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**Client participation
in the rehabilitation process**

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ABSTRACT

This thesis evaluates the rehabilitation process with respect to client participation. The Swedish version of a client-centred structure, the Canadian Occupational Performance Measure (COPM), is evaluated from the perspectives of the clients, the occupational therapists and the members of a rehabilitation team. Data have been collected through diaries, the COPM, assessments of ability to perform activities of daily living, mobility, self-assessments of pain and health, interviews with clients, interviews with staff, and focus groups interviews.

The results show that a structured method is needed in order to improve clients' active participation in goal formulation.

The Swedish version of the COPM has high responsiveness to change over time. The use of the COPM improved client participation in the goal-formulation process, according to the results from a study with experiment and control groups. The clients perceived that treatment goals were identified, they were able to recall the goals and felt that they were active participants. They also perceived they had a higher ability to manage after the rehabilitation period was completed compared to clients in the control group.

The clinical utility of the Swedish version of the COPM was confirmed in focus-group interviews with occupational therapists. The occupational therapists perceived the COPM as helpful in the goal-setting process and planning of treatment interventions. Even though problems are identified, they are directly related to, and formulated as, goals. Clients receive feedback on improvement over time. The COPM ensures a client-centred approach, facilitates communication within the rehabilitation team, and encourages therapists in their professional role. Therapists need knowledge about the theoretical foundation of the instrument and have to develop a personal interview technique.

When the COPM is used in a team setting, it provides the team with broader information on what is purposeful occupation to the client. The focus is on occupational performance rather than function. According to team members the use of the COPM as a team tool increased client participation, was a good outcome measure, resulted in distinct goals, and focused on goals that were meaningful to the client.

Implementation of a client-centred approach is facilitated when a structured method is used, but this is not enough. Involvement and motivation from all team members are required, as well as support during the introduction and implementation period. Support from management, knowledge about the underlying theory, time for discussions and reflections as well as opportunities to develop a personal interview technique are pointed out as important factors for a successful implementation.

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LIST OF PAPERS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals I-V.

- I Wressle E, Öberg B, Henriksson C. The rehabilitation process for the geriatric patient - an exploratory study of goal setting and intervention. *Disability and Rehabilitation*, 1999; 21: 80-87. *
- II Wressle E, Samuelsson K, Henriksson C. Responsiveness of the Swedish version of the Canadian Occupational Performance Measure. *Scandinavian Journal of Occupational Therapy*, 1999; 6: 84-89.
- III Wressle E, Eeg-Olofsson A-M, Marcusson J, Henriksson C. Improved client participation in the rehabilitation process using a client-centred goal formulation structure. *Journal of Rehabilitation Medicine*, 2002; 34: 5-11.
- IV Wressle E, Marcusson J, Henriksson C. Clinical utility of the Canadian Occupational Performance Measure – Swedish version. *Canadian Journal of Occupational Therapy*, 2002; 69(1): 40-48.
- V Wressle E, Lindstrand J, Neher M, Marcusson J, Henriksson C. The Canadian Occupational Performance Measure as an outcome measure and team tool in a day treatment program (submitted).

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ABBREVIATIONS

CMOP	Canadian Model of Occupational Performance
COPM	Canadian Occupational Performance Measure
COVS	Clinical Outcome Variables Score
HAQ	Health Assessment Questionnaire
ICIDH	International Classification of Impairment, Disability and Handicap
ICF	International Classification of Functioning, Disability and Health
SF-36	Short Form 36 Health Questionnaire

INTRODUCTION

Social and health culture changes emphasise the need for increased client participation in the rehabilitation process (Dalley, 1999). The role of both patient and relatives has changed during the recent decades, which should effect the client-therapist relation as well as methods used in both data collection and evaluation of intervention. The Swedish Code of Ethics for Occupational Therapists is very clear on this point; in every intervention the occupational therapist should develop an individual plan together with the patient (FSA, 1998^a). It also states that the patient's participation presupposes that the therapist bases all interventions on the wishes and needs of the patient and informs the patient about alternative methods of treatment.

Swedish law states that care should be given with respect for each person's equal value and the individual's dignity (SoS, 1982). The care given should be founded on respect for the individual's autonomy and integrity. Individually adapted information should be given about a person's health status as well as about methods of investigation, care and treatment. The care and the treatment should, as far as possible, be designed and performed in co-operation with the individual. According to the National Swedish Board of Health and Welfare (SOSFS 1996:24) all professional staff have a responsibility for implementing systems for quality assurance. The aim of quality assurance systems is to guarantee that the patient and relatives are treated with consideration and respect, that their integrity is assured, that they receive information, and that they get the opportunity to become active participants. Thus it is obvious that clients should be active participants in the rehabilitation process.

Donabedian (1980) has presented a definition of quality in health care and approaches to its assessment, embracing structure, process and outcome. Wade and deJong (2000) discuss these terms from the perspective of rehabilitation, concluding that rehabilitation is a complex and multidisciplinary process that has recently moved from a predominantly medical approach to one in which psychological and socio-cultural aspects are equally important. Structure entails a rehabilitation service with a multidisciplinary team who work together towards common goals for each individual and who involve and educate the individual and his or her family. The process is an active and educational problem-solving process focused on disability and including the components of assessment, goal-setting, intervention and evaluation. Outcome

refers to the aims of rehabilitation: to maximise the participation of the individual in his or her social setting, to minimise pain and distress experienced by the individual, and to minimise the distress and stress on the family (Wade & deJong, 2000). Wade (1998) also claims that the most specific characteristic of professionals involved in rehabilitation may well be goal-setting skills. Evaluation of client participation is one issue of rehabilitation that needs to be addressed. However, it is difficult to isolate the effects of specific interventions from other factors, and the lack of measurement of participation is still a problem (Wade & deJong, 2000).

A client-centred approach to practice may be one method of enhancing client participation in the rehabilitation process. In Canada occupational therapists have been working with guidelines for practice since the 1980s, using the Donabedian structure (CAOT, 1991). The therapists have developed a model for client-centred practice in occupational therapy, the Canadian Model of Occupational Performance (CMOP). They also addressed the problem of the lack of outcome measures based on client-centred practice and developed the Canadian Occupational Performance Measure (COPM), an instrument for obtaining outcome based on the client's perception. Other models in occupational therapy are also concerned with occupational performance, but the CMOP is the only one that is totally grounded in client-centred practice and occupational performance.

The intention of this thesis was to evaluate client participation in the rehabilitation process, and to evaluate a structure that might improve client participation. In the Background section client participation, client-centred practice, and goal formulation are discussed. In addition, client-centred practice in occupational therapy, in theory (Canadian Model of Occupational Performance) as well as in practice (Canadian Occupational Performance Measure), will be presented. Strategies for implementation of client-centred practice will be penetrated. The evaluation of a rehabilitation process, before implementing the COPM, is presented in paper I. Papers II-V evaluate the COPM as a structure to ensure client participation and as an outcome measure, as well as its usefulness, from the perspectives of the client, the occupational therapist and the members of a rehabilitation team.

BACKGROUND

Client participation

Genuine participation includes shared aims and desires between the interactors (Ashworth et al, 1992). The participants are emotionally and motivationally engaged with each other. The individual has to be seen as a worthy contributor and perceive a feeling of confidence to be able to participate in planning. In a model that stresses the participation of the client, the provider's role is to be active as a partner in the decision process influenced by the client's desires and abilities, and generating options based on these desires as well as expertise (Chewning & Sleath, 1996). Such a model enhances the control and status of the client, whereas a medical model enhances the control and status of the provider. Jewell (1994) found the patient's right to make decisions and to have input in treatment planning as central to patient participation. The significance of each individual situation was fundamental. From a nurse's perspective patient participation includes both the formal structure of the nursing process as well as the intimate nurse-patient relationship, and collaboration involves information sharing or negotiation between the patient and the nurse (Jewell, 1994).

Client participation and a client-centred focus are also central features in the latest version of the Classification of Functioning, Disability and Health, ICF (WHO, 2001). Whereas the 1980 version, the International Classification of Impairments, Disabilities and Handicaps, ICIDH (WHO, 1980) had a linear relationship between impairments, disabilities and handicaps, the final version of the ICF systematically groups functional states associated with health conditions and accentuates the dynamic interaction between the health condition and the contextual factors. The focus is shifted from consequences of disease to components of health. The first part of the classification is *Functioning and Disability*, comprising the two components of Body Functions and Structures, and Activities and Participation. Activity is the execution of a task or an action by an individual, and participation is the individuals' involvement in life situations. Activity limitation is defined as "difficulties an individual may have in executing activities" and participation limitation as "problems an individual may experience in involvement in life situations" (WHO, 2001, p. 14). The second part is *Contextual factors* containing two components; Environmental and Personal factors. The Environmental factors are divided in individual environmental factors, and services and

systems. They can facilitate or limit performance. Therefore, they are coded from the individuals' perspective and situation. The Personal factors are not classified but encompass the particular background of an individual's life and living, for example age, gender, personality, lifestyle, habits, education and profession.

The ICDH-2 (ICF) will probably become the international standard for describing various health states in terms of activity, according to McLaughlin Gray (2001). There is an emphasis on participation in everyday activities as a significant component of health. This is parallel to the focus of occupational therapy, i.e. the use of meaningful activities - occupation - is seen as a means of intervention and goals for intervention. These aspects of meaningful occupation and client participation are also essential foundations in the Canadian Occupational Performance Measure, COPM (Law et al, 1998).

The occupational therapist's emphasis on patient participation in defining outcomes as well as goals is unique, according to Payton et al (1990). Therapy or rehabilitation can be seen as a recurrent planning cycle. It is important to recognise outcomes even if they are only small parts of the original set of goals and to enable the person to take credit for the accomplishments. The outcome should describe not only *what* was accomplished but also *when* and *where*. The patient should also participate in setting the time line for evaluation. The aim is to maximise patient participation.

Kane (1997) points out that few would doubt the importance of including patients' perceptions as a central part of outcome measure, and that patient satisfaction has been an important component of any taxonomy of outcome domains. Some problems must be kept in mind. For example patients may have faulty memories, or unpleasant aspects of care may be forgotten with time, or the patient may not appreciate some aspects of rehabilitation. Kane (1997) also discusses that the central goal of rehabilitation is to achieve autonomy. Patients should play a central role in decision-making about care and its goals. Good decisions require good information. Patients should participate in determining the weights assigned to various outcomes. Simply summing domain scores implies equal weighting. Weights must be based on importance, which involves acknowledging preferences for one outcome over others. There is no theoretical reason why patients cannot establish their own weights based on their personal preferences (Kane, 1997).

Client-centred practice

Carl Rogers (1939) introduced the concept “client-centred practice”, with focus on the individual. Behaviour is influenced by the interaction of factors such as heredity, environmental factors, needs, and cultural and social influences. Client-centred therapy is built on close, intimate, and specific observations of human behaviour in a relationship (Rogers, 1951), and has developed from a method of non-directive counselling to an approach to human relationships. It is not a static method or technique. Instead change and development rather than rigidity are key characteristics of client-centred therapy. The therapist should facilitate problem-solving by stimulating the individual’s desire and ability to understand problems and propose solutions that are appropriate for his or her life. The term “client” was chosen because a client is someone who comes actively and voluntarily to seek help with a problem, taking his or her own responsibility for the situation. The term avoids the connotations that the person is sick or is an object of an experiment. Rogers (1951) declared that if a better term emerges, he would be happy to use it, but in 1951 it was the most appropriate term. The term “client” will be used in this dissertation except when authors referenced use the term patient.

Law and Mills (1998) have found that there are several common ideas within different frameworks that can be used to define client-centred practice in occupational therapy. These common ideas about client-centred practice embrace respect for clients and their families, and their choices. Clients and families have the ultimate responsibility for decisions about daily occupations. Clients must be provided with information, physical comfort, and emotional support. Communication must be emphasised. Client participation in all aspects should be facilitated. Occupational therapy should be flexible and individualised, focused on enabling clients to solve occupational performance issues. The person-environment-occupation relationship should be in focus.

Gage (1995) describes different models of client- or patient-centred care. The term client-centred is applied to any model that centres care on what is believed to be the clients’ needs and has thus many different meanings. She assumes that it may be reasonable to refer to the empowerment of the client through partnership and client control. Gage (1995) discusses two different terms in client-centred practice: patient-focused care and client-driven practice. Patient-focused care is more a way of organising routines close to the patient and cross-

training of staff in order to decrease the number of different people that the patient must interact with. Client-driven practice is a relationship between the therapist and the client that places decision-making control in the hands of the client. It is based on a philosophy of client empowerment and a belief that the perception of the client is the only reality that matters. Gage and Polatajko (1995) argue that client-centred practice implies that the professional attention focuses on the needs of the client, but does not address the role of the client in the care process. Therefore, they suggest the term client-driven as the most appropriate term.

