demonstrate to participants their possible end point to be achieved in rehabilitation. When discussing the value of using the goals menu in rehabilitation, one participant identified that "the patient wants to know just how far they can go" [5-12].

Participant 4 identified that although the goals menu consisted of many items which she performed poorly, she did not recognise these as being an interest, a need or a want, and thus she did not include them as her goals. Subsequently, items not identified as an interest, need or want were not included in her rehabilitation program, as she explains when asked what purpose the goals menu served for her:

Participant: It made me aware of how many things I wasn’t good at and I had to learn to get better at.

Researcher: Were you trying to get better at everything?

Participant: No, only the things that I knew I would really need to be better at. [4-10]

The above quote demonstrates that the goals menu highlighted to participants their occupational deficits: “things I wasn’t good at” [4-10], or “weak points” [3-12]. For some participants this raised their awareness of activities they were unsafe to perform but wanted to get back to: “Because if I didn’t remember [how to do things correctly such as showering or walking], this wasn’t safe for me” [3-5].

One participant deferred need identification to the therapists: “I didn’t know what I wanted. I was just watching and listening to them, because I knew that they know what I might need, if they can help me or not.” [3-10]. This participant relied on the therapists using their own knowledge of both the rehabilitation service and her health condition to determine the direction of rehabilitation and what they provided. She herself only wanted to ensure that she was safe to engage in these activities and the goals menu assisted her in this process.

b. Imagining possibilities creates hope.

The goals menu presented “possibilities of what you could achieve and that gave you motivation to go and achieve the goals?” [1-19]. When participant 2 first sighted the menu, he realised that there were many things that he could do, that he had not previously considered: “oh that means I could to this, I could do that, I could… Things started to run into my mind and [I] said, okay [2-11].

This sub theme consists of two linked ideas, discussed by only two of the participants:

These 'possibilities' became a goal which in turn presented a future for the client, giving them something to look forward to and thus enhancing their confidence in achieving their goals. When asked what the key benefit was from using the goals menu, participant 2 answered:

> It gives you an indication of where you want to go in life…. It … give(s) you something to look forward to so that basically you feel more confident about fulfilling a goal that you thought that maybe you weren't able to do because you didn't have anyone behind you or someone to talk about it with or even to have an idea of what you could do after this operation. So the goal, what it does is it gives you an indication. It gives you something to look forward to and go forward basically. So that's the benefit. [2-16].

The goals menu was considered to provide hope with respect to goal achievement. Hope was pronounced as being very important:

> Participant: It presented ideas to me that made me realise that perhaps I could achieve the goals.
>
> Researcher: So it allowed you to think that there was some possible improvement that you could make?
>
> Participant: In other words a sort of thought process of achieving something.
>
> Researcher: So it gave you some hope, is that what you're sharing with me.
>
> Participant: Yes, yes, hope. Hope. Which I think is very important, isn't it? [1-17]

c. Hope is a driver for doing.

Five of the six participants contributed to this theme which identifies that having goals is to have hope which facilitates moving towards a new future. Hope was identified as essential, and is displayed through the words and actions of the therapists, and through the provision of help.

The goals menu was seen to have contributed to the development of hope by means of presenting an idea which could be carried out. One participant described the goals menu as a:

> sort of hypnosis thing…. That you're not thinking about something and then someone puts that idea into your mind, and then you carry it out to achieve a certain thing. I mean that's the only way I can put it. [1-18]

That is, thinking about things which could be achieved enabled the participants to work towards that achievement. Participant 4 stated that "I think once you start thinking about achieving these things (goals from the goals menu) well then you do them with caution" [4-15].

Hope, as presented in the guise of the goals menu, focussed the participants on moving towards a new future. For participant 2, identification of his own goals "gave me strength to go forward and do something with the future" [2-13].

Hope is what kept the participants going. Participant 6 and her daughter used the word hope throughout their interview and warned "Don't take the hope away, because hope is the one thing that keeps them going" [daughter - 6-18]. The participant herself added "if there wouldn't be hope then there is no life….Not to live if you haven't got any hope to get better" [6-21].

Although it was commonly identified that hope was a driver for doing, it was simultaneously identified that a lack of hope prevented doing. Three of the participants suggested that their current limitations may not be permanent, and they needed to ‘wait and see’ before they envisioned a new future. These clients were on hold with some of their goals, placing them at a standstill. Participant 1 stated: “as regards to the goals, as I say, just at the present moment … I’m at a standstill, if you understand?” [1-11].

