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IMPROVED CLIENT PARTICIPATION IN THE REHABILITATION PROCESS USING A CLIENT-CENTRED GOAL FORMULATION STRUCTURE

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The aim was to evaluate whether the use of a client-centred instrument, the Canadian Occupational Performance Measure (COPM), affects the patients' perception of active participation in the rehabilitation process. The study included 155 patients in the experiment group and 55 in the control group, within geriatric, stroke, and home rehabilitation. The COPM was used in the experiment group. A structured interview was performed within 2–4 weeks after discharge with 88 patients in the experiment group and 30 patients in the control group. The results show significant differences between the groups. More patients 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 with patients in the control group. The study indicates that the COPM improves client participation in the rehabilitation process.

Key words: COPM, client-centred, participation, goal, evaluation.

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INTRODUCTION

Goals are central to the process of rehabilitation. Individual members of a team are more likely to coordinate their contributions if they share common goals, therefore it is important to involve the patient in the goal-setting process (1). Rehabilitation definitions may refer to either structure, process or outcome. The structure comprises a multidisciplinary team of people who have common goals for each patient, and involve the patient and family. Two important components of the process are identification of the patient's problems and goal-setting (2). Whiteneck (3) states that the individual should be viewed as the primary focus of the rehabilitation process, and subjective perceptions are needed to fill in the gaps left by the traditional objective assessments. Pollock (4) claims that when the client participates in goal-formulation, planning and decision-making, the potential for active participation in the rehabilitation process has been shown to increase. Individuals must set the goals in order to be able to solve the problems, or else the feeling of control over their health is decreased (4). A study of the participation of geriatric stroke patients in a traditional treatment program (5) indicates that geriatric stroke clients are usually not involved in the formulation and determination of treatment goals. There appears to be a need for a structure or model that involves the client in the process of rehabilitation.

Occupational therapy is one important factor in the rehabilitation process. In occupational therapy, and especially in Canada, a lot of efforts have been made to implement and improve client-centred practice. A definition of client-centred practice is "an approach to providing occupational therapy which embraces a philosophy of respect for, and partnership with, people receiving services" (6, p. 253). The concept is focused on respect for the clients and their families, who have the ultimate responsibility for decisions about daily occupations and who should be provided with information emphasising person-centred communication (7). This concept can be useful for all client-centred rehabilitation, not just occupational therapy.

The Canadian Model of Occupational Performance (CMOP) is based on the assumption that individuals should have a fundamental part in the therapeutic process in order to enhance their performance of activities of daily living (ADL), production and leisure. Therapists and clients collaborate to meet occupational performance goals that clients define as meaningful (8). The COPM (9), developed on the basis of the model, presents a structure for formulating treatment goals identified by the client in cooperation with the occupational therapist through a semi-structured interview. The COPM was designed as an outcome measure to capture perceived changes over time in occupational performance, and is standardized in that there are 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. A pilot study of the COPM (10) demonstrated that 32 of 55 test sites found the COPM helpful in providing information relevant to the assessment and intervention process. It was easy to administer, taking an average time of 30–40 minutes. Toomey and colleagues (11) showed that the clinical utility depended upon the degree to which therapists had incorporated the client-centred approach and the degree to which management valued and supported the use of the COPM. Chan & Lee (12) gathered evidence on the content-related and criterion-related validity of the instrument, suggesting that the assessment content and processes reflected the client's occupational performance issues. Responsiveness

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has been evaluated and supported (10, 13). Reliability has been tested with good results, according to the manual of the COPM (9), but the results are unpublished.

However, there is still a lack of knowledge as to whether the use of a client-centred structure has any advantages from the client's perspective compared to traditional rehabilitation. The primary focus was to study whether the use of the COPM affects the client's perception of active participation in the rehabilitation process in problem identification, goal formulation, evaluation of results, and satisfaction with treatment.