In the early 1980s the Canadian Association of Occupational Therapists (CAOT) started to develop a framework for Canadian occupational therapy, with a focus on client-centred practice. Client-centred practice in occupational therapy embraces a philosophy of respect for, and partnership with, the client (CAOT, 1997). National guidelines for client-centred practice based on this concept were published (CAOT, 1991), representing a paradigm shift in Canadian occupational therapy from a medical-based practice to a practice based on the needs of the client.

The definition of client-centred practice used in Canadian occupational therapy is as follows:

Client-centred practice refers to collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others. Occupational therapists demonstrate respect for clients, involve clients in decision making, advocate with and for clients in meeting clients' needs, and otherwise recognize clients' experience and knowledge.

(CAOT, 1997, p. 49)

Basic assumptions of a client-centred approach, according to Law et al (1995), are that clients are experts about their own occupational function, each client is unique, and clients have the right to receive information to enable them in decision-making. On the basis of these assumptions, clients and therapists can focus on their unique contribution and responsibilities to build a client-centred partnership where clients expect to lead the decision-making process. Clients and therapists work together to define the occupational performance problem, the focus and need for intervention, and the preferred outcomes (Baum & Law, 1997). Clients request information that will enable them to make decisions and to define occupational performance priorities for intervention. They expect to receive service and to be treated with

respect and dignity. The therapist encourages clients to use their own resources to help solve problems. Clients participate at different levels, depending on their capabilities. Therapists support client decisions or communicate the reason why he or she cannot support the decision. The therapist also respects the client's values and visions as well as the client's style of coping. She or he encourages clients to recognise and build on their strengths. It is important for the client to understand the scope of the therapist's knowledge and access to resources. It is also important to be aware of the client's insight into his or her own condition, the client's earlier experiences of the problems and a mutual understanding of the formulated goals (Baum & Law, 1997).

By focusing on occupational performance, occupational therapy practitioners assist clients in becoming actively engaged in their life activities. Baum & Law (1997) maintain that occupational therapists must work collaboratively with persons in the client's environment to assist the client in obtaining skills and to make modifications to remove barriers that create a social disadvantage. Shires (1993) confirms the opinion that occupational therapy needs to emphasise teaching the patient skills for self-direction, such as comparing choices, assessing risks, setting priorities, identifying resources, crisis management and creative problem-solving.

A British definition of client-centred practice has been developed through studies performed by Sumsion (1999^a, 2000). A literature review resulted in a questionnaire containing a list of possible components of a definition. Using the Delphi technique this questionnaire was answered by 64 occupational therapists in four rounds resulting in a draft definition (Sumsion, 1999^a). In a subsequent study Sumsion (2000) included 67 occupational therapists in focus groups interviews, with the aim of further developing the draft definition. A final validation was obtained through a revision by members of the Council of the College of Occupational Therapists. The British definition was presented with this preamble: "There are many factors that influence the successful implementation of client-centred practice, including a clear determination of who the client is and the recognition of the impact of resources." (Sumsion, 2000, p. 308).

The British definition is:

“Client-centred occupational therapy is a partnership between the client and the therapist that empowers the client to engage in functional performance and fulfil his or her occupational roles in a variety of environments. The client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the client’s values, adapts the interventions to meet the client’s needs and enables the client to make informed decisions.” (Sumsion, 2000, p. 308).

In Sweden no explicit definition of client-centred occupational therapy has been published. However, in the Code of Ethics, developed and published by the Swedish Association of Occupational Therapists (FSA, 1998a), the following statements could be interpreted as supporting the concepts of client-centred practice. The client should be treated with respect, treatment should be based on the wishes and needs of the client, and necessary information should be given to the client. The tasks of the occupational therapist shall focus either on the individual or the environment and relate to the client’s activities of daily living (FSA, 1998^a).

Goal formulation and planning

According to Nordenfelt (1996), the health of the individual should be defined as the capability to realise vital goals. Vital goals are all states that have a high priority along a person’s scale of preferences, what is necessary for the realisation of the person’s state of minimal long-term happiness. A person is healthy only if he or she is able to attain certain vital goals in life.

The most important step in the enabling client-centred process is when the client sets the goals (Sumsion, 1999^b). Pollock (1993) favours a client-centred process for goal formulation and assessment of change. She argues that if individuals do *not* formulate the goals themselves, they are not able to solve them either, and patient participation and a feeling of control over health is reduced. On the other hand, when the patient participates in the goal formulation process, the potential for an active participation increases (Pollock, 1993).

An essential factor for client-centred practice is to have the client identify occupational performance issues that will be the goals for therapy, and thus a foundation for treatment planning. Goal formulation helps the client to orient towards the future and to receive feedback. Focusing on what is meaningful to the client facilitates engagement in therapy, but goals that have little value to the client are likely to result in low motivation and a poor outcome (Matheson, 1998). Hong and colleagues (2000) argue that the client should be involved in the assessment process because the client is the expert on his or her problems, and therefore every effort must be made to involve the client in decisions about the nature and direction of therapy.

Also Schut and Stam (1994) maintain that treatment goals should be formulated in activities that are essential for the patient. Goals should be formulated in terms of performance, be easy to understand for all team members, be attainable, facilitate program planning, and be measurable. It is important to have precisely expressed goals in rehabilitation teamwork. In teamwork common objectives are essential. Goal setting has a communication impact and is a prerequisite for interdisciplinary teamwork as it requires the participation of the team members in problem analysis. Goal setting has a motivational aspect, and provides a means for assessment of the outcome and evaluation of the rehabilitation process.

Nelson and Payton (1991) question how effectively therapists are involving patients in program planning. The authors believe that health care consumers have a right to participate in the planning of their treatment. They present the use of a Patient Participation System, a format with which the therapist conducts interviews with a patient, initially and after a period of therapy. The questions asked initially embrace the clients' perception of his or her concerns and goals. After completed therapy questions are asked about what has been achieved. The extent of patient participation in this process depends on the patients' ability to identify problems, goals and results. The Patient Participation System also permits therapists and patients to work together on the same specific goals related to the same real concerns, and serves as an aid in treatment planning. The patient experiences a goal setting process and learning situation that could be valuable after completed therapy.

Measures of outcome

According to Kleinpell (1997), outcomes are used for describing the impact of care/rehabilitation on patients' lives, establishing a basis for clinical decision making, evaluation of effectiveness, and identifying areas for improvement in health care. The emphasis should be patient-centred because the patient can best judge the outcomes. Outcome measures can only be reliable and comprehensive indicators of the effects of care if patients are involved in identifying those outcomes that make an impact on their lives (Kleinpell, 1997). Rehabilitation outcomes must reflect how rehabilitation enables a person to become more independent, productive and active, and able to maintain health (DeJong, 1987). The author argues that the unit of analysis is the individual and the individual in relation to the environment, and the goal is to enhance the ability to function as independently as possible within a specific set of activities.

Patients' perceptions of improvement or satisfaction with level of performance predict whether individuals seek care, accept treatment and consider themselves recovered (Bowling, 1997). Therefore, measures of outcome should take account of the individual's own assessment.

Patients should not only play a central role in decision-making about care, but also in weighting the importance of the various outcomes. Advantages of client-centred approaches to assessment are that they tend to enhance the sense of mastery and control among clients, the extent to which the therapy is individualised, and the opportunity for the therapist's own personal and professional growth and development (Pollock & McColl, 1998). Assessment difficulties arising from a client-centred perspective may be that some clients rely on the therapist to tell them what their problems are. Client-centred assessment may not be acceptable to all therapists depending on the therapists' personal views and belief in the clients' resources. There is also a need for more assessments that support the client-centred approach, since there are few occupational therapy assessments suitable for application in client-centred practice (Pollock & McColl, 1998). Outcome measures currently in use rely on provider information and measure patients' performance, but do not record patients' perceptions of important components of outcomes (Kane, 1997).

A model for client-centred practice in occupational therapy

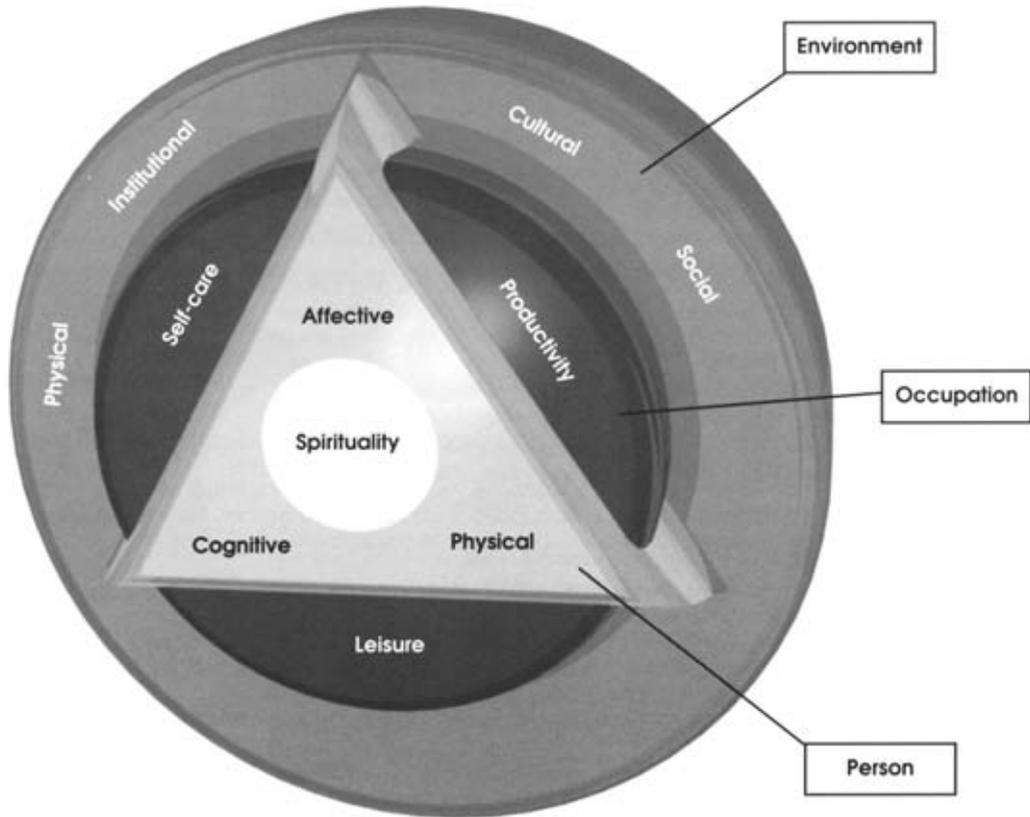
Only one model specifically designed to promote client-centred practice in occupational therapy has been developed and published. The Canadian Model of Occupational Performance (CMOP) has a client-centred perspective and provides a framework for enabling occupation for all people (CAOT, 1997). The Model is based on the assumption that individuals should have a fundamental part in the therapeutic process in order to enhance their performance of self-care, production and leisure. Therapists and clients collaborate to meet occupational performance goals that clients define as meaningful (CAOT, 1997). If people have a sense of control in their life, occupations are more likely to be effective.

According to the CMOP, there is a dynamic relationship between the person, the environment and the occupation, resulting in occupational performance (CAOT, 1997). Occupational performance could be defined as:

“Occupational performance refers to the ability to choose, organize, and satisfactorily perform meaningful occupations that are culturally defined and age appropriate for looking after one’s self, enjoying life, and contributing to the social and economic fabric of a community” (CAOT, 1997, p. 30).

Occupation occurs in the interaction between persons and their environment (figure 1), and if there is a change in any aspect of the CMOP, all other aspects would be affected. An activity is the basic unit of a task, something that contributes to its completion. A task encompasses more than one purposeful activity but is not as broad as an occupation. Occupation brings meaning to life and concerns what a person considers meaningful activities. The purposes of different occupations are structured in three areas: leisure, productivity and self-care.

Leisure includes occupations for enjoyment and ranges from active recreation to socialisation. Productivity refers to occupations that make a social or economic contribution: school work, paid or unpaid work and household management. Self-care entails occupations for looking after one’s self like personal care, personal responsibilities, functional mobility and organisation of time (CAOT, 1997).