Participant 2 entered the rehabilitation service feeling very depressed and unable to picture a worthwhile future that was not solely directed towards the alleviation of his back pain. He focussed on what he was unable to do and was unable to identify new options to work towards:

> In the last ten years, I’ve been working in this restaurant and I think what am I going to do now? My back is like this. This is the only thing I can do. What am I going to do? [2-6]

This focus on his inability to resume prior occupations resulted in negative emotions and an inability to move forward. He stated:

> Oh I was really down. I was very, very down. I was actually depressed. I didn’t want to go out. I didn’t trust anybody any more. I had all these problems in terms of very low moments…. I was spending all this time at home by myself. [2-7]

It was not until rehabilitation started that he was given assistance to identify a new future:

> She [the occupational therapist] was helping me in terms of [saying] don’t do this, do that, or do the right thing, and always having a chat in terms of the future. How are you going to be for the future? [2-7]

A participant’s own beliefs also contribute to their recovery as their beliefs play a role in their goal achievement. Faith beliefs can also contribute to hope and thus goal achievement. Participant 2 discussed that he was feeling more positive towards his future due to his belief in God. He described how his belief in God had made him stronger and more positive, and this positivity directed his recovery. He associated his physical recovery with rehabilitation, and his mental improvement with his belief in God.

d. A road map for action.

The goals menu was identified by one participant as providing direction for them. It clarified for her what she was aiming to achieve. This participant found the process of presenting ideas on the goals menu as:

> good because it brings clearer to your mind what you are trying to do, you know. You're trying but perhaps sometimes you're not aware of what it is you are trying to do, you know? You're so involved in getting there. [4-8]

Furthermore, the written statements gave her something to refer to and thus provided validation for her achievements. Being goal driven provided her with a plan of action.

The goals menu provided guidelines regarding what clients wanted to do and how far they wanted to go. The goals menu was understood by the participants to be a tool to enable the therapists to understand them. It provided a link for the therapist between the client and their rehabilitation.

> Because it's [the goals menu] a guide to both the patient and whoever is the therapist. They (the therapist) need(s) to have some sort of guidelines about what the patient wants to do, and the patient wants to know just how far they can go. [5-11]

The goals menu facilitated realistic appraisal of abilities and appropriate goals setting for the participants. Although the goals menu provides an action plan, rehabilitation is a fluid process. Changes to goals and plan can result from a more realistic appraisal of the participant's capacity by both the therapist and participant. For example, participant 1 accepted a personal alarm after realising that she was unable to get herself off the floor after this had been practised during rehabilitation. This same participant aimed to walk a shorter distance than she had originally set, as over-extending herself had resulted in an overnight hospital stay due to a flare up of pain associated with her arthritis.

Participant 5 identified additional goals based on the progress she had made. She described using the goals menu to generate additional goals:

> you might fill in that sheet (goals menu) at the beginning and then you don't keep referring to it, obviously, but you keep thinking of things as you're going along that yes, I want to be able to do this, or I want to be able to do that, and you talk to your therapist, and she says "Yes, you're going well enough, you'll be able to do such and such, just keep going the way you are, [5-13]

In summary, in the theme 'open to new possibilities' the goals menu presented new possibilities which enabled the participants to identify their rehabilitation goals according to their interests, needs and wants and, and also helped them to modify their goals as required. This created hope for the participants which in turn resulted in them moving forward towards the achievement of their chosen goals.

3. Establishing Priorities for a New Future: Participant Goals

The goals expressed by the participants varied in nature, with four types of goals identified:

1) the goals were expressed directly as the statements from the goals menu, that is, “get into and out of a chair” [3-6]

2) as broad goals with no actual articulation of a particular occupation “ to get back to doing something” [2-14];