METHODS

Design and procedures

An experimental design with an experiment and a control group has been used in order to compare results of intervention with and without the COPM. Two hospitals in two towns in the same region of Sweden have been involved; one for the experiment group, the other for the control group. These hospitals are comparable in terms of the level of care provided, have similar referral routines, but cover two geographical areas with different total population sizes. Data collection for the experiment group was collected in the larger population. Data collectors were registered occupational therapists (OT) and physiotherapists (PT) employed at the two hospitals at the time of the study, and interested in participation. In order to study if the two groups of patients were comparable measures of ability to manage activities of daily living and mobility were performed on admission and discharge. Type and frequency of treatment interventions between assessment and re-assessment were noted in both groups, in order to compare whether the groups were receiving different frequencies of treatment. On discharge, the treating occupational therapists and physiotherapists rated type and frequencies of treatments. Interventions in occupational therapy were ADL, assessment of intellectual functions, training of physical abilities, and instructions and training in the use of technical aids. For physiotherapists, the interventions included motor function, mobility, balance/co-ordination, and technical aids. The frequency of both occupational therapy and physiotherapy was classified as "a few times", "2–3 times a week" or "more often". Data were collected over a period of 14 months. A break in inclusion of patients was made for 10 weeks during summer, due to holidays and stand-ins in the rehabilitation teams.

Patients

The study was performed on a consecutive sample of 151 patients (201 rehabilitation periods) in the experiment group and 55 patients (71 rehabilitation periods) in the control group. Inclusion criteria were: need for rehabilitation interventions, ability to communicate, and living not more than 30 minutes journey by car from the hospital. Some patients received both in-patient rehabilitation and subsequent rehabilitation at home. These patients, 50 in the experiment group and 16 in the control group, were interviewed only at the end of the latter rehabilitation period. The number of dropouts from decision about inclusion in data collection to patients actually participating in the interview after discharge is presented in Table I. Dropouts during the rehabilitation period amounted to 44 patients in the experiment group, and 5 in the control group. Interview data were missing for 19 patients in the experiment group and 20 in the control group. The most common reason for dropout during the rehabilitation period was not being a rehabilitation patient, even though this was one of the inclusion criteria. The decision to include patients or not was made very early in the process, and in these cases the patients had either progressed very rapidly and were discharged, or the patients could not participate in rehabilitation interventions due to declined functions. Another reason for dropout was that the COPM was not applicable, although all inclusion criteria were fulfilled. In these cases, the patient did not understand how to identify problems in occupational performance, or could not perform the scoring process. Some patients who were included declined to participate in the interview after discharge. Staff errors include situations when information about patients relevant for interview was not reported in time to the interviewer, or when there were changes in staff during the data collection period, and the new therapist was not introduced in time. Complete data in the interview phase were collected from 88 patients in the experiment group (median age 80 years; range 53–97) and 30 patients in the control group (median age 79 years; range 45–90). Gender, type of care and diagnosis is shown in Table II.

Table I. *Number of dropouts from decision about inclusion in data collection to participation in interview after discharge*

	Experiment group *n*		Control group *n*	
Included subjects	*151*		*55*	
Dropouts during rehabilitation period	*44*		*5*	
Rehabilitation not relevant		22		2
Subjects re-admitted: new diagnosis/ward		10		2
COPM not applicable		8		–
Ad mortem		4		1
Dropouts prior to interview	*19*		*20*	
Subjects declined participation in interview		10		8
Subjects not reachable by phone for interview		6		4
Staff error		2		7
Too great distance for interview		1		1
Interviewed after discharge	*88*		*30*	

Instruments

The COPM process encompasses the following steps: with support from the therapist the client identifies problems within the three areas of self-care, productivity and leisure, rates the importance of each problem in order to make priorities, and scores performance as well as satisfaction with performance. The defined problems are noted, and the same problems are re-assessed after intervention. For scoring the self-perceived performance, and satisfaction with this performance, 10-point scales ranging from 1, meaning "not able to do it" or "not satisfied at all", to 10, which is "able to do it extremely well" or "extremely satisfied", are used (9).

In both groups, an ADL measure, the Klein-Bell ADL Scale (14, 15) and a measure of mobility performed by physiotherapists, Clinical Outcome Variables (COVS) (16, 17), were used in order to compare the groups of patients. 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 independent or dependent. 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 (15). The Klein-Bell ADL Scale was empirically constructed to yield a score of independent functioning for both research and clinical purposes; inter-rater reliability and validity have been tested with good results (15). It has been translated to Swedish (18), and has been found to be sensitive to small changes in function (18, 19). Hagsten (20) reported Klein-Bell ADL Scale as effective in demonstrating the individual's development towards independence in daily activities. The Klein-Bell ADL Scale was chosen for its capacity to detect small changes.