Enabling Occupation: An Occupational Therapy Perspective, CAOT 1997

Figure 1: Canadian Model of Occupational Performance (CAOT, 1997, p. 32)

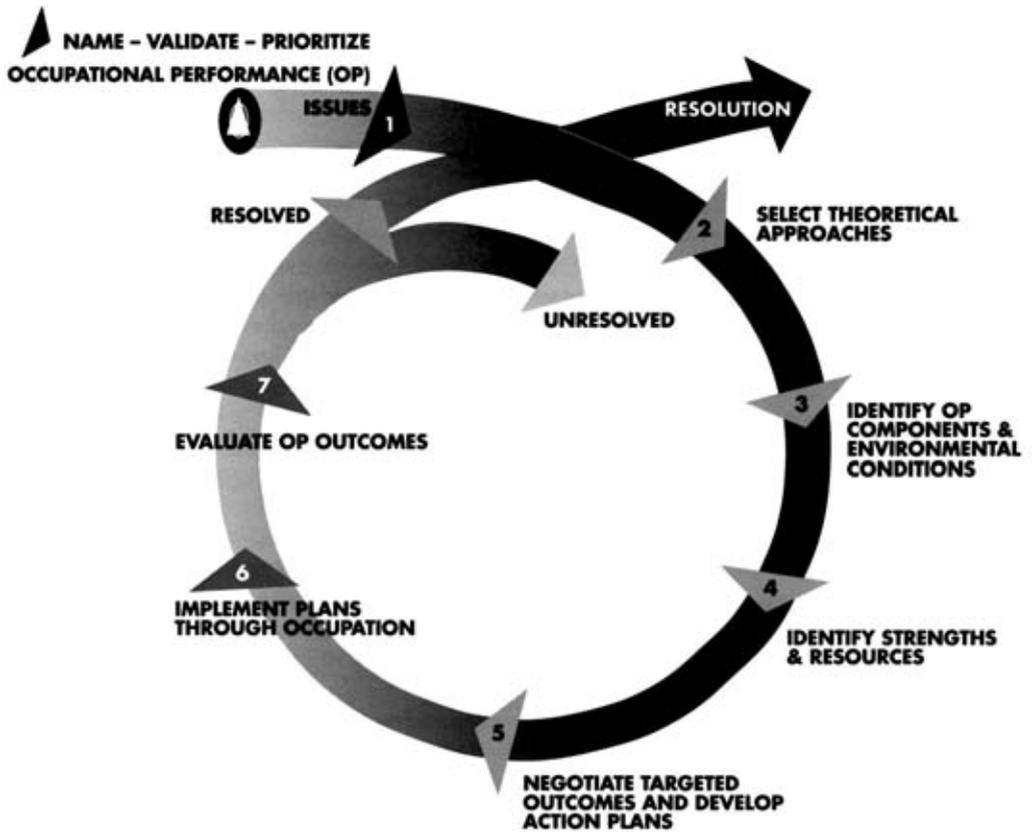
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The person is seen as an integrated whole, where spirituality has a core role. “Spirituality resides in persons, is shaped by the environment, and gives meaning to occupations” (CAOT, 1997, p. 33). The concept of spirituality concerns the essence of self. The uniqueness of every person is the expression of will and motivation and a source for personal control. The performance components contain affective (feeling), cognitive (thinking) and physical (doing) aspects.

The CMOP defines the environment as the context where occupational performance takes place. The environment has an influence on occupation, and is also influenced by the behaviour of a person. It can have an enabling or a constraining effect on occupational performance. Important elements are the cultural, the social and the physical environment. The cultural environment encompasses ethnic, ceremonial and routine practices based on the value systems of particular groups. The physical environment is built or natural surroundings; for example buildings, roads, technology and weather. The social environment concerns social priorities, patterns of relationships of people in an organised community and groupings based on common interests, values and beliefs. In addition, the institutional environment is considered to have impact on occupation and encompasses policies, decision-making, financial priorities and political components on a societal level.

The guiding principles for the process of occupational therapy are described in the Occupational Performance Process Model (CAOT, 1997), and are based on the CMOP. This process model (figure 2) shows how the core concepts of the CMOP can be applied in work with clients. Essential to this process is the partnership between the client and the occupational therapist. The occupational therapists' knowledge and experience assist in enabling occupation.

The first stage of the Occupational Performance Process Model relates to the identification of problems in occupational performance. These occupational performance issues must be confirmed with the client. Then the occupational therapist selects the theoretical approaches relevant for the remaining process. In the third stage occupational performance components and environmental conditions that contribute to the issues are identified. This includes determining what to assess, selecting methods and analysing findings. In the fourth stage the clients' strengths in affective, cognitive and physical performance components are identified, as well as their resources in environmental conditions. The targeted outcome, the goal, represents the estimated result from occupational therapy negotiated between the client and the therapist. Stage five concerns this negotiation and the development of an action plan. The strategies for enabling change in occupational performance and/or environmental conditions are discussed. Actions are implemented in stage six, and the results are evaluated in stage seven. The process is completed if the occupational performance issues are solved. It is continued if the issues are unresolved, or new issues are present (CAOT, 1997).



(Adapted from: Fearing, Law & Clark, (1997).
Canadian Journal of Occupational Therapy, 64, p. 11)
Enabling Occupation: An Occupational Therapy Perspective, CAOT 1997

*Figure 2: The Occupational Performance Process Model (CAOT, 1997, p 61)
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A tool for client-centred practice in occupational therapy

The Canadian Occupational Performance Measure, COPM, (Law et al, 1991; 1994^a; 1998) presents a structure for formulating treatment goals identified by the client in co-operation with the occupational therapist. The theoretical foundation is the Canadian Model of Occupational Performance. Designed as an outcome measure to capture perceived changes over time in occupational performance the COPM has specific instructions and methods for administering and scoring the test. It is not norm-referenced; the theoretical base upon which the COPM was developed describes occupational performance as an individual subjective experience.

The assessment is performed through a semi-structured interview, in which the client identifies perceived problems in occupational performance. The identified problems serve as a basis for the specification of targeted outcomes and the establishment of intervention priorities (Law et al, 1998). The client identifies problems within the three areas of self-care, productivity and leisure. When the problems have been identified, the client is asked to rate the importance of the identified activities in order to become engaged in setting intervention priorities. Importance is scored on a ten-point scale ranging from 1, meaning “not important at all”, to 10, “extremely important”. This process is intended to facilitate the treatment planning, and those activity problems that are of the highest priority will be used as the basis for scoring performance and satisfaction. Then the client evaluates his or her perception of performance and satisfaction with performance in relation to the previously formulated goals. For scoring the self-perceived performance a ten-point scale ranging from 1, meaning “not able to do it”, to 10, which is “able to do it extremely well” is used. Satisfaction with this performance is scored on a scale ranging from 1, “not satisfied at all”, to 10, “extremely satisfied”. Summary scores for performance, as well as satisfaction, are calculated by summing the scores of each problem and dividing by the number of problems. Perceived performance and satisfaction with performance are reassessed after intervention. After completed re-assessment, two total scores are calculated, being the difference between the initial mean score and the re-assessment mean score. These two total scores show the change in performance, as well as in satisfaction with performance.

The Swedish version of the COPM (FSA, 1999) is shown as an Appendix in this dissertation, reprinted with permission from the publisher.

The application of the COPM interview (Law et al, 1998; FSA, 1998^b; 1999) and scoring are presented in a case example:

Eric is a 74-year-old man living with his wife. His diagnosis is Parkinson’s disease. He walks without technical aids inside the house, but has a stick for longer walks outside. In the COPM interview he is asked to define problems with occupational performance in daily activities in self-care, productivity and leisure. The therapist asks him to identify the daily activities he wants to do, needs to do or is expected to do by encouraging him to think about a typical day. Eric identifies three problems, all of high priority according to his scoring of importance (table 1). Then he is asked to score his performance of the identified problems, and his satisfaction with this performance. Improvement of performance of the three identified problems is considered as the goal. This process forms the basis for the program planning. Re-assessment is performed at a set point after a period of rehabilitation. The calculations show a positive change in performance (5 points) and increased satisfaction with performance (3.7 points).

Table 1: Case example of identified problems, scores and calculations

Problems	Importance	Initial assessment		Re-assessment	
		Perform.	Satisf.	Perform.	Satisf.
Getting out of bed	10	4	4	8	8
Eating (cutting, holding glass)	10	3	5	10	10
Gardening	8	2	3	6	5

Calculating mean: $9/3 = 3$ $12/3 = 4$ $24/3 = 8$ $23/3 = 7.7$

Change in performance: $8 - 3 = 5$

Change in satisfaction: $7.7 - 4 = 3.7$

Previous testing of the COPM

The Canadian version of the COPM is tested for the instrument's psychometric adequacy in several studies (table 2), whereas the Swedish version is only tested in the papers II-V in this dissertation.

Table 2: Testing of the psychometric properties of the Canadian version of the COPM

Property	Aspect	References
Reliability	Test-retest	Sewell & Singh (2001)
Validity	Content validity	Chan & Lee (1997)
	Criterion validity	Chan & Lee (1997), McColl et al (2000)
	Construct validity	McColl et al (2000)
	Concurrent validity	Carpenter et al (2001)
Responsiveness	Sensitivity to change	Law et al (1994 ^b), Carpenter et al (2001)
Utility	Clinical utility	Law et al (1994 ^b), Toomey et al (1995), Carpenter et al (2001)
	Community utility	McColl et al (2000)

Sewell and Singh (2001) examined the test-retest reliability of the COPM in 15 clients with chronic obstructive pulmonary disease (COPD). A consecutive sampling of clinically stable COPD clients participated. All the COPM interviews were completed by the same occupational therapist. After 7 days the scoring process was repeated for each client. The results indicate that the COPM is a reliable tool in this client group. Test-retest reliability has been tested with good results according to the manual of the COPM (Law et al, 1998), but these results have unfortunately not been published.

Results from a pilot study (Law et al, 1994^b) indicate good clinical utility and also that the instrument is sensitive to changes over time. The study was completed in three phases.

Initially the authors tested the format, directions and wordings of the measure in clinical facilities in their communities. The second phase included further testing across Canada in order to identify clinical and measurement issues arising during the administration of the COPM. During the third phase, including data from Canada, New Zealand, Greece and Britain, detailed information was collected concerning the manual, administration guidelines, video for training purposes, client demographics and COPM scores. The majority of clients and therapists indicated that the administration of the COPM was easy, and the format and scores were clear. The COPM process appears to identify a wide range of occupational performance issues in the areas of self-care, productivity and leisure. It was highlighted that the process of learning how to use the COPM takes time, and that the therapist needs to develop an effective interview technique. The findings resulted in changes in the second edition of the COPM manual; more detailed instructions, case examples and elimination of a weighting formula in the scoring procedure (Law et al, 1994^b).

Toomey and colleagues (1995) studied the factors that both hindered and facilitated the use of the COPM. The method used was focus group sessions with a final plenary session. Data obtained from one group were analysed and presented to the next group. All data were audio-taped and transcribed. In the plenary session the themes were validated. The authors reported the COPM to be a clinically useful tool when used with selected clients and when it is introduced at an appropriate time. The COPM was considered to be inappropriate when a single specific task is to be accomplished, such as providing an aid or adaptation. The use depends on the clients' skills in identifying and scoring, and the therapists' interview skills. It is necessary that the therapists be well prepared to work with this tool and have incorporated the client-centred approach into their practice. Support from management was requested from the therapists for an effective use of the COPM.

Chan and Lee (1997) studied the content and criterion validity of the first edition of the COPM, suggesting that the assessment content and processes reflected clients' occupational performance issues. The COPM was seen as a good method to incorporate clients' perceptions of performance, but not to measure the performance components of clients. A solution to this is to combine the COPM with other clinical assessments.

McColl and colleagues (2000) evaluated community utility, construct and criterion validity in a cross-sectional study. A package of self-administered instruments was sent out to 61

disabled persons who had received community occupational therapy services. A week later the COPM interview was performed, as well as a utility questionnaire. The COPM scores were compared with measures of satisfaction with performance, independent living, life satisfaction, and client-identified occupational performance problems. Multivariate analyses showed that the COPM scores were significantly related to theoretically related constructs. The results indicated support for construct and criterion validity. All participants reported that there were no problems in understanding the COPM; 75% of them found the COPM useful in identifying and rating their problems.

Carpenter and colleagues (2001) tested the utility of the COPM as an outcome measure for a pain program. Eighty-seven clients completed a battery of tests including the COPM at baseline, and end of program, with a follow-up after 3 months. The authors considered that the results showed good evidence of concurrent validity and sensitivity to change. The use of the COPM enhances a relationship between the client and the therapist giving opportunities to share problems and fears with someone who is interested.