3) goals which articulate an occupation “to make sure I could walk” [4-11], and

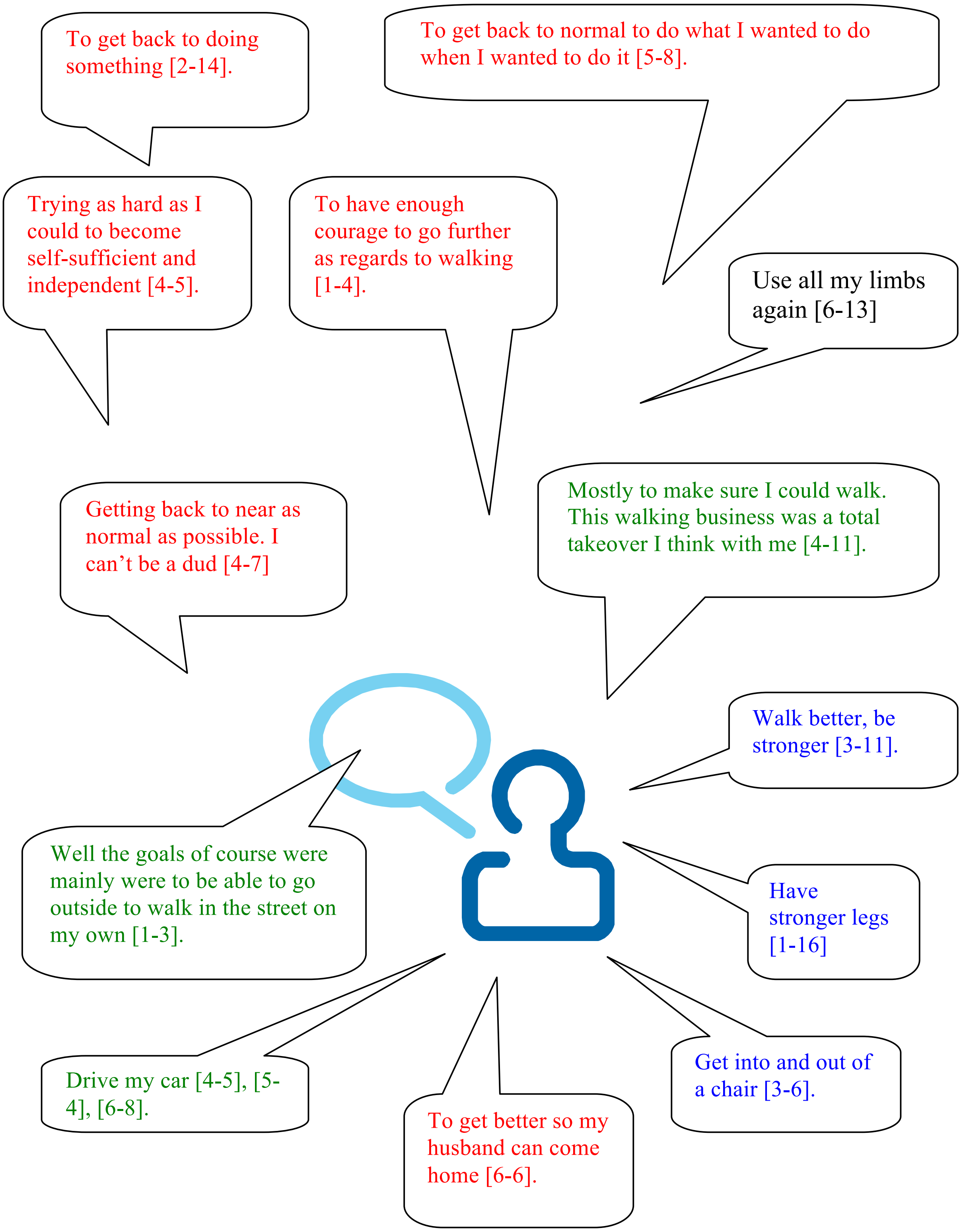
4) goals which focus on improving body impairments “ use all my limbs again” [6-13].

Figure 4 depicts some examples of the goals identified by participants during this study. They are included to show the breadth of goals identified using a goals menu.

Regardless of the goal type identified by participants, the goals menu facilitated participants to set their own goals, and helped the participants to move forward with hope.

FIGURE 4

Examples of goals identified by participants



Key:
1) Goals from the goals menu
2) Goal with no occupation stated
3) Goals articulating an occupation
4) Goal focussed on improving body impairment

4. Working Collaboratively Towards a New Future

There are four subthemes within the theme ‘Towards a new future’.

a. Working together collaboratively: Communication
b. Being understood
c. Taking control
d. What therapists do

Each of these sub themes is discussed separately below.

a. Working together collaboratively: communication.