The COVS (17) 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. A higher score indicates 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 (16). Reliability testing of the COVS in a rehabilitation setting demonstrated significant inter-rater and intra-rater reliability, concurrent validity and high internal consistency (17). The COVS was chosen because it was already in use in both hospitals.

Before the study, the instruments were introduced to all data

Table II. *Gender, type of care and diagnosis of interviewed clients in experimental and control groups respectively*

	Experiment group ($n = 88$)		Control group ($n = 30$)	
	n	%	*n*	%
Gender				
Women	52	59	19	63
Men	36	41	11	37
Type of care				
Home rehabilitation	15	17	14	47
Stroke unit	26	30	9	30
Geriatric ward	47	53	7	23
Diagnoses				
Stroke, other neurology	34	39	11	37
Orthopaedic diagnoses	35	40	19	63
Cardiopulmonary diagnoses	10	11	0	–
Other internal medicine diagnoses	9	10	0	–

collectors, and a training period carried out. Information was provided and discussions were held on several occasions for all data collectors. Written information about the study, the measures, and routines was available for the data collectors. Approval was obtained from the ethics committee.

Experiment group

Data were collected at 5 units; 3 in-patient wards within geriatrics, 1 stroke rehabilitation unit, and 1 unit within the home rehabilitation program. The COPM, COVS and Klein-Bell ADL Scale were used on admission and prior to discharge. The ADL assessment was performed before the COPM interview in order to make patients better aware of their present ADL ability. From the beginning 201 sets of data were gathered from 151 patients. In this group 50 patients were treated in two units as the in-patient period was followed by a home rehabilitation program. These patients were interviewed after the latter period.

Control group

Data were collected from patients in another hospital but within the same type of clinics as the experiment group; geriatric, stroke and home rehabilitation. In this group, containing 55 patients, 71 sets of data were collected, as 16 of the patients had two rehabilitation periods during data collection. These patients were interviewed after the latter period. COVS and Klein-Bell ADL Scale were used on admission and prior to discharge.

Interviews after discharge

Structured interviews were held within 2–4 weeks after discharge in both groups to gather data on the patients' perception of the rehabilitation process. At time of discharge, the patients were asked if they agreed to participate in the interview. Those who accepted were given written information. The interviewer later telephoned the patient to set up a time for the interview, at which time the patient was also given an opportunity to withdraw from the interview. The interview was performed in the patient's home. Two experienced occupational therapists who had not been involved in the treatment of patients performed the interviews. Before data collection, these persons had discussed how to perform the interviews in order to reach consensus about the interpretation and confirmation of answers. The questions (presented in detail in Table V) focused on the rehabilitation process, from admission to discharge; initial problem identification, goal setting, planning of interventions, interventions performed, results, patient participation and satisfaction with the process. The questions had three alternative answers, "yes", "to some extent" and "no". A description of the word "goal" and some examples of goals were first given to the patient. The interview was performed as a dialogue between the patient and the interviewer, who interpreted the patient's answer to one of the three alternatives. The choice of answer was confirmed with the patient. At the end of the interview the patient was asked to give examples of opportunities to influence the treatment, whether they had any suggestions for changes, or to discuss other issues that were not covered by the interview. Goals stated by the patient, and the patient's comments on all questions were noted continually. These comments were not collected in order to make a qualitative analysis. The intention was to obtain useful information on areas that were relevant for the clinical activities, and to be able to give feedback to all staff in the wards.

Analyses

Due to the ordinal scales of the instruments, non-parametric statistical methods were chosen. The Mann-Whitney *U*-test was used to compare results between the groups from assessments with the Klein-Bell ADL Scale and COVS. Wilcoxon's 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 with the chi-squared test. The comments were merely arranged in categories or areas to illustrate patients' opinions.

RESULTS

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. There was a higher proportion of patients receiving home rehabilitation in the control group than in the experiment group. Most patients in the experiment group were patients in the geriatric wards. There was a significant difference in diagnostic groups between the experiment and the control group. The control group had more orthopaedic patients, but no patients with cardiopulmonary diagnoses or other internal medicine diagnoses ($p < 0.01$). The proportion of patients with stroke was comparable between the groups.