Previous studies on implementation of client-centred practice

A number of studies have been published on the use of the COPM in clinical practice, mainly from Canada and Great Britain. Sumsion (1999^b) remarks that numerous issues related to the application of the client-centred practice have to be considered by the therapist before implementation. The definition of the term “client” is important as is the acceptance of this term. The balance of power must be considered. This embraces giving power to clients. The therapist has a role as educator, and therefore needs communication skills in order to provide the client with sufficient information and negotiate the focus of the intervention. The client’s ability to choose and to make decisions is also important (Sumsion, 1999^b).

Parker (1999) has developed strategies for implementing client-centred practice. Before starting, the philosophy should be reflected in a clear statement that reflects the client-centred approach throughout intervention, treatment and discharge planning, and follow-up. Clear expectations of staff performance should be built in; for example, that all case notes should have a clear statement of client-centred goals. Parker (1999) underlines that the role of the manager is to empower and encourage the development of the team in order to achieve a client-centred practice.

The following strategies for implementing client-centred practice are given:

1. Evaluate existing practice and attitudes.
2. Debate, discuss and explore issues with the team.
3. Educate, read and observe practice.
4. Provide support, supervision and training.
5. Develop a plan of action, pilot studies and trial interviews.
6. Implement client-centred practice into all aspects of assessment and intervention.
7. Review record-keeping.
8. Evaluate, audit and give feed-back (Parker, 1999, p. 50).

This list of strategies clearly shows that the preparation phase (points 1–5), before implementation, is time-consuming and definitely requires a person or group of persons that are devoted to client-centred practice. The managers have to empower and encourage the therapists, and managers must have their own vision. After implementation (point 6), another phase (points 7-8) begins that comprises continuous evaluation of practice, including discussions amongst therapists, and opportunities to further develop the therapists' interviewing skills. Again, time is needed for reflection and feed-back.

There are challenges at different levels when a client-centred practice is to be implemented; at the system or organisational level, at the level of the therapists and at the level of the client (Wilkins et al, 2001).

Challenges at system or organisational level

Wilkins and colleagues (2001) discuss the challenging task of transforming client-centred practice into action. There is a need for commitment from all levels of the organisation, and it is important that there is a person or a group who guides and facilitates the change process. Therapists must constantly reflect on their practice, and discuss this with colleagues. Waters (1995) points out that the effectiveness of the COPM process is limited if the approach is not accepted by all team members. Also Toomey and colleagues (1995) state that the COPM is a clinically useful tool when therapists are well prepared to work with this instrument. Moreover, management must support the use of the COPM. This support must include recognition of the contribution the outcome measure makes to quality in care, and also

authorise extra time for initial learning, and for therapists to refine their interviewing skills (Toomey et al, 1995). One problem at the organisational level is that client-centred therapy is difficult to practice in a system dominated and structured by a biomedical model (Pollock & McColl, 1998). Factors such as team philosophies, documentation and oral reports, as well as limitations in resources must be analysed in order to create an awareness of obstacles that may exist.

Challenges at the level of the therapist

Several authors discuss implementation challenges at the level of the therapists. Client-centred practice requires a shift from the traditional model to an approach that emphasises equality, sharing and partnership. To be able to cope with this challenge therapists need enhanced skills in negotiation, collaboration and consultation (Wilkins et al, 2001). Sumsion (1993) suggests that client-centred practice is a great challenge for the therapists as it requires the use of all knowledge and skills to motivate clients to meet their potential. She affirms that it is more challenging to facilitate a decision about a direction to take than it is to make that decision for the client. The COPM is considered an excellent example of the application of client-centred practice. According to Baum (1998) focus must shift from performance components to knowledge and understanding of why occupational performance problems occur and what might be done about them. This focus requires that therapists reframe their thinking of occupational therapy. The therapists should assist the clients in becoming actively engaged in daily life activities.

Northen and colleagues (1995) studied whether occupational therapists involved patients and their families in a goal-setting process, and identified the methods used. Thirty occupational therapists practising at ten adult rehabilitation settings were included in their study. Data were collected through audio-taped sessions when therapists administered an initial evaluation with clients, by reviewing documentation, and via interviews with therapists. Results showed that although therapists involved patients and families in a goal-setting process, they were not involved to the maximum extent. The use of a structured method or technique to involve clients in goal setting was reported to affect the results in a positive way; clients' involvement was facilitated and their control was enhanced.

Neistadt (1995) conducted a study to determine what methods occupational therapists are using to assess clients' priorities for treatment. Questionnaires were sent out to department

directors in adult physical disability settings, and 269 answers were analysed. Of these 95% used informal interviews to gather information about clients' priorities. Formal methods of assessment like the COPM or Goal Attainment Scaling were not listed on any of the respondents' surveys. The author argues that the quality of information derived through informal interviews is likely to vary amongst different therapists, and that the use of a formal method could ensure that all clients were helped to define their goals for treatment. However, the value of the client-therapist collaboration is not supported by a procedure that has become automatic, and education how to use formal tools to set collaborative goals should be emphasised.

Mew and Fossey (1996) identified three aspects of client-centred clinical reasoning; collaboration to define problems and to negotiate goals, the therapist's acknowledgement of the client's feelings and the therapist's understanding of the client. The authors point out that the therapists need to critically consider their practice and to be aware of which approach they prefer, and that congruent strategies and tools are used. Working client-centred within the current health care environment is challenging. Rebeiro (2000) performed in-depth interviews with two occupational therapy clients in psychiatric care to gather information from their experiences as clients of an occupational therapy service. The clients described their experiences of the therapy as prescriptive, and as less than client-centred. The profession must allow practice to be guided by the clients' visions, to provide choices for the client and to develop an accepting, supportive environment (Rebeiro, 2000).

Sumsion & Smyth (2000) studied which barriers that were perceived by occupational therapist to hinder a client-centred approach, and which methods they considered most effective to overcome these barriers. After a literature review regarding barriers and methods to overcome barriers, a postal questionnaire was developed and sent out to therapists listed in the United Kingdom's Canadian Occupational Performance Measure Network. The highest rated barriers were therapists and clients having different goals, therapists not accepting clients' goals, therapists feeling uncomfortable letting clients choose their own goals, and interventions dominated by the medical model. Methods to overcome barriers included using case examples showing how to work client-centred, support from management, involvement of all staff in the training of client-centred practice, and time for education concerning how to practice. The authors conclusion was that the therapists need to explicitly check formulated

goals with the clients, and that therapists should strive to foster enabling, client-centred attitudes.

In a discussion article Dalley (1999) questions whether a client-centred approach is compatible with professional issues. She concludes “that a client’s requirements for evaluation are too broad to allow attribution of the outcomes to physiotherapy while the professional requirements are too specific to be client-centred” (p. 491). She argues that physiotherapy should be client-centred, but evaluation of therapy should be developed from two perspectives; in a client-centred direction as well as considering the effects of specific therapy (Dalley, 1999).

Challenges at the level of the client

All clients are not willing or able to become involved in a partnership with the therapist. In these cases, for example clients with cognitive problems, clients with lack of insight or clients with depression, a family member might be the informant, and therefore the primary client (Wilkins et al, 2001). Clients may lack confidence or opportunities to question given information, to disagree with the direction of interventions, or cultural issues may hinder the client from taking full advantage of the client-centred approach. Clients may expect the therapist to take a leading role and direct the interventions (Sumsion, 1999^b). When using a client-centred approach with elderly people, barriers like health status with frailty and co-morbidity may be present. The strategy for overcoming these is to enhance communication, advocacy with and for the client, and moderate the demands for decision-making. Another barrier may be the attitudes of the elderly, attitudes that may be held by the older client but also by the therapist (Hobson, 1999^a).

AIMS

The general purpose of this thesis was to evaluate client participation in the rehabilitation process. A further purpose was to test the usefulness in clinical practice of a structured method, the COPM.

The specific aims of the studies were:

- to describe and analyse the rehabilitation process for the geriatric stroke patient concerning treatment goals expressed by the staff and the patient, and treatment interventions chosen by the physiotherapist and occupational therapist (I).
- to validate the Swedish version of the Canadian Occupational Performance Measure as an outcome measure by testing the responsiveness to change over time (II).
- to evaluate whether the use of the Canadian Occupational Performance Measure affects the patients' perception of active participation in the rehabilitation process (III).
- to test the clinical utility of the Swedish version of the Canadian Occupational Performance Measure from the perspective of occupational therapists (IV).
- to investigate whether the Canadian Occupational Performance Measure is useful as a tool in a rehabilitation team (V).

METHODS

This thesis combines quantitative and qualitative research methods. Four studies (I-III, V) have been performed in daily clinical practice. In addition to the COPM different questionnaires have been used, some of them already being used in daily practice in that particular clinic. An overview of the aims, the subjects and the observations performed is presented in table 3.

Table 3: Overview of the studies: aims, subjects included in analysis, and observations.

Study	Specific aim	Number of subjects	Number of observations
I	to describe the rehabilitation process concerning goals and interventions	19 clients	Diaries (19)
		5 clients + 17 team members	Client and staff interviews (30)
II	to test the responsiveness of the COPM	108 clients	COPM (216)
III	to evaluate whether the COPM improves client participation	88 clients (exp.gr) + 30 clients (contr.gr)	Client interviews (118) COPM (176) Klein-Bell (236) COVS (236)
IV	to evaluate the clinical utility of the COPM	27 Occ ther	Focus groups interviews (6)
V	to evaluate the COPM as a team tool	16 clients before COPM + 40 with COPM	Client interviews (52) COPM (80) SF36 (80) HAQ (80) Perceived pain (80) Perceived health (80)
		7 team members	Staff interviews (14)
COPM	Canadian Occupational Performance Measure		
COVS	Physiotherapy Clinical Outcome Variables		
HAQ	Health Assessment Questionnaire		
Klein-Bell	Klein-Bell ADL Index		
Occ ther	Occupational therapist		
SF36	Short-Form Health Survey		

Subjects and methods in study I-V

Study I

Study I included a consecutive sample of 19 clients with stroke (mean age 81, range 70 – 92) admitted to a geriatric ward. Interviews were performed with 5 of these 19 clients (mean age 82, range 76 - 89). The inclusion criteria for being interviewed were the ability to communicate and being in an early phase of the rehabilitation process. Data were collected from intervention diaries, written by occupational therapy and physiotherapy staff. The team members (physiotherapists, occupational therapists and physicians) who treated the interviewed clients were also interviewed. Altogether, 8 interviews with clients and 22 interviews with staff were performed, including interviews early in the rehabilitation process as well as after discharge. Figure 3 shows the logistics of data collection.

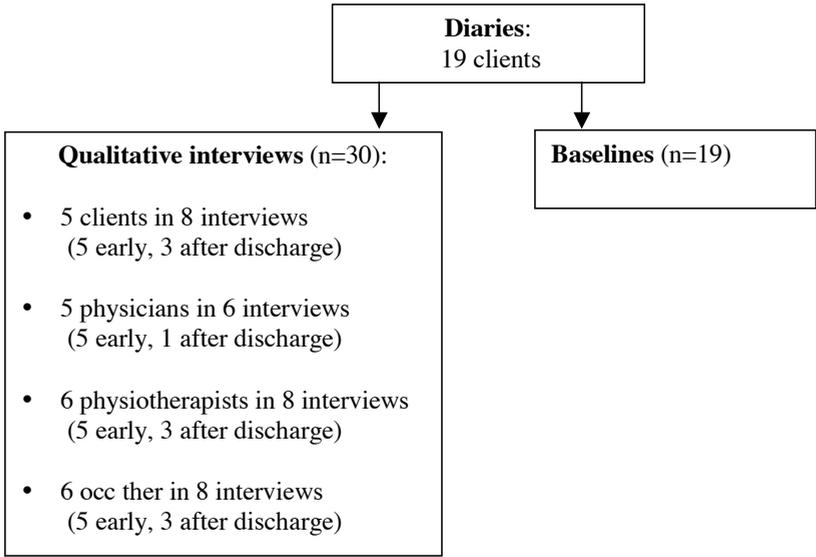


Figure 3: Logistics of data collection in study I.

Study I was explorative and resulted in a description of the goal formulation process, choice of treatment interventions, and different patterns of the rehabilitation process. The methods used were qualitative interviews and diaries following each client. A question guide for the interviews was developed defining the important areas: the patient’s pre-stroke situation, the falling-ill period, the rehabilitation interventions, the goals and the methods for outcome

measuring. The same question guide was used for interviews with clients and personnel. All interviews were transcribed. The analysis of the interviews had a qualitative approach. The diaries, written by occupational therapy and physiotherapy staff in their own words, contained information about treatment interventions, decisions at team conferences and on other occasions that influenced the rehabilitation process. The diaries constituted the basis for baselines of the rehabilitation process, one for each patient. The baselines were used in a search for patterns of decision points, connections in time, and causes of change in the rehabilitation process. All treatment interventions and goals were classified according to the ICDH (WHO, 1980).