Communication is central to participants and therapists working together in rehabilitation. Communication is a two-way exchange between therapist and participant. Communicating the aims of rehabilitation enhances participant engagement in rehabilitation, and results in clients feeling respected. Communication enables achievement, especially when the rehabilitation is difficult and requires moving forward in a different direction. However, communication alone is not sufficient to result in achievement; the participant must also complete the work as recommended by the therapists.

Communication needs to be consistent, clear and informative. Participant engagement in rehabilitation is enhanced when the participant is informed. Participants valued being informed as it enhanced their understanding of what they were doing and why they were doing it. This increased the meaning they attributed to the task when performing their rehabilitation exercises and facilitated their motivation and effort. Participants wanted therapists to share their knowledge and felt respected when the therapists did this. Being informed enabled the participants to make the decisions based on the therapist's advice. The statement below demonstrates how a participant values being informed by her therapists:

> Well we would possibly talk about an exercise, perhaps a new one…. she would say "I want you to do this because…" and she would explain the use of the muscles and everything else. Then we'd go ahead with it. I thought that's good, to be told why you're doing something and you understand the meaning of what it is you're doing. I think that's good. [4-12]

The participants identified that verbal discussion, and subsequent action, between the therapists and participant regarding participant goals enabled the achievement of that goal. One participant identified that the therapist's role was to communicate what had to be done in rehabilitation, whereas the participant's role was to complete the work: "I had to do the work, they gave me only hints what to do" [3-10].

Goal based discussion and subsequent progress in rehabilitation required the participants to share their understanding of their own capabilities. The participants had either a realistic assessment of their capabilities, had overestimated their capacity, or they had imposed restrictions and limitations on themselves. To achieve effective rehabilitation the therapeutic relationship needed to accommodate the sharing of negative expectations and any issues arising during rehabilitation. Participant 4 discussed how she responded when she was offered the opportunity to talk about how she was 'feeling' and 'doing' in regard to her rehabilitation. She felt it was safe to inform the therapists that things were difficult and she reported that this led to consultation to determine a way forward to enable achievement. This is evident in the following excerpt in response to the therapist's question regarding how she was feeling:

> I'm not too good at this but give me time", … "I'm not going to be marvellous at that because…" and [I would] give a reason. We always sort of…we met in the middle. We'll do it this way or we'll only do so many and then see if you can work it up, which I did …. The opportunity was always there to speak to her. [4-6]

Therefore opportunities for communication and consultation facilitated agreement about the direction of rehabilitation.

Participant 4 identified that she was able to state what she was finding hard in her rehabilitation program, because she was goal focussed and driven to achieve. When participant 4 was asked to identify what enabled her to say why she was not coping with her rehabilitation she replied "because I wanted so badly to do it well. I wanted to achieve. I wanted to do it" [4-11]. Therefore, striving to achieve her own goals enabled the participant to know what they currently experienced as difficult, and to state this.

Information provided by the participants influenced the therapists' findings, which in turn influenced the rehabilitation provided. Therefore honesty in information sharing supported the participants to achieve their best outcomes. However one client stated that she did not offer negative information as this may have negatively influenced the therapist's assessment of her.

As identified above, the participant needs to engage in rehabilitation by both sharing with the therapist their goals and their subsequent rehabilitation journey, and by doing the work recommended by the therapist.

Being informed enhances engagement in rehabilitation. Conversely, if conflicting or unclear information is provided the participants experience frustration. Participant 2 discussed his emotional response to conflicting information. He had been told by his therapist that the pain he was feeling was ‘in his mind’, yet his doctor said “it can’t be in your mind because the pain has to come from somewhere” to which he stated “So it’s a bit – sometimes I feel a little bit frustrated … because I don’t know” [2-4].

b. Being understood.

The participants identified that they had needs, wants and hopes that needed to be communicated to the therapists. Participant 5 stated: “they wanted to know what I wanted to be able to do and how far I wanted to be able to go, I suppose health wise, and what I’d be able to achieve.” [5-7].

When discussing his involvement with the occupational therapist, Participant 2 justified his lengthy discourse regarding his recent experiences with the health systems, stating: “she needed to know exactly what was going on from the beginning to enable her to understand my position” [2-1]. He described concern that the therapist would be “another person that says yeah, yeah, yeah, and then they don’t do the right stuff” [2-6]. However, subsequent actions by the occupational therapist led the participant to the conclusion that the process of listening by the therapist had enabled her to understand him. A therapist’s understanding of the participants is thus demonstrated by their actions.