In the experiment group ($n = 88$) COPM assessments resulted in a total of 352 identified problems. Of these, 267 problems (76%) were in the ADL area, 60 problems (17%) in the productivity area, and 25 problems (7%) in the leisure area. The median score change for all problems was 3 points for both performance and satisfaction. No change was reported between initial assessment and re-assessment in 52 problems with respect to performance, and 61 problems related to satisfaction. Decreased performance score at re-assessment was shown in 10 problems, decreased satisfaction score in 19 problems. Analyses resulted in statistically significant changes at group level between initial assessment and re-assessment for both performance as well as satisfaction scores ($p < 0.001$). The correlation between initial performance and satisfaction was 0.60 ($p < 0.005$), at re-assessments the correlation between performance and satisfaction was 0.82 ($p < 0.005$), whereas the correlation between change in performance and satisfaction scores was 0.74 ($p < 0.005$).

Data on both groups concerning assessments of ADL and mobility are presented in Table III. The patients in the control group had higher median scores using the Klein-Bell ADL Scale than the experiment group at initial assessment and re-assessment, indicating a higher ability to perform activities of daily living. These differences are statistically significant for initial assessment ($p < 0.001$) and re-assessment scores ($p = 0.002$). In

Table III. *Results from assessments with Klein-Bell ADL Scale and Clinical Outcome Variables (COVS) before and after rehabilitation, and size of change during the rehabilitation period*

	Experiment group ($n = 88$) Median (range)	Control group ($n = 30$) Median (range)	p-value
Klein-Bell before	47 (13–91)	64 (21–94)	0.001
Klein-Bell after	72 (21–96)	80 (30–98)	0.002
Klein-Bell change	19 (−6–61)	10 (0–46)	0.014
COVS before	57 (24–78)	59 (20–87)	0.614
COVS after	68 (26–91)	71 (29–89)	0.486
COVS change	11 (0–42)	10 (0–55)	0.140

the control group the median score for change was lower than in the experiment group, but still statistically significant ($p = 0.014$). Assessments of mobility, using COVS, showed no statistical differences between the groups. Analysing paired data, the assessments before and after rehabilitation with COVS and the Klein-Bell ADL Scale resulted in statistically significant improvements ($p < 0.001$) in both the experiment and control groups. A comparison between the groups concerning frequency of treatment interventions (Table IV) showed that there were significant differences in the frequency of treatment of physical abilities (OT), motor function/strength (PT), and balance/coordination (PT). The patients in the experiment group had a higher frequency in these treatments than those in the control group.

The results from the interviews showed significant differences between the groups in 4 of the 14 questions, in favour of the experiment group (Table V). Significantly more patients in the experiment group indicated that goals were formulated for their treatment (question 4) and they had a better ability to recall the goals (question 5). More patients also felt that they were active participants in the goal-formulating process (question 6) and that they were able to manage more tasks after the rehabilitation period than before (question 11).

The majority of the patients 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 and specified primary skills such as taking a shower, being able to dress, preparing their breakfast and climbing stairs. Over 50% of the patients indicated that they had participated in creating their treatment goals, in terms of agreeing to a certain treatment, working together with the staff and that nothing had been decided without their approval. On the question whether they managed more after the rehabilitation period than before, the patients verified that they were now more able to manage personal care tasks and to prepare their meals as they did before the injury. They also talked about being in the process of getting rid of their technical aids. Patients in the control group mentioned some activity goals but usually talked about treatment interventions instead and expressed vague goals, such as becoming as healthy as possible.

DISCUSSION

If asked, staff working within rehabilitation would probably

Table IV. *Frequency of treatment interventions and result of chi-squared test*

Type of treatment intervention; alternative frequencies		Experiment group ($n = 88$) Frequency	Control group ($n = 30$) Frequency	χ^2	p
ADL	A few times	37	5	3.848	>0.1
	2–3 times a week	43	6		
	More often	8	4		
Intellectual functions	A few times	9	7	0.942	>0.1
	2–3 times a week	4	1		
	More often	2	1		
Physical abilities	A few times	17	8	9.353	<0.01
	2–3 times a week	25	3		
	More often	3	5		
Technical aids	A few times	48	19	2.520	>0.1
	2–3 times a week	22	2		
	More often	4	–		
Motor function/strength	A few times	6	10	23.888	<0.001
	2–3 times a week	32	5		
	More often	38	3		
Mobility	A few times	14	7	3.220	>0.1
	2–3 times a week	35	9		
	More often	32	5		
Balance/co-ordination	A few times	11	7	10.395	<0.005
	2–3 times a week	35	4		
	More often	35	3		
Technical aids	A few times	46	8	3.665	>0.1
	2–3 times a week	5	–		
	More often	20	–		