As the results showed an insufficient goal formulation process, this study became the entry point to the following studies, testing an instrument that is designed to improve the client's ability to be an active participant in the process.

Study II

The subjects were 108 clients in geriatric wards, neurological wards, neurological day care or home rehabilitation. The mean age of the clients was 72, ranging from 22 to 93 years. A majority were female (67%). Inclusion criteria were the need for rehabilitation interventions and being able to communicate for the interview.

Data were collected through assessments with the COPM before and after completed rehabilitation. Statistical analyses performed were Wilcoxon signed rank test to examine differences between initial assessment and re-assessment of performance and satisfaction, and Spearman rank correlation to test the correlation between initial assessment and re-assessment, and between change in performance and satisfaction scores.

Study III

This study included 151 clients in the experiment group and 55 in the control group, within geriatric, stroke, and home rehabilitation at two different hospitals (table 4). Inclusion criteria were the need for rehabilitation interventions, ability to communicate, and living not more than a 30-minute journey by car from the hospital. Clients who received both in-patient rehabilitation and subsequent rehabilitation at home were interviewed at the end of the latter rehabilitation period. Dropouts during the rehabilitation period totalled 44 clients in the experiment group, and 5 in the control group. Interview data were missing for 19 clients in the

experiment group and 20 in the control group. The interview after discharge was performed with 88 clients in the experiment group (median age 80 years; range 53 – 97) and 30 in the control group (median age 79 years; range 45 – 90).

Table 4: Included subjects and dropouts in experiment and control groups, n (%)

	Exp group n (%)	Control group n (%)
Subjects included in rehabilitation	151	55
Dropouts during rehabilitation period	44 (29)	5 (9)
Dropouts prior to interview	19 (13)	20 (36)
Interviewed after discharge	88 (58)	30 (55)

An experimental design was used in Study III. The clients in the experimental group were interviewed with the COPM on admission. In the control group, at another hospital, the COPM was not used, and an informal unstructured interview was performed in the same way as in current daily practice. Assessments regarding ability to perform activities of daily living (Klein-Bell ADL Scale) and mobility (Clinical Outcome Variables, COVS) were made on admission and on discharge in order to compare the clients in the experimental and the control group.

The research question about clients' perception of active participation in the rehabilitation process was studied through structured interviews with clients from both groups, performed 2-4 weeks after discharge. The questions focused on initial problem identification, goal setting, treatment planning, interventions performed, results, client participation and satisfaction with the process. The questions had three alternative answers; "yes", "to some extent" and "no". The interview was performed as a dialogue, and the interviewer interpreted the client's answer to match one of the three alternatives. The choice of answer was confirmed with the client. At the end of the interview the client was given the opportunity to discuss other issues that were not covered by the interview. Written notes were made during the interview.

Statistical analyses used were the Mann-Whitney U-test to compare results between the groups from assessments with the Klein-Bell ADL Scale and the Clinical Outcome Variables (COVS). Wilcoxon signed-rank test compared scores from initial assessment with re-

assessment for all instruments. Comparisons between the experiment and control groups concerning the interview data, frequency of interventions, and diagnoses were analysed using the chi-squared test. Permission from the ethics committee was obtained.

Instruments used in study III. The Klein-Bell ADL Scale is composed of 170 items in six areas of function: dressing, elimination, mobility, bathing/hygiene, eating, and emergency telephone communication. Each item is scored as “achieved” (behaviour is performed without assistance from another person) or “failed” (assistance is needed). Results are presented as a percentage of the total achievable independence score. The scale is useful in determining the current level of ADL function and for noting progress (Klein & Bell, 1982). The Klein-Bell ADL Scale was empirically constructed to yield a score of independent functioning for research and clinical purposes. Inter-rater reliability and validity have been tested with good results (Klein & Bell, 1982). It has been translated to Swedish (Söderback & Guidetti, 1992), and has been found to be sensitive to small changes in function (Söderback & Guidetti, 1992; Smith et al, 1986). Hagsten (1994) reported Klein-Bell ADL Scale as effective in demonstrating the individual’s development towards independence in daily activities.

The COVS (Seaby & Torrance, 1989) is a functional assessment developed by physiotherapists as a clinical tool to assist therapists in identifying treatment goals and expected outcome, as well as planning treatment protocols to achieve these outcomes. It consists of 13 seven-point rating scales measuring different aspects of mobility. The highest obtainable score is 91 points, with a higher score indicating better mobility. The COVS has been translated to Swedish, tested for inter-rater reliability and is considered to be “a reliable tool for a standardised assessment of patients’ mobility function” (Hasselgren et al, 1997, p. 109). Testing of the COVS in a rehabilitation setting demonstrated significant inter-rater and intra-rater reliability, concurrent validity and high internal consistency (Seaby & Torrance, 1989).

Study IV

A strategic sample of 33 occupational therapists were invited to participate in this study, all with experience of using the Swedish version of the COPM. Thirty therapists accepted the invitation, and 27 actually participated. Data were collected in 6 groups using focus group technique. A focus group is a group of individuals with shared key characteristics who are selected to discuss, from personal experience, the subject of research with the goal of

obtaining lively interaction between the participants (Powell & Single, 1996). An interview guide was developed containing question areas concerning experience of using the COPM, the instrument itself, client participation, clinical utility in daily practice and the client-centred approach. The interviews were performed by two independent occupational therapists, both attending all focus groups interviews as moderator and assistant moderator. The interviews were taped and transcribed, and field notes were taken. The analysis was qualitative, using the constant comparative method (Strauss & Corbin, 1990), and the results were penetrated and discussed with the interviewers.

Study V

A consecutive sample of clients with inflammatory joint disease participating in a day treatment program was included. The study was performed during two periods, before the COPM was introduced and when the COPM was used as a team tool (figure 4). There were 16 clients in part one of data collection (mean age 56, range 21 - 75 years) and 40 clients in part two (mean age 58, range 24 - 80 years), resulting in a total of 56 individuals altogether. Four clients who declined to participate dropped out after discharge. Seven team members were interviewed (2 physiotherapists, 2 occupational therapists, 1 physician, 1 social worker and 1 assistant nurse). Permission was obtained from the ethics committee.

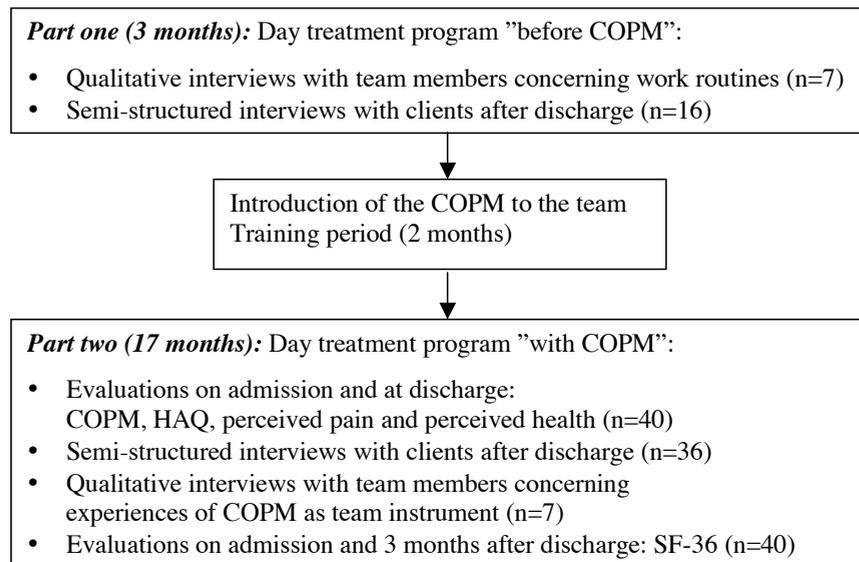


Figure 4: Logistics of data collection study V

Study V included qualitative and quantitative methods. Interviews were performed with the team members in two parts. The first part contained interviews with a qualitative approach. The aim was to describe the routines in the day care program and within the team. The questions used covered goal formulation, treatment planning, co-operation within the team, information sharing, documentation and evaluation. The interviews were taped, written notes were made, and they were analysed question by question. In part two, when included clients were discharged, qualitative interviews with team members were performed. This time the questions concerned whether and how the COPM had affected the teamwork according to the team members. The question guide comprised areas concerning the COPM's effect on the professional role in the team, client participation from the perspective of the team member, degree of client-centredness, influence on team conferences and documentation, whether they wanted to continue to use the COPM as a team tool. The interviews were taped, transcribed and analysed qualitatively.

Interviews with clients were performed 2-4 weeks after discharge from day care programs in both parts and were performed by one experienced occupational therapist who was not involved in the treatment of clients. For part one "before COPM" as well as part two "with COPM" data were collected concerning age, gender and disease duration. In part two, data were collected with the COPM, the SF-36, the Health Assessment Questionnaire (HAQ), perceived pain and perceived health, on submission and at discharge. Goals formulated by the clients were categorised according to the ICF (WHO, 2001). Statistical analyses used were Fisher exact test, Wilcoxon signed-rank test and Spearman rank correlation.

The HAQ (Fries et al, 1980) is a self-administered instrument measuring disability with 20 questions in eight subcategories (Ek Dahl et al, 1988). Response alternatives vary from 0 = "without any difficulty" to 3 = "unable to do". The score is calculated as the sum of scores for the subcategories divided by the number of subcategories responded to, resulting in a score between 0 and 3. Ek Dahl and colleagues (1988) studied the validity and reliability of the HAQ and found support for content and construct validity. The test-retest reliability was also high ($r=0.91$). Hammond (1996) found the instrument to be easy to administer but of little use to aid treatment planning and insufficiently sensitive to show change in chronic disability.

The SF-36 was constructed to survey health status as a self-administrated instrument (Ware et al, 1992). It comprises eight health concepts: physical functioning, role limitations because of

physical health problems, bodily pain, general health, vitality, social functioning, role limitations because of emotional problems, and general mental health. In addition, one single item concerns reported health transition. Scores are transformed to a scale from 0 (lowest possible score) to 100 (highest possible score), indicating no problems or good health. The SF-36 (Standard Swedish version) scoring and transformations were performed according to the Swedish manual and interpretation guide (Sullivan et al, 1994). Criterion validity tests support the cross-cultural stability of the SF-36 according to Sullivan and Karlsson (1998). Internal consistency has been estimated for each of the SF-36 scales in a Swedish material with Cronbach's alpha ranging from 0.79 to 0.91 (Sullivan et al, 1994). Data were also collected before and after the rehabilitation period on perceived pain (visual analogue scale from 0 = no pain to 10 = worst imaginable pain), and on perceived health (visual analogue scale from 0 = excellent to 10 = worst imaginable).

Qualitative approach

In this thesis, a qualitative method was used in three studies (I, IV, V). The analysis was inspired by grounded theory, but without theory building. Data is collected primarily from interviews and analysed through systematic procedures. The analysis is the interplay between researchers and data (Strauss & Corbin, 1990). Grounded theory is referred to as the constant comparative method of analysis (Glaser & Strauss, 1967). The approach to grounded theory (Strauss & Corbin, 1990) used in this thesis includes the following steps: After data transcription, the data material was read through several times. Then open coding commenced, during which comparisons were made and questions asked. The material was broken down into units of information and conceptualised into phenomena. Comparisons were made in order to examine similarities and differences in opinions. Concepts that seemed to pertain to the same phenomena were categorised and further revised. The axial coding followed in which the final categories were developed and named. Summaries were written for all categories, and relevant quotations used to illustrate each category.

RESULTS

Study I

The results of the interviews did not indicate that any active discussion or process concerning goal formulation took place. The goals were focused on housing, the home and its surroundings, and physical conditions were stressed rather than psychological factors. Mainly prerequisites for discharge and consequences of disease were discussed. The approach used by the rehabilitation professionals seems to emanate from physical factors.