Being understood ensured that both the participant and therapist worked together in addressing the participant’s needs. Giving the participant time and listening to them promoted engagement in rehabilitation and was valued by the participants as they felt more equal in the therapy relationship. Participant 6 stated:

> They understood me. They took their time to listen when I had to say something. Even when I have to cry [the therapist] said 'Let go, cry'. [6-20]

Being understood requires the participants to also express their issues and problems so that the therapist could act on that information and provide appropriate rehabilitation. Participant 4 stated "I also wanted her to know that I wasn't coping too good with that particular exercise. To make sure that she was aware of it" [4-11]. However, participants may not always disclose negative issues. Participant 4 stated that she may not have informed her therapist that she had depression, a decision that could hinder the therapist's understanding of the participant.

The goals menu facilitated participants to feel understood and cared for, and they did not feel alone in trying to achieve their goals. They felt that the therapists cared whether they achieved their goals. Feeling cared for by the therapists was a positive experience for the participants. Participant 1 stated "My thoughts and feelings were, it [the goals menu] was helping me, in other words someone was trying to help me to achieve my goals" [1-16].

c. Taking control.

Participants taking control of their own direction in rehabilitation requires them to make their own decisions, which is guided by knowledge of their own capabilities and limitations.

Participants articulated that they were responsible for themselves, and it was their responsibility to make the decisions, "well the decision making was up to me actually" [1-21], and do the work. This gave them ownership and a sense of control in the rehabilitation process. This commitment resulted in the client engaging in the work therapists expected them to do. Participant 2 explored this expectation, stating:

> And it was probably [a] reciprocal way of understanding each other because they saw that I was putting the input into doing, for example, doing their exercises, doing what I was meant to do.… she saw that I was doing that. She didn't tell me but I could feel it, sense it, that she was thinking, oh this guy's doing good. He's doing. And that makes you feel good that she understands that. [2-13]

A focus on goals also contributes to clients aiming to achieve. Participant 3 stated "I would have to do the exercise, and I did them religiously, every morning and every afternoon, because I wanted to help myself, I knew nobody can help me, only myself. So I continued. I did the work" [3-12].

Similarly, Participant 4 acknowledged the connection between working hard and goal attainment:

> Well whatever it is, I'll work on it really hard as best I can to get it right. Because at the back of my mind always was the goal of getting back to normal as near as possible. I can't be a dud. [4-7]

Five out of six participants discussed the importance of knowing their own limitations and capabilities. This awareness of their physical limitations empowered the participants to have a realistic view of their capabilities. This acceptance enabled them to learn to perform within the boundaries imposed by their physical limitations, resulting in a sense of self-management of their health conditions:

> I know my limitations that I mustn't overdo it. Because once I'm out of pain, then I tend to do too much, and then I have pain. So it's limited. [1-12]

In contrast to the concept that participants need to take control, four of the participants adhered to the therapist's advice even when they did not agree. Participant 4 accepted that she was due for discharge even though she herself was doubtful. Participants relied on the advice they were given as they perceived the therapists had appropriate knowledge of rehabilitation. Participant 2 stated the he was "relying on them (the therapists) because they are the ones that were giving me the right advice, the right things to do" [2-13]. Success in rehabilitation required a balance between taking personal control and relinquishing some control to the expertise of the rehabilitation team.

d. What therapists do.

All participants discussed what therapists do in the therapy process, with three subthemes identified:

i. Therapists painted a future.
ii. Therapists addressed the goals selected.
iii. Therapists determined improvement results in discharge

Each of these will be discussed below.

Therapists painted a future.

Therapists predicted the participants' achievements based on an assessment of the participants' current performance. This prediction was shared with the participants, which in turn, enabled the participants to understand their own capabilities and potential. The therapists shared their prediction by:

a. Incorporating opportunities for successful task completion into therapy.

This was based on the therapists ‘knowing’ that the participant was capable of the task prior to performing it. Participant 4 stated: the therapist “took me on the tram, to prove to me and to her that I could go by myself. [3-8]

b. Providing encouragement which included a view of the participant’s future regarding their improvements.

Encouragement was deemed to be important and was the usual approach taken by the therapists:

> You weren’t being directed to do something or being told you must do this, you must do that, or you should be able to do this or should be able to do that. It was more a case of well, you’re going along marvellously. [5-13]

Other encouragement provided by therapists included positive feedback on the quality of the performance, reflecting on their achievements. When therapists informed them of their achievements participants felt proud.

c. Articulating what would happen in therapy, including the participants’ expected involvement.