Table V. *Results of the interviews, descriptive and result of chi-squared test*

Questions, and alternative answers	Experiment group ($n = 88$)	Control ($n = 30$)	χ^2	p
1. Did you get an opportunity to describe/explain your problems?				
Yes	60	20	0.062	>0.1
To some extent	15	5		
No	13	5		
Missing data	–	–		
2. Did you get an opportunity later on to describe/explain your problems?				
Yes	34	12	1.099	>0.1
To some extent	11	2		
No	8	4		
Missing data	35	12		
3. Did you experience that the staff listened to what was important to you?				
Yes	69	24	0.036	>0.1
To some extent	16	5		
No	3	1		
Missing data	–	–		
4. Do you feel that there were goals formulated for your treatment?				
Yes	67	13	13.121	<0.005
To some extent	9	6		
No	10	11		
Missing data	2	–		
5. Can you recall these goals?				
Yes	61	11	24.098	<0.001
To some extent	8	5		
No	6	14		
Missing data	13	–		
6. Did you have the opportunity to participate in the goal-formulation process?				
Yes	49	8	11.816	<0.005
To some extent	13	8		
No	16	14		
Missing data	10	–		
7. Did you get the opportunity to practice what was decided?				
Yes	55	17	4.838	<0.1
To some extent	13	7		
No	5	6		
Missing data	15	–		
8. Do you think that you recovered during the rehabilitation period?				
Yes	69	27	2.182	>0.1
To some extent	11	1		
No	6	2		
Missing data	2	–		
9. Do you think that you can do more today?				
Yes	69	21	0.643	>0.1
To some extent	6	3		
No	12	5		
Missing data	1	1		
11. Does it mean that you can manage more now than earlier?				
Yes	62	6	30.667	<0.001
To some extent	10	5		
No	12	19		
Missing data	4	–		
12. Did you reach the expected result of your treatments?				
Yes	42	20	1.792	>0.1
To some extent	22	6		
No	16	4		
Missing data	8	–		
13. Are you satisfied with the treatment received?				
Yes	71	25	1.573	>0.1
To some extent	10	2		
No	4	3		
Missing data	3	–		
14. Do you think that changes need to be made concerning patients' opportunity to influence their treatment?				
Yes	23	6	0.435	>0.1
To some extent	7	2		
No	55	20		
Missing data	3	2		

claim that they use a client-centred approach and that they have done so for years. To be able to call an intervention "client-centred", there is a need to show evidence that the theory behind client-centred praxis works in reality in daily praxis. The present study shows that a client-centred approach is greatly enhanced when a structured model and tool for client-centred practice is used. The results also support the construct validity of the COPM, as the instrument behaves as it should according to the underlying theory (21) and its theoretical conceptualization (22).

Aspects of goal formulation that are inherent in the use of the COPM, such as being active participants in the goal formulation process and clients having knowledge about rehabilitation goals, are of vital importance for client-centred praxis. The partnership between the client and the therapist, essentially in the definition of client-centred practice, was mentioned by patients in the experiment group in terms of active participation in creating their treatment goals. The majority felt that the goal formulation process was made in cooperation with the staff. Sumsion & Smith (23) showed that barriers to client-centred practice were found when the therapist and the client had different goals, when the therapist did not accept the client's goals, and when the therapist felt uncomfortable letting the clients choose their own goals. To resolve these barriers case examples, management support, education and training in client-centred practice were recommended.