The patient goals concerned activities of daily living. There was a clearly expressed desire to be able to live at home again and to attain pre-stroke status. The goals were on a disability level according to the ICDH (WHO, 1980). *The physiotherapist* formulated goals at the disability level, mainly with respect to mobilisation ability. Being mobile was a prerequisite for being active and capable of carrying out activities of daily living. The goal was often expressed as a goal for the whole team. *The occupational therapist* formulated goals concerning activities of daily living, communication, and the patient's ability to be active. It was not obvious that the process of formulating a goal was performed together with the patient. The degree of independence, especially concerning personal care, was of great importance. Instead of defining specific goals, the occupational therapist discussed the consequences of stroke, as being changes in patient habits and roles. The responsibilities the patient had before the stroke often differed afterwards, which could be seen as a loss for the patient. Methods for assessments and interventions were discussed more than the goals. *The physician* was not concrete about goals. Instead more general aspects concerning function and housing was expressed. It was considered essential for the patients either to return to where they had lived before the stroke or to obtain a new housing with appropriate help. The goals that were formulated by patients, occupational therapists, physiotherapists and physicians were classified according to the ICDH (table 5). The recorded treatment interventions showed that both physiotherapists and occupational therapists provided interventions at all three levels of the ICDH.

Table 5: Goals formulated by the patient, the physiotherapist, the occupational therapist and the physician categorised according to the ICDH (WHO, 1980).

	Patient	Physiotherapist	Occ. therapist	Physician
Impairment	-	-	-	-
Disability	Mastering daily activities	Locomotor disability	Mastering daily activities	-
Handicap	Occupation Social integration Mobility	Housing*	Occupation	Housing* Social integration

* not included in the ICDH

Three different patterns of rehabilitation process were found:

- one pattern with a set programme which did not change during the process
- one pattern with clearly identified decision points
- one pattern where the goal was changed according to changes in medical status

The first pattern of the rehabilitation process was characterised by long periods of time between assessments. Team meetings did not seem to constitute clear decision points. They were used for reporting events, and no changes were made in the rehabilitation program. The second pattern showed a short rehabilitation period with most of the interventions being at the disability level. Team meetings were clear decision points concerning the rehabilitation. At the end of the period both physiotherapy and occupational therapy addressed the handicap level. The third pattern showed a change in treatment goals due to changes in the patients' medical status. The agreed goal was low, and the interventions concerned activation and different housing. The interventions were at the disability level and at the end of the period occupational therapy were also at the handicap level; no physiotherapy was offered at all. The interventions were aimed at the surroundings instead of the individual.

Study II

The performance, and satisfaction with performance, scores were completed in the initial scoring as well as in the re-assessment by 108 clients. A total of 418 problems (table 6) were identified. Most of the clients identified three or more problems, the majority (74%) in self-care. Changes between the initial and re-assessment scoring, of two points or more, were shown in self-perceived occupational performance and in satisfaction with performance in 307 (73%) of the 418 identified problems. The median score change for performance was 3 points (range 2 - 6) and for satisfaction 4 points (range 2 - 6). Changes in scores vary from -4 to +9 points. Significant differences were shown between initial assessment and re-assessment for performance and satisfaction in the majority of problems. The conclusion of this study is that the Swedish version of the COPM has high responsiveness to change over time.

Table 6: Problems identified by clients at time of initial assessment (n, %)

	n	%
Self-care:	309	74
Dressing	78	19
Walking	74	18
Hygiene	63	15
Transfers	43	10
Toileting	37	9
Feeding/drinking	8	2
Wheelchair mobility	3	1
Sitting	3	1
Productivity:	62	15
Meal planning/preparation	50	12
Cleaning/laundry	12	3
Leisure:	47	11
Quiet recreation	20	5
Active recreation	8	2
Social	19	5

Study III

The median number of days of care was 24 (range 6 – 98) in the experiment group and 26 (range 8 – 161) in the control group. The two groups were comparable concerning gender and age.

The results show significant differences between the groups in 4 of the 14 interview questions:

- Do you feel that there were goals formulated for your treatment?
- Can you recall these goals?
- Did you have the opportunity to participate in the goal-formulation process?
- Does it mean that you can manage more now than earlier?

Significantly more clients in the experiment group perceived that treatment goals were identified, were able to recall the goals, felt that they were active participants in the goal formulation process, and perceived themselves better able to manage after completed rehabilitation compared to clients in the control group. The majority of the clients in the experiment group remembered and identified distinct treatment goals for their rehabilitation. The goals were related to their ADL situation at that particular time for example taking a shower, being able to dress, preparing their breakfast and climbing stairs. Clients in the control group mentioned some activity goals. They talked more often about treatment interventions instead of goals. They expressed vague goals, such as becoming as healthy as possible. The study indicates that the COPM improves client participation in the rehabilitation process.

Study IV

The analysis of the data obtained through the focus group interviews resulted in five themes:

- goal setting
- preparations
- limitations
- interaction with client
- impact on practice

Goal setting: The occupational therapists stressed that the COPM was helpful in formulating treatment goals and facilitated the rehabilitation process. Some *preparations* are needed

before using the COPM, therapists need knowledge about the theoretical foundation of the instrument, and they have to develop an interview technique. *Limitations* were expressed when using the instrument with clients with poor insight or in acute settings. Scoring problems could be a problem when clients had difficulties in understanding the meaning of the scales. The *interaction with client* was supported through the client-centred approach. Therapists found that using the COPM ensured that the clients' needs were focused on during the rehabilitation process. When the COPM was used, the identified problems were related to activity and occupational performance. The *impact on practice* concerned that the COPM was seen as a complement to other instruments that facilitated communication within the team. It was also highlighted that the COPM as an outcome measure provides opportunities to detect changes over time, and assures that treatment focuses on the client's perspective. The instrument made it possible for the clients to receive feedback on improvement over time and was helpful for their own reflection. The majority (78%) of participating occupational therapists claimed that they want to continue to use the COPM.

In conclusion, therapists stated that the COPM ensures a client-centred approach, facilitates communication within the rehabilitation team, and encourages therapists in their professional role. However, knowledge about the theoretical foundation is a prerequisite. The COPM was considered as being a useful outcome measure.

Study V

The findings from this study indicate that the COPM seems to broaden the information on what is purposeful occupation to the client, focuses on occupational performance and is sensitive to change over time. The COPM also provides the team with broader information. The COPM evaluations were performed on admission and on discharge and resulted in 190 identified problems, with statistically significant changes between initial evaluation and re-evaluation for both performance as well as satisfaction scores.

The use of the COPM did not make any difference according to clients' perceptions of participation. However, a higher proportion of clients in the group "with COPM" answered positively to questions about goals being formulated, and fulfilled, and their ability to recall the goals. When the COPM was used, clients expressed goals concerning involvement in life situations, indicating a broader area of occupational performance problems compared with goals formulated by clients "before COPM" according to the ICF (table 7).

Table 7: Goals formulated by clients “before COPM” and “with COPM” categorised using the ICF (WHO, 2001) concepts.

	“before COPM” (n=16)	“with COPM” (n=40)
Body functions and structures	Improved mobility and stability of joint functions Improved muscle power functions Eliminating pain	Improved mobility and stability of joint functions Improved muscle power functions Eliminating pain
Activities and Participation	Manage personal care Manage household activities	Manage personal care Manage household activities Manage needlework Ride a bicycle Go for a walk Manage to walk in stairs Active participation in society Go back to work/remain in work Participation in social relationships Participation in recreation and leisure Use PC Hold telephone Manage garden work Change napkins on baby Write letters Drive a car Be together with friends

Four categories emerged from staff interviews:

- Clear positive effects
- Change of focus
- Effects on routines
- Change of approach

Clear positive effects: Team members stated that the use of the COPM as a team tool increased client participation, which resulted in distinct goals that were meaningful to the client. Another positive effect was the ability to achieve an outcome that was clear and evident to the client. *The change of focus* from function to activity and occupational performance was viewed as an advantage by the occupational therapists. However, other

members of the team thought they would perform the COPM interview in a different way than the occupational therapists and focus more on their own profession's perspective. *Effects on routines:* The routines at the team conferences were affected positively when the occupational therapists reported from the COPM interview, but were completely unaffected when the team fell back on old routines. The implementation of the COPM as team instrument led to discussions about work routines, which was deemed valuable. *Change of team approach:* It was difficult to involve and motivate staff to change practice. Further discussions about the degree of client-centredness might result from this attempt with the COPM. The team was not yet sufficiently prepared for the change to client-centred practice.

GENERAL DISCUSSION

Main findings

The results of study I showed that in clinical practice the goal formulation process for clients with stroke expressed by clients, occupational therapists, physiotherapists and physicians was insufficient. Goals were vague, client participation seemed low, and goals were not measurable. The rehabilitation process was not optimal at this time, lacking a method that would enhance communication between the therapist and the client. This indicated a need for a more structured goal-formulation process, with a structure that enhances client participation (Northen et al, 1995). The results from study I became the starting point for the following studies with the aim of testing the usefulness in daily practice of a structured method, the COPM.

The findings show that the COPM increases client participation from the perspectives of the clients (III) and as expressed by the staff (IV-V). Communication between the client and the therapist regarding the client's perceived problems was improved. The majority of problems identified by the client (II) were in the area of self-care (74%), confirming the pilot study by Law et al (1994^b), who found that the majority (54%) of the problems were in the area of self-care. In study II, compared to the pilot study by Law et al (1994^b), clients were older, which may be the reason for the higher proportion of self-care problems. When clients (II) were split into two age groups, the pattern was slightly different; a shift from self-care activities to leisure activities was shown in the younger clients.

The significant difference in the perception of participation in goal formulation shown between the experiment and the control group (III) is of vital interest. The COPM claims to be client-centred, which must be proven in clinical practice. Otherwise we do not know if the theory is just a theory, not a reality for the clients. The finding also confirms the construct validity of the COPM (Granger et al, 1996; Polit & Hungler, 1999).

The occupational therapists in study IV found the COPM to be a helpful tool in goal-setting, focusing on the client's needs. Some of the participating occupational therapists in study IV had a rather limited experience of using the COPM as the inclusion criteria included having

performed four COPM interviews or more. However, they had all participated in courses about how to use the COPM and its underlying theoretical foundation. Replicating the study when more experience is gained might give more information. However, if the inclusion criteria had required experience of using the COPM during a longer period, the sample might have been positive, resulting in therapists that had already decided to use the COPM.

The findings in study V showed that the introduction of the COPM in a team requires more preparation time and training for the whole team as well as continuing discussions and opportunities for team members' reflections than could be achieved in this study. Even though the conditions were not optimal, the results indicated that the COPM increased client participation, encouraged the team to focus on occupational performance issues, and was useful as an outcome measure because of its sensitivity. A limitation in study V was a large staff turnover, which may have influenced the result. Keeping up the team members' motivation for client-centred practice was difficult when new staff joined the team during the data collection period. Well-established routines are needed as well as knowledge about the purpose of the study in order to enhance control over the data collection period. Changing routines in a team involves taking a large step and requires the motivation of all team members over a long time. This has also been observed by other authors (Wilkins et al, 2001; Waters, 1995; Pollock & McColl, 1998). In this particular rheumatology clinic the team had been working for years to improve the day-care program. Before this study was performed, clients already defined three important goals before they came to the first session of the program. This could be the reason why there was little difference in perceived participation between the two groups of clients. Furthermore, the number of clients investigated before the COPM was introduced was rather small.

The results of studies II-V indicate that the COPM seems to be a good outcome measure. This confirms an earlier study by Fedden and colleagues (1999). The staff also expressed the advantage of giving the clients feedback on their improvement (IV, V). As shown in study V, and also highlighted in study IV, other assessments are needed to evaluate functions as a complement to the COPM. Further assessments of performance components or environment may be needed as the COPM does not replace all other assessments (Law et al, 1998). The COPM focuses on occupational performance problems and on client-centred practice. Goals are formulated on occupational performance, not on functions (IV, V). Dalley (1999) points out that therapy has to be evaluated both from a client-centred direction as well in relation to

specific effects of therapy. It is difficult to identify a specific professional input if the evaluation is purely client-centred. The COPM cannot be used to measure the effects of a certain therapy since many different factors may contribute to the result, for example spontaneous recovery or other concurrent interventions. The COPM shows the client's subjective opinion of change in performance and satisfaction, but is not an objective measure of change. Thus, other assessments are usually needed as complements.

The findings (II-V) showed that the use of the COPM resulted in defined problems in a very broad area, due to the flexibility of the instrument in problem formulation and with no predetermined items to assess. Law and colleagues (1994^b) also found this wide area of defined problems in occupational performance. The ICIDH, and later the ICF (WHO, 1980; 2001), was helpful in two of the studies (I, V) in categorising defined goals on different levels of the classification. The categorisation gave a clear description of goals and interventions in a uniform language in health care, which is one of the aims of the ICF (WHO, 2001).