Participant 2 highlights the importance of therapists sharing their expectations of the participant’s future:

> And so the fact that they actually were talking to me and they took me hand by hand, step by step, and said, okay this is what we’re going to do, this is what you’re going to be, that’s what you’re going to do. [2-15]

Therapists addressed the selected goals at the right time.

The participants identified that the therapists provided a graded, incremental therapy program to facilitate goal achievement that enhanced the participants’ capacity and confidence. The participants trusted the therapists' knowledge to provide an appropriate program for their needs. The participants identified that their progress was incremental and that the rehabilitation program addressed their improvement over time. They understood that the stepwise program was structured to address their goals, and this enabled them to persist with 'the work' of therapy. The participants also understood that they contributed to determining the size of each step taken. At times, the amount of work undertaken by a participant was negotiated with their therapist based on self-belief of their own capacity. When a participant asked about how she managed the changes she made during rehabilitation, she replied: "I wouldn't have got on as well without them. They (the therapist) led you into the next step and the next step" [4-3]. She later identified that she had realised that an overarching goal consisted of many smaller parts which needed to be achieved. When discussing her goal of being "as near as normal as possible" she stated that the goals menu "made me realise that there was a lot of little side issues that went to making the complete finish" [4-15]. Therapists worked to address each of these parts.

Therapist-determined improvements result in discharge.

The participants stated that the therapists initiated discharge based on the participant's improvement and their ability to self-manage in the community. Participant 2 stated:

> she said, okay, at this stage, I think that's it. There's nothing else we can do for you because I think you've reached the goal where you can manage yourself now. And that's about it. If you have any problems, just go to your doctor. [2-15]

The therapists stated that improvement had occurred and did not identify specific areas of improvement. Overall, the goals menu was not overtly used by therapists in decisions about discharge or to measure improvement. The participants' improvement was not discussed in relation to the goals set initially. Participant 3 reported that the therapist said: "I can't do any more for you, because you improved so much" [3-10]. This same participant was able to identify her own improvement. With respect to her memory impairment, she stated "I am not back where I started, but I have improved a lot" [3-9]. Like the therapist, the participant expressed general improvement and did not relate her improvement back to her goals.

Participants reported the goals menu was not overtly used to make decisions about discharge or measure progress: the goals menu was only discussed when setting initial goals, and a copy of the goals were not given to the participants. One participant however felt that lack of discussion of initial set goals worked favourably with his "action approach" to living. He felt that this lack of goal discussion was justified because the therapist understood the best approach to be used with him as a client.

5. 'Doing a Normal Life'

All participants were able to broadly identify the positive influence of rehabilitation on their lives, and presented an overarching notion that participating in rehabilitation enables participants to return to a normal life and feel that they belong back in society. Their journey to achieve this was a stepwise process guided by the therapist. Participant 2 stated that rehabilitation was helpful "in terms of understanding and in terms of going from one point to another and, back to where you belong in society" [2-17].

Participants were able to resume managing things for themselves as they were able to do more and feel mentally stronger. The result of rehabilitation is a re-focus away from their injury state to one filled with the capacity to contribute to life in a meaningful way. The participants may have returned to doing the same things they did previously or they may have taken their lives in new directions. This was reported positively by participants: “But in terms of taking you back where you think you should go, or maybe even in another direction not necessarily back where I came from, I think they’ve done a very good job, yeah”. [2-17]

Being “as near as normal as possible” required being both independent and self sufficient [4-5]. Independence was valued highly, with one participant suggesting that the health condition requiring rehabilitation had limited her independence, and that she had needed to redress this to recover her independence: “You could say I’m somewhat independent… It worried me that I mightn’t be able to drive again – that was something I was concerned about.” [5-7].

Being able to drive was indicated by two participants as denoting freedom. It signalled having resumed living a normal life. Lack of resumption of ‘a normal life’ meant that participants continued to ‘dream’ that they would achieve this. For client 6, her hope of resuming driving was kept “very much alive” [6-8] beyond the duration of rehabilitation, and she continued to engage health services in achieving this.

Participants accepted that despite progress made, problems were still present after rehabilitation, resulting in a myriad of changes in how they lived their ‘normal life’. Their normal life required different adjustments as outlined below.