The differences in results found in this study between the experiment and the control groups concerning the patients' abilities to manage after completion of the rehabilitation period support the use of a structured instrument in treatment planning and evaluation. In the control group, the patients' comments indicated a lack of information, and passivity about willingness to participate in decisions. These patients were vaguer than the patients in the experiment group. Furthermore, their goals, collected in the field notes, were oriented towards training rather than towards activity. The crucial point in using the COPM is that the therapist has to give enough information for the patient to be able to make decisions, formulate goals and have an opportunity to be an active participant in the rehabilitation process. A well-defined problem converted into a goal guides the rehabilitation plan and the interventions in a direction that is essential for the patient. The question concerning the patients' satisfaction with received treatment in the present study showed no statistically significant differences between the groups. This was not a surprising result; measuring satisfaction with treatment is difficult as the result could be affected by a number of factors. Owens & Batchelor (24) demonstrated that even where levels of satisfaction are high, patients' expectations may be low or non-existent. This was explained by the tight relationship of dependency and friendship between patient and staff.

The interpretation of the results of this study is that the use of a structured model and assessment instrument based on client-centred praxis is of great value in daily clinical work. Implementing client-centred praxis is a demanding task that could be facilitated by the use of a model. Neistadt (25) evaluated whether and how therapists assessed clients' priorities. The findings indicated that an informal interview is not enough to precisely identify client priorities for treatment. Northen and colleagues (26) also support the conclusion that there is a need for a model or theory for patient participation. Even though therapists traditionally involved patients and their families in a goal-setting process, they did not consistently involve patients to the maximum extent. McKinnon (27) found that competency of the therapists was seen as essential and as a requirement for active clinical client-centred practice. Rebeiro (28) pointed out that if occupational therapy strives to be client-centred, clients must be guided in identifying needs from their own perspective. Bodiam (29) reported that the COPM enables the client and the therapist to identify a wide range of role expectations that may not be identified with other assessments.

In this study, the patients in the different groups were of similar age and gender. However, there were differences in the following areas; in the control group, there was a higher proportion of patients in home rehabilitation, more patients had orthopaedic diagnoses, and they were better able to perform ADL both at the start and at re-assessment. They also received a lower frequency of training of physical functions, motor functions and balance. Home rehabilitation replaces in-patient care when a patient is able to live at home but has a need for both occupational therapy and physiotherapy. These patients are in their own homes during interventions and therefore can have better control and be more active participants than the in-patients. The home environment can be considered a resource for the patient, enhancing participation. Thus, the control group can be expected to have a higher level of ability, and perhaps also a better opportunity to improve their ADL abilities. The above differences between the two groups may be confounding variables and should be considered when interpreting the results of the study.

One shortcoming in this clinical study was the large amount of dropouts. The inclusion criterion "need for rehabilitation interventions" was a decision made by the therapist on admission or when the patient was leaving the acute phase. This decision was based on the clinical assessment whether it was likely that a rehabilitation period would follow. If the patient's condition changed, planned progress might not be fulfilled, and the patient was consequently excluded from the study. Whether the original decision was right or wrong could thus only be decided later on. Therapists with different experience of rehabilitation or an insufficient dialogue within the rehabilitation team could also have influenced the decision, and may be another reason for missing data.

Another weakness in the methodology may be that two persons performed the interviews. Unfortunately, this was unavoidable due to practical reasons such as workload and transportation problems. In order to reach agreement about the content of the questions, the performance of the interview and documentation, the two interviewers had thoroughly discussed these matters before data collection. The interviewers were not blind to the group affiliation. This was not possible, as the two hospitals were located in different cities.

Some patients had difficulties in understanding that their problems in everyday life were the focus of attention and intervention at the hospital and in home rehabilitation. For that reason the interview question concerning goals—whether the patients succeeded in identifying and recalling goals—needed to be clarified and to be comprehended by the patients. Therefore that question was clarified by an example of what is meant by the word "goal" within this context. Field notes, such as the patient's comments, were used to elucidate results (30). These notes have been valuable as feedback to staff in the quality development work in the wards. The Klein-Bell ADL assessment was performed before the COPM in order to give the patients more information about their ability to perform these activities. This logistic is supported by the study of Chan & Lee (12), who pointed out that as the COPM was used before other instruments in their study, the clients did not have much opportunity to engage in daily activities prior to the COPM. The responses made to the COPM are likely to be more realistic when clients actually try to perform the tasks before the problem identification phase.

Using the COPM in rehabilitation improved client participation in the goal formulation process. The patients perceived that treatment goals were identified. They were able to recall the goals and felt that they were active participants. They perceived they had a higher ability to manage after the rehabilitation period was completed compared to the patients in the control group. A focus on problems that are important for the patients makes more efficient use of rehabilitation resources.

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