The COPM has been used in different settings in the included studies (II, III, V): day care, inpatient care, home rehabilitation, geriatric rehabilitation, and neurological rehabilitation. It has been used on clients of different ages (II, III, V), though the majority were elderly, and with different diagnoses (II, III). The results confirm the clinical utility of the COPM as a generic instrument (Law et al, 1998) and the flexibility of the instrument. This flexibility is an advantage, but also demanding on the therapist. It should be handled with care and always be based on the client-centred approach.

The studies performed (II-V) indicate that the rehabilitation process is facilitated by the use of the COPM. Client participation is improved, goals that are meaningful to the client are formulated, and clients are given feedback on their improvement.

Even though the results of study II-V are overall promising, the implementation of the COPM is challenging and leads to demands on the occupational therapist and the members of a rehabilitation team. This has also been seen in Canada (Law et al, 1995). The implementation puts high demands on staff motivation, not only at the time of introduction but also throughout daily practice. Parker (1999) and Sumsion (1999^b) point out that the result of the implementation depends on the motivation of the team members to change practice and on practical strategies for implementation. According to the therapists (IV-V), there is a need for

continuous discussions about client-centred practice and reflections over each therapist's attitude to the client-centred approach. Time for introduction, education, knowledge about the theoretical foundation, discussions, case examples, and reflections are necessary (Northen et al, 1995; Wilkins, 2001; Law et al, 1994^b). There is also a need for support from the management. Most important of all, the occupational therapist and the team members must have a personal involvement in client-centred practice (Toomey et al, 1995).

Methodological considerations

Some specific considerations in performing clinical studies will be discussed in this section. The first concerns the samples included. All data (I-III, V) were collected in ordinary clinical practice. The sampling was limited to what was clinically feasible. All clients that participated in the studies (I-III, V) were admitted to health care and required professional rehabilitation interventions. In order to test the COPM in clients with different diagnoses, data were collected in different settings. Inclusion criteria were defined in all studies. Exclusions were made by treating therapists when the client was not able to perform in an interview. Professionals participating (I-III, V) were the ordinary staff at the settings at the time of data collection. The fact that the ordinary staff collected data may have influenced the data negatively as well as positively. The data collectors may have been less consistent in collecting data and may have experienced time pressure in daily practice. On the other hand, these professionals know the clients well, are interested in development in the rehabilitation area and are therefore motivated. In addition, the COPM was tested by ordinary staff in clinical practice in accordance with the aim of the COPM. The intention was to test it by the actual users to gather results on usefulness in clinical practice.

A large amount of data collectors were involved in studies I, II and III. This may lead to problems in information about the study, about the inclusion criteria and about routines. Different methods for avoiding lack of information and ensuring that the same information was given to each data collector have been used in the included studies. Explicit oral information to all personnel who collected data through diaries (occupational therapists, assistant occupational therapists, physiotherapists and assistant physiotherapists) was given in study I. The diaries used also had written instructions in order to facilitate and ensure the

routines for filling them in. The instructions included who should fill in the diaries, when and why, and also the aim of the whole study. In study II courses were given about the COPM and the theoretical foundation prior to the start of data collection. In addition, oral information about the aim and about data collection was given to the data collectors at information meetings. The meetings also included time for questions from the data collectors.

In study III, written information combined with oral information on several occasions was used in order to improve knowledge about data collection routines among the data collectors. A folder was given to each clinic that participated. The information included instructions about the aim, the methods, criteria for inclusion and exclusion, the letter to the client about the interview and routines for data collection. It also included the instruments used as well as relevant articles about these instruments. Before the study, the instruments were introduced to the data collectors, and a training period carried out. There were several meetings at each clinic in order to motivate and instruct data collectors. The meetings also included time for questions and discussions, in the same way as in study II. There was also a possibility to make phone calls to the researcher when needed. All these strategies were used to ensure information about routines was communicated correctly.

Due to the distance between the two hospitals, two different, independent, interviewers performed the interviews with clients in study III. A questionnaire was used. In order to reach consensus about how to perform the interviews, the two interviewers discussed the questionnaire and the meaning of the question areas. They also discussed how to interpret the client's answer and how to confirm the answer with the client. The word "goal" was defined in writing, and this definition was read to the client before the questions about goal formulation were asked. Having one interviewer that was blind to clients' affiliation to experiment or control group would have strengthened the study, but this was not practically feasible. The use of two different interviewers could be a weakness, but their discussions before performing the interviews were important for them to reach agreement on how to perform the interviews.

In study III one limitation is the large amount of dropouts, during the rehabilitation period and prior to the interview. Decisions about the client's need for rehabilitation had to be taken early in the rehabilitation period. Sometimes the decisions turned out to be wrong, and dropouts were a fact. This could be due to an incorrect inclusion decision or to changes in the client's

status during rehabilitation. Some clients in this study received care in two organisations during their rehabilitation process; first in-patient rehabilitation and later on in the process also home rehabilitation. In these cases data from the first period were excluded, and clients were interviewed after discharge from the latter period. Dropouts after completed rehabilitation but prior to interview were more frequent in the control group than in the experiment group. Clients' high age may result in a tendency not to participate. Staff errors resulting in dropouts also include cases when the interviewer did not get information that clients were discharged. This shows that the control over the data collection period could have been better. However, control is often difficult to achieve, especially in research with humans in naturalistic settings (Polit & Hungler, 1991).

A recommended research design is to randomise clients to experiment or control groups (Szczepura & Kankaanpää, 1996). This would have been an advantage in study III but was not possible to achieve, as the same occupational therapist would then be treating clients from both experiment and control groups at the same time. Thus, she or he would collect data from both groups. Either the therapist has adopted the COPM or not. The COPM is more than just a formula, it is an approach with a focus on co-operation and partnership with the client. This approach requires that the occupational therapist reflect over her or his own attitude to client-centred practice. The solution to the randomisation issue was to use two different hospitals that were as equal as possible with respect to the type of care and rehabilitation offered.

The invitation to participate in focus group interviews (IV), sent to occupational therapists, included information about the aim, the method, the interviewers, and the audio-taping of the interviews. The same information was given orally at the time of the interview. The interviewers in study IV, the moderator and the assistant moderator, were independent of both the COPM and the researcher in order to avoid respondents feeling inhibited about making negative statements about the COPM. Both interviewers were active in the development of the question guide in co-operation with the researcher. Literature about focus group techniques was used to develop the question areas (Trost, 1997; Morgan, 1997). The interview technique and methods of performing the focus group interviews was discussed. The respondents were asked about advantages as well as disadvantages of the COPM in different situations, and were asked to give examples. The result was also discussed and confirmed with the interviewers. A focus group should comprise between 6 and 10 participants (Powell & Single, 1996). Two of the focus groups in study IV were very small,

but according to the literature (Morgan, 1995; Dahlin Ivanoff et al, 1996) small groups can still be very dynamic. They were included in the analysis since they provided valuable information through broad discussions between participants from different areas of practice.

In study V meetings were held with all team members presenting information about the COPM, the underlying theory and client-centred practice. Written information about client-centred practice, how to use the COPM, the CMOP, the aim, the method of data collection and the timetable was given. Practical exercises in client-centred practice were performed. Two additional information sessions were held when new members joined the team. In the interview session with clients, the word “goal” was defined for the client, and different examples of goals were given.

In study V assessments were performed with the HAQ and the SF-36 because they were used routinely in this day care program. The HAQ is a commonly used instrument in rheumatology but of little use in treatment planning, according to Hammond (1996). The COPM may be a good complement to the HAQ for goal formulation and treatment planning. As they had weak or no correlation with the COPM, this indicates that they do not measure the same properties.

It is important that data collectors can see an advantage in participating in clinical studies. The advantages could be enhanced knowledge about instruments, knowledge about client groups and their problems, feedback from results, and personal satisfaction. This can improve daily practice in the long run. Thus, the researcher needs to work hard to stimulate and motivate data collectors. Feedback to data collectors was given at several meetings in studies I and II. Each ward or clinic was visited after the completion of the study (III). The rehabilitation team participating in study V was given information about the results.

In order to ensure the trustworthiness of the qualitative studies, different methods were used. According to Guba & Lincoln (1989) the quality or goodness of an inquiry in qualitative research can be assessed by the trustworthiness criteria of credibility, transferability, dependability and confirmability. The credibility criterion (internal validity in positivistic terms) refers to the truth value, the intention being to give descriptions so others can recognise, interpret and understand the phenomenon. Patton (1990) argues that the credibility of qualitative research depends on the credibility of the researcher as the instrument of data collection and the center of the analysis process, and the findings constitute a perspective

rather than the truth. To enhance credibility sufficient time was given for interviews with clients for conversation before and after the interview in order to establish a contact with the interviewed client (I, III, V). Audio-taping and verbatim transcriptions were made (I, IV, V). The literature was used supplementary, and results were related to the field of interest (Glaser, 1978). During and after the analysis (IV), data were discussed by the analyst, the moderator and the assistant moderator, a debriefing session was held concerning the constructs obtained. In grounded theory, credibility means that the findings fit the data, explain what occurs in data, and have relevance for the participant group (Glaser, 1978). Transferability could be seen as a parallel to the positivistic term external validity or generalizability (Guba & Lincoln, 1989). The receivers decides whether and to what degree the results can be applied to their situation after examining the strategies for procedures, methods and analysis (Krueger, 1998). The procedures in a qualitative study must be explicitly described so the reader can assess their appropriateness (Strauss & Corbin, 1990). A “thick description” of the setting must be provided, with enough information to make transferability judgements possible on the part of the reader (Lincoln & Guba, 1985). Dependability refers to consistency (reliability), meaning that the method used must be presented in a proper way so the reader can understand the procedure in order to enhance transferability. The result of the analysis depends on the context. The method of analysis used strictly followed the steps described by Strauss and Corbin (1990), from open coding to the axial coding (I, IV, V). The interventions were categorised according to the ICIDH (I) by the researcher and a co-examiner independently in order to enhance dependability. The technique used to promote confirmability included the use of field notes (III, IV, V) as part of data collection and part of the analysis.

Psychometric adequacy of the COPM

Different aspects of validity, content validity, construct validity and criterion validity, and responsiveness, as well as clinical utility, have been tested (table 2, p. 19). Results concerning the reliability of the COPM have been tested in a small sample of clients with COPD (Sewell & Singh, 2001). Furthermore, some unpublished studies of test-retest reliability are summarised in the manual of the COPM. This lack of reliability testing could be considered a weakness, thus further studies of the reliability of the COPM are required. However, the scoring is performed by the client. Different clients' scores are not compared with each other. The instrument is individualised and dependent on the problems identified by each individual client. It is reasonable to believe that the client relates to the scales in the same way at the initial evaluation as at the re-evaluation. Clinically useful information as outcome, according to the

manual, is a change between the initial and the re-evaluation scoring of at least two points. High reliability does not guarantee high validity, but low reliability implies that the tested instrument is not valid (Polit & Hungler, 1999). When the instrument is used as a tool for securing an approach, not as an outcome measure, the reliability issue may be of less importance.

The Swedish version of the COPM has been tested in the four studies (II-V) included in this dissertation. The only papers published are the included study II that evaluated responsiveness, study III that supports the construct validity and study IV testing the clinical utility. Reliability has not been tested. Some unpublished studies performed by students indicate that the COPM contributes to a broad area of defined problems, that are not comprised in common measures of activity of daily living. However, the reliability and validity issues need to be further addressed. The reliability aspect needs to be clarified in both the Canadian and Swedish versions of the COPM.

COPM scales

The scales in the COPM are ordinal but according to the manual the calculations should be performed with parametric statistics, and therefore the mean is calculated for all defined problems. This could be seen as a limitation in research, but is practical and useful in daily practice when outcome can also be described in words, and not just figures. The COPM is individualised because each client defines his or her own problems. Different clients should not be compared with each other.

Reflections on practical implications

Will the COPM become a useful tool for occupational therapists in Sweden? The Canadian occupational therapists are very engaged in the discussion regarding client-centred practice in occupational therapy, and many papers and books penetrate the issue. The Canadian occupational therapist seems to work alone and independently to a higher extent than therapists do in Sweden. In Sweden it is not unusual to work in a rehabilitation team. Working in a client-centred way in a rehabilitation team makes higher demands on the occupational therapist than working more independently (Waters, 1995). As shown in study V, the

introduction of a new approach requires not only commitment from all team members, but also support from management, as well as time to introduce the approach, to discuss cases and to reflect over practice (Parker, 1999). The therapists also need time to train their interviewing skills.