Getting on and doing things.

This subtheme was identified by three of the participants. For these participants, they had returned home from hospital wanting to take each day as it comes by just randomly doing things in order to keep busy. One participant identified the importance of engaging in activities both in their home and in their broader community. They found that they had been able to resume doing activities which had previously been too hard.

> Well first and foremost, taking each day as it comes, and seeing what I can do each day. Not necessarily setting an actual goal for the day; it's just simply doing things as I see they need to be done, and getting on and doing it. And that's what I did down at my daughter's. I tried to give her a bit of a break in some respects, because that's why I took on the washing, a bit of the ironing, not a lot, there's not a lot to do and cleaning the house, cleaning the floors. [5-5]

New ways for doing things.

Prior occupations could now be done differently, or better than before, depending on the reason for prior limitation. If the participant had a prior physical health condition which had been alleviated by surgery, then their return home included doing things better than before. For other participants who had sudden onset change of health they reported doing things differently in comparison to their prior occupational performance. For some participants, they now relied on external supports including both family and services to engage in prior activity. Participants used aids and equipment, completed activities for a shorter duration, or over a longer time period, and incorporated rests into their occupations.

Doing something new.

One participant had identified that a new direction regarding working life was required as he would be unable to sustain his former job as a waiter due to ongoing back pain post surgery.

> And that was connected to the goal that I had in terms of doing something else in my life rather than to go back to the job that I was doing. So that's when basically she helped me in that sense to reach a level where – she got me into this CRS [Commonwealth Rehabilitation Service] and that's when the goals started to come together. [2-13]

Although problems with occupation remained after completion of rehabilitation, participants reported that their hope had been maintained throughout rehabilitation, and they continued to work towards a resumption of former activities.

Summary of the Participants' Experience

The participants in the study identified a common journey in a goal-based community rehabilitation program, whereby they developed an understanding of their own capabilities, which was re-evaluated throughout their rehabilitation program. The introduction of the structured goal setting tool, the goals menu, broadened the participants' possibilities for future activity engagement which enabled them to set goals for their own future. The participants identified that their final outcome did not relate to the individual rehabilitation goals agreed on at the outset of the program. Rather, the participants re-engaged with many former activities, and stated that this was a return to normal life. The setting of rehabilitation goals contributed to the process undertaken during their rehabilitation journey but the achievement of those initial goals were not the participants' primary concern.

The presence of the participant-set rehabilitation goal enabled both the therapist and participant to engage together in the rehabilitation program in order to achieve those goals. This process of working together enabled the participants to engage in rehabilitation in order to resume their 'normal' life. The therapist and participant's working relationship consisted of a fluid process whereby each had a separate set of 'roles', as well as a collaborative role. The dynamics of the therapist and participant relationship ebbed and flowed during the rehabilitation program. This relationship was important for achieving the end-point of the rehabilitation program: a return to an 'adapted' normal life.

Findings from the second thematic analysis regarding the impact of the goals menu in the participants' rehabilitation experience

As discussed in the methodology chapter, the impact of the goals menu on the participants' rehabilitation was identified as a core theme in the findings, and therefore additional analysis was conducted to identify the key impact of the goals menu on the participants' experience.

The goals menu impacted on how the participants identified and explored their life beyond rehabilitation, which in turn impacted on how they engaged in their rehabilitation program and the subsequent results of that program. It was identified that:

1. The goals menu presented the participants with a new future, and directed the devised rehabilitation program.

2. Hope is derived from the possibility of having a new future, and from the self awareness of their own capabilities and limitations. Having hope contributed to engagement in their rehabilitation program and in the development of the rehabilitation program.
3. The therapists and participant’s ability to work together arises from both the therapist and participant knowing the participant’s capabilities and limitations.
4. The participants knowing their capabilities and limitations is derived from comparisons made against other criteria. It also arises from and impacts on the direction of rehabilitation.
5. The participant’s ability to engage in rehabilitation comes from their having hope, and their being able to work together in rehabilitation with their therapists.
6. The outcome achieved is about the participant living a re-framed life and does not relate to achievement of goals initially set on the goals menu. This outcome arises from the participant and therapist’s engagement in rehabilitation.

The results are presented below in Figure 5: The impact of a goals menu in community rehabilitation: the participants’ perspective. Each of these will be discussed in detail in the discussion chapter.