Rochon and Baptiste (1998, p. 151) defines professionalism as “the manner in which a practitioner interprets and enacts the mantle of being a professional”. The codes of ethics for professional groups stipulate that the therapist should put the clients’ needs above his or her own, and should maintain professional knowledge and skills. The decision to use a client-centred approach involves a moral choice by each individual therapist, and this decision is linked to the therapists’ interpretation of what it means to be a professional (Rochon & Baptiste, 1998). The Swedish Code of Ethics (FSA, 1998^a) emphasises that the therapist should work on the basis of scientific knowledge and proven experience, and to remain informed about new research results and new methods. The therapist must take account of the ethical rights of the client. Results from study IV confirm the need, and also the opportunities, emerging from the COPM interviews for personal reflections from the perspective of the therapist. These reflections should embrace considerations about the therapist’s own attitude to client-centred practice, and about whether and how the COPM is adequate to use. Situations when the COPM was inappropriate were expressed (IV), for example in acute phases and when interventions were aimed at a specific task. Concerning clients with cognitive deficits, the COPM gives useful information but the process must be adapted to the individual. Negotiating goals at an appropriate level are vital, and graded decision-making could be a helpful strategy (Hobson, 1999^b).

If the client-centred approach is taken to its extreme the client decides upon goals and treatments. The power is shifted from the professional to the client. In this scenario the therapist supports the client in decision-making and accepts the client’s decisions as they are presented. When client-centred practice does not exist at all, the professional decides about goals and treatments, and the client is passive. The use of the client-centred practice (CCP) works on a continuum (figure 5) between professional power and client power. In the extreme form of client power, the therapist may decline all responsibilities.

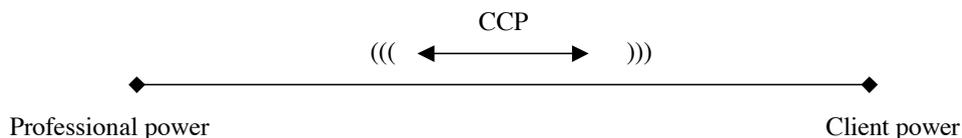


Figure 5: The continuum of client-centredness. Client-centred practice (CCP) moves between professional power and client power, depending on the client's ability in the current situation. The therapist should strive to enhance the client's power.

The therapist should always strive to enhance the client's power. Depending on different aspects in the current situation, the therapist moves to the left or the right on the line. In all situations the therapist must use his or her experience and knowledge within different fields. Aspects that influence the optimal level of client-centredness could be the client's ability to identify problems, motivation, cognitive deficits or willingness to be active in decision-making. Some elderly people are not used to making demands on care, relying instead on the knowledge of the professionals and simply waiting for treatment. Client power might be low in the beginning of a rehabilitation process, but rise later on in the process. The therapist must strive to enhance client participation and, thus, client-centredness. There is a process of maturity for the therapist, from the first attempt to work client-centred to a sense of confidence in this approach. However, merely accepting client goals that are unrealistic without negotiating them is not in accordance with client-centred practice or with ethics. An unrealistic goal can and should be broken down and formulated in temporary goals that must be obtained first. It is important that the client is not left with unrealistic expectations. Hobson (1999^b) suggests that graded decision-making and advocacy should be used with clients with cognitive deficits. In rehabilitation of elderly, Hobson (1999^a) discusses enhanced communication, advocacy, therapeutic use of self, client education, promotion of self-efficacy and client choice to overcome barriers to client-centred care.

Attitudes that may present barriers to client-centred care can come from both clients and professionals. Wilkins et al (2001) pointed out that the therapist's responsibility is to understand the clients' needs and act accordingly. The therapist cannot claim that client-centred practice only works for some clients, but has to find ways for it to work with all clients. Strategies for this include clarifying who the client is, a clear introduction of

occupational therapy initially, and methods and material to provide the client with information. The type of partnership should also be discussed with the client, and the best working strategy should be used to find the client's priority issues. However, using the COPM does not guarantee a client-centred approach since client-centred practice deals with *how* to relate to the client. The COPM is a structure that, if properly used, secures data collection in a client-centred fashion. If the COPM is used without the therapist's commitment to client-centred practice, the approach will not be client-centred. The therapist has to make reflections on her/his attitude to client-centred practice before making the choice whether to use the COPM or not. Reflections about how to improve occupational therapy and what methods to use should be made recurrently in order to analyse one's own attitude. The results in study IV confirm the importance of reflections from the perspectives of both the client and the therapist. The use of the COPM gave the therapists opportunities to reflect over their profession.

One aspect that needs to be reflected over is how the COPM should be used with each client, as the instrument is flexible. The interview to identify occupational performance problems is necessary. If needed, it might be performed over two or more sessions. Some structure for prioritising is also needed in order to develop an intervention plan, either by using the ten-point scale of importance or by discussing and verbally ranking the identified problems. The scoring of performance and satisfaction is useful when achievable, and the re-scoring has clinical importance as an outcome measure. If clients have difficulties with the scores, the scoring process could be excluded. In this case the client-centred practice is still used, but the outcome is not measured.

The cost-effectiveness of using the COPM has not been studied. However, focusing on what is meaningful to the client during goal formulation and the following interventions could be an effective use of time and resources. This is confirmed by Pollock & McColl (1998), who point out that the client becomes actively engaged in the process from the outset. Effective use of therapists' time may be less costly, require less input, and enhance accountability (Hammell, 1998).

The COPM is the only standardised and published instrument that is totally open to all kinds of activities that can be identified by a client. It is standardised in that there are specific instructions and methods for administering and scoring the test (Law et al, 1998). There are no predetermined activities that must be chosen by the client. This is a strength and also

necessary if an instrument claims to have a client-centred approach. Limitations of the COPM include the lack of studies of reliability and lack of tests on the Swedish version. The COPM may be inappropriate for use in acute phases or when interventions are aimed at a specific time-limited task (IV). When client identified problems are out of the occupational therapist's domain of concern or responsibilities, this must be discussed with the client. The COPM may give valuable information with clients suffering from cognitive disorders but requires negotiations and that goals be broken down into short-term goals.

There are similarities between different models in occupational therapy, for example the relationship between the person and the environment, that influence occupational performance. Occupation is in focus in all models, even if the term is categorised in different ways. However, if the COPM is chosen as a tool to ensure client-centred practice, it is appropriate to adopt the model it is built upon, the CMOP.

It is possible to work client-centred even if the therapist collects data which the patient does not ask for as long as the therapist can inform and make the client understand its purpose. It is possible to use a client-centred approach with clients who have impairments that limit their ability to give adequate information, since information could be collected from relatives who know the client better than the therapist does. It is possible to use other methods than the COPM to collect information concerning what is important to the client, for example clients identifying goals prior to a day-care program (V). The COPM seems to be a relevant and useful method if one wants to introduce a client-centred approach into a traditional medical clinical setting (II, III, IV). However, it should not be used without a commitment to the client-centred approach. Bodiam (1999) confirms that the COPM is not suitable for use in a setting that is not client-centred.

The COPM is one way to collect data in order to secure information on what is important to the individual client. The information has to be collected from the patient him/her self or, as an alternative, from a person who knows the client well. In order to formulate realistic goals and intervention plans in relation to this information, the therapist has to contribute with other kinds of information in every or in certain different areas, affecting occupational performance (CAOT, 1997).

CONCLUSIONS

A structured method is needed in order to improve clients' active participation in goal formulation. Client participation in the rehabilitation process was enhanced by the use of the COPM: The goal formulation process was enhanced. Clients received feedback on improvement over time, and the COPM interview was helpful in the clients' own reflection. The COPM facilitated communication within the rehabilitation team, facilitated occupational therapists' documentation, and encouraged therapists in their professional role.

The use of the COPM does not automatically ensure client-centred practice. The instrument is a structure for gathering data from the client's perspective, on perceived activity problems, occupational performance and satisfaction with this performance. To ensure that the use of the COPM is in accordance with client-centred practice, the therapist needs to be committed to the principles of client-centred practice. The starting point for the therapist should be to use the client-centred approach. Then the COPM may be useful as a structure.

The focus of the COPM is on occupational performance, not on functions. The clients' perception of what is meaningful occupation in their daily life must form the basis for the goal formulation. Even though problems are identified, they are directly related to and formulated as goals. Goals are identified on a broad area, on activity and participation according to the ICF (WHO, 2001).

The Swedish version of the COPM has high responsiveness to change over time. The instrument is useful as an outcome measure on clients in different settings of different ages and with different diagnoses. However, the COPM includes only the client's perception of problems, performance and satisfaction with performance. Thus, other analyses and assessments, for example of functions have to be made with other instruments that complement the COPM.

Implementation of the COPM requires support from management, a thorough introduction, and knowledge about the theoretical foundation of the instrument. The therapist also needs to develop a personal interview technique. Involvement and motivation from other team members are required, as well as support during the introduction and implementation period.

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CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

SVENSK VERSION

Författare:

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The Canadian Occupational Performance Measure (COPM) är en individualiserad bedömning, konstruerad att användas av arbetsterapeuter för att konstatera självupplevd förändring av aktivitetsutförande över tid.

Översatt av Kersti Samuelsson, Neurorehab, US, 581 85 Linköping 1997

Namn:		
Ålder:	Kön:	Personnr:
Diagnos:		Insjukn datum:
Uppgiftslämnare (om inte klienten:)		
Datum för bedömning:	Planerat datum för ny bedömning:	Datum för ny bedömning:
Arbetsterapeut:		
Klinik:		

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**STEG 1:
IDENTIFIERA PROBLEM MED UTFÖRANDE AV AKTIVITET**

För att kunna identifiera problem med utförande av aktivitet, betydelse och resultat, intervjuas klienten.

Fråga om personliga dagliga aktiviteter inom personlig vård, produktivitet och fritid. Be klienten att identifiera dagliga aktiviteter som han/hon vill göra, måste göra, eller förväntas göra genom att uppmuntra honom/henne att tänka igenom en vanlig dag. Be därefter klienten att identifiera vilka av dessa aktiviteter som är svåra att genomföra till hans/hennes belåtenhet nu. Notera dessa aktivitetsproblem under Steg 1A, 1B eller 1C.

**STEG 2:
VÄRDERA
BETYDELSEN**

Genom att använda skattningskortet får klienten värdera på en skala mellan 1 och 10, hur viktig varje aktivitet är. Placera poängen i motsvarande ruta under Steg 1A, 1B eller 1C.

Steg 1A: Personliga dagliga aktiviteter

Personlig vård

(ex v påklädning, bad, hygien)

Förflyttning

(ex v förflytta sig inomhus, utomhus)

Klara sig i samhället

(ex v transport, inköp, ekonomi)

BETYDELSE

1B: Produktivitet

Arbete betalt/obetalt

(ex v hitta/behålla ett arbete)

Sköta hushållet

(ex v städa, tvätta, laga mat)

Lek/Utbildning

(ex v lek, läxa)

1C: Fritid

BETYDELSE

Stillsam fritid

(ex v hobbies, hantverk, läsa)

Aktiv fritid

(ex v sport, utflykt, resa)

Social samvaro

(ex v besöka, ringa, parties, brevväxling)

STEG 3 OCH 4: POÄNG - FÖRSTA BEDÖMNING OCH UPPFÖLJNING

Bekräfta med klienten de 5 viktigaste problemen och notera dessa nedan. Genom att använda poängmallen ombuds klienten att värdera varje problem under utförande och tillfredsställelse, beräkna därefter total poäng. Total poäng beräknas genom att addera utförandet eller tillfredsställelsepöäng för samtliga problem och dividera med antalet problem. Vid uppföljning, poängsätter klienten åter varje problem under utförande och tillfredsställelse. Beräkna den nya poängen och skillnaden.

Första bedömning:

Problem med utförande av aktivitet

1. _____
2. _____
3. _____
4. _____
5. _____

Utförande 1

Tillfredsställelse 1

Uppföljning:

Utförande 2

Tillfredsställelse 2

POÄNG:

Total utförande-
Total = el tillfredsställelse-
poäng poäng
Antal problem

Utförande
Poäng 1

Tillfredsställelse
Poäng 1

$$= \frac{\quad}{\quad} = \text{[]}$$

$$= \frac{\quad}{\quad} = \text{[]}$$

Utförande
Poäng 2

Tillfredsställelse
Poäng 2

$$= \frac{\quad}{\quad} = \text{[]}$$

$$= \frac{\quad}{\quad} = \text{[]}$$

SKILLNAD I UTFÖRANDE = Utförande Poäng 2 [] - Utförande Poäng 1 [] = []

SKILLNAD I TILLFREDSST. = Tillfredsst. Poäng 2 [] - Tillfredsst. Poäng 1 [] = []

ÖVRIGA ANTECKNINGAR OCH BAKGRUNDSINFORMATION

Första bedömning:

Uppföljning: