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Creating a continuing professional development course on setting occupation-focused goals

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ABSTRACT

Quality insurance processes use goal attainment as criteria for funding occupational therapist (OT) services in Switzerland. As this is an important issue for the Swiss OT association, a continuing professional development (CPD) programme was implemented to assist OTs to set occupation-focused and person-centred goals. This qualitative study was conducted using three focus groups to understand the difficulties met by clinicians in the context of setting goals. Sixteen OTs reported that time constraints and routines make it difficult to define and formulate goals well. The problem is not a lack of knowledge, but to change one's habits and practices the results. A CPD course was developed, adapted in three languages and implemented. Evaluation of the course indicates that it helps the participants to better understand the need for writing goals that are person-centred and occupation-focused. This course may be supportive of improved occupational-based goal setting in other countries.

KEYWORDS

Occupation-based goal setting; CPD course; person-centredness

Introduction

Structured and collaborative goal setting is widely supported as the best practice in contemporary health care (Levack et al., 2015; Turner-Stokes, Rose, Ashford, & Singer, 2015; Wressle, Eeg-Olofsson, Marcusson, & Henriksson, 2002). In occupational therapy practice, goals additionally need to be occupation-focused, but few occupational therapists (OTs) negotiate occupation-focused goals with their clients (Doig & Fleming, 2015).

Various strategies to enhance goal pursuit can be implemented, like negotiating occupation-focused goals that contribute to solving the client's problems in his/her everyday life, provide the client with the adequate challenge, or giving regular feedback to clients (Baird, Tempest, & Warland, 2010; Levack et al., 2015). Negotiating occupation-focused goals contributes to increased satisfaction, motivation and engagements of clients in therapy (Turner-Stokes et al., 2015). Clients are better able to recognise the direction and structure of the intervention with specific occupation-focused goals (Doig, Fleming, Cornwell, & Kuipers, 2009) and have increased volition to engage more effectively in the intervention. Improvements in health-related quality of life and in self-reported emotional status such as a sense of well-being have

also been found (Costa, Brauchle, & Kennedy-Behr, 2017; Hunt, Le Dorze, Trentham, Polatajko, & Dawson, 2015). Furthermore, active participation in goal setting has been reported to contribute to the development of self-awareness (Doig, Fleming, Kuipers, Cornwell, & Khan, 2011) and a higher belief in their own ability to achieve goals that they choose to pursue (Levack et al., 2015).

However, OTs' intentions to include clients with various conditions such as brain injury, mental health disorders or children under 10 years old, in goal setting are often by-passed in practice (Levack, Dean, Siegert, & McPherson, 2006; Rosewilliam, Roskell, & Pandyan, 2011), due to lack of time, lack of know-how, client's impairments and situations (like small children for example), and institutional constraints (Barnard, Cruice, & Playford, 2010; Playford, Siegert, Levack, & Freeman, 2009). More specifically, the involvement of clients with cognitive impairments in goal setting has been challenging (Holliday, Antoun, & Playford, 2005; Hunt et al., 2015), as these impairments make goal negotiation more difficult.

Clinicians often prefer short-term goals, such as those concerned with activities of daily living, mobility, and upper arm function, even when the client's long-term goal is to recover, or to be able to drive, for

example. Professionals tend to identify barriers to participation as being located in the client, such as inadequate understanding of the situation, unrealistic expectations, and communication difficulties (Rosewilliam et al., 2011). Setting occupational-focused goals in spite of organisational challenges is one way of moving one's practice towards person-centredness (Hunt et al., 2015; Kjellberg, Kählin, Haglund, & Taylor, 2012). Therefore, the challenge for OTs in being person-centred is to find ways to enable the person to define and formulate precise and realistic goals (D'Cruz et al., 2016; Kjellberg et al., 2012); and overcome theoretical and empirical limits to negotiating goals.

A further layer of complexity is added by the asymmetric context of goal setting in which the clinician has both expert knowledge about health conditions, possible interventions and outcomes, and the power that comes with being a therapist (Barnard et al., 2010). Clients need to be guided and supported within a person-centred practice (Egan, Scott-Lowery, De Serres Larose, Gallant, & Jaillet, 2016), as they may well find it difficult to identify specific goals that are formulated in terms of the occupations in which s/he would like to engage. Strategies for therapists to address the challenges have been suggested, including using interpersonal skills of listening and negotiating (Costa et al., 2017), using rehabilitation techniques to meet the need of adaptation of clients with cognitive impairments (Watermeyer et al., 2016), and providing education (Flink et al., 2016; Holliday, Ballinger, & Playford, 2007). In addition, some authors emphasise the importance of training therapists to become person-centred and active listeners, instead of asking clients to communicate their expectations (Park, 2009).

Goal setting in Switzerland

The Swiss OT Association has been working in partnership with financial stakeholders to improve goal setting in order to comply with the law on health services, choosing to use the Goal Attainment Scaling (GAS) (Kiresuk, Choate, Cardillo, & Larsen, 1994) for the quality insurance process included in the law. The GAS is a method for formulating goals with attainable and measurable criteria, showing the impact of interventions on functional outcomes. OTs have to fill in the GAS for five clients per year and are being benchmarked to the other OTs in the country.

A study conducted by Page et al. (2015) looked at the state of goal setting in 1129 goals (for 335 cases/clients) written by OTs in the year 2008, in all areas of practice. Considering how occupation-focused goals (Fisher, 2013) are, results show that only 5.9% of cases included at least one goal, which was completely occupation-focused. More goals (17.2%) showed the inclusion of the client's context in the formulation of the goal, and even more (53.2%) included an action

verb referring to ordinary and extraordinary daily life activities. Considering the International Classification of Functioning, Disability, and Health (WHO, 2001) components, results show that about two-thirds of goals are related to 'activity and participation' components. And 90% of goals are specific, measurable and/or realistic (Page et al., 2015). Although OTs working in Switzerland seem to comply with the structure of goal setting, writing them as occupation-focused is a challenge. Despite the number of tools and recommendations available for negotiating and formulating goals, like the specific, measurable, achievable, relevant, time-bound or 'SMART' acronym, the Canadian Occupational Performance Measure (COPM) or Park's recommendations clinicians themselves often describe their goal-setting practices as a weak competency in context and asking for more continuing education for health professionals in this area (Rosewilliam et al., 2011).

Therefore, the association needed to explore the issues and challenges faced by OTs in Switzerland when setting occupational-focused goals in a person-centred practice. As a result of the exploration, a continuing professional development (CPD) course was created to support OTs in setting occupational-focused goals in person-centred practice. The research and development was conducted from September 2011 to October 2013 in two phases. Each phase addresses one aim: (a) phase one, 'understanding difficulties in context' shows the difficulties experienced by OTs when setting goals using focus groups to make the tensions between opinions more apparent (Krueger & Casey, 2015) and (b) phase two, 'development, adaptation and testing of the CPD course' describes the development and cultural adaptation of the course, then its testing/implementation in each linguistic region of Switzerland. Methods and results will be presented together phase-by-phase.

Processes, methods and findings

Phase 1: understanding difficulties in context (methods)

After having analysed over a thousand goals written by OTs in Switzerland, there was a need to better understand the difficulties in context and the need for continuing education courses. Three focus groups of about 2 hours involving 16 participants (6, 5, 5) were conducted in the French-speaking region of Switzerland, between November and December 2011. Participants were recruited through the Swiss OT Association, had to have at least two years of practice and worked in all fields of practice and in various settings (hospital-based and home-based, public and private), to represent the population under study. Five participants (31%) did not have a Swiss degree, reflecting the

usual distribution of foreign OTs in clinical practice in Switzerland.

The aims of the focus groups were to (a) explore how clinicians consider goals in the clinical process; (b) identify problems clinicians encounter in practice when setting goals and (c) identify clinicians' needs for support in setting goals.

A physical therapist (PT) experienced in the method and in physical therapy goal setting conducted the focus groups, which were audio recorded and transcribed, while a research assistant (RA) observed and took notes. Participants were informed of the aim of the focus groups beforehand and agreed to participate by signing a consent form. The ethical commission did not request an authorisation for this study, as it did not involve clients. The first and last authors joined the PT and RA for the qualitative content analysis to enable the emergence of themes and facilitate understanding.

Results of phase 1

Participants of the focus groups reported that goal setting, especially defining and formulating, was very much a part of the profession's culture. They found that formulating goals increased communication with their clients and improved volition, supported the structure and direction of the intervention, allowed for outcome measurement, enabled interdisciplinary team building and increased the recognition of the profession. One participant said:

I always take a lot of time to discuss the goals with my clients; you see I work in mental health and if the client doesn't see the benefit of the therapy and doesn't adhere ... well, there is no way you can improve anything, so I take the time to negotiate. In the end it's a good investment, because it clarifies the direction of the treatment.

Still, they pointed out that the way they defined and formulated goals in practice did not correspond to the standards proposed by the literature like occupation-focused, or SMART (which helps phrasing goals), of which some of them knew. Although they understood and expressed the need for well-formulated goals, they found themselves not doing that in their work setting, because of time constraints, being immersed in routines and lack of reflective practice.

A tension was expressed relating to the contents to be included in the goal – i.e. what the goal should address and focus on. At the same time, participants believed that the client's goals should address everyday activities and occupations and expressed a need to set goals on body functions and skills. Their reasons for doing this were often vague, reflecting assumptions of expectations in clinical settings, and the tendency of clinicians to follow custom and practice. One

participant with 10 years' experience in a rehabilitation clinic says:

I learned to write goals when I first took this position with the senior OT, and I keep using the same goals over and over with the patients that come through the clinic. It helps bench-marking with the interdisciplinary teams and it's easy to plan when the patient has reached the goals and can be discharged.

Some participants complained that negotiating goals with their clients is difficult when the clients have any sort of cognitive or affective impairments. One participant says: 'I tried to discuss the goals with this patient, she comes every week at my private practice with her husband, but I ended talking with the husband rather the client, because she has too many cognitive deficits.' Furthermore, even when the goals were negotiated, some participants said they did not systematically focus on them for their interventions, mostly because they did not pay enough attention to them. In interdisciplinary teamwork, OTs complained about being unable to make their goals understood by other therapists or by social workers. They added that the concept of occupation was not present in their goals, because the medical model in their clinical setting influenced them. On the other hand, they sometimes appeared not to grasp the concept of occupation, lacking theoretical knowledge: 'it's the Universities of Applied Sciences (UAS) which focuses on occupation, I don't see how it relates to practice'.

Considering the SMART acronym, participants said their goal formulation was rather unspecific, vague and juxtaposed instead of hierarchised, reporting they do not take the time to organise the negotiated goals. Some participants know about SMART and have learned to use it during their education, but they tend to abandon it with time and practical experience. Measuring goal attainment has been problematic. OTs rarely use outcome measures or client-assessed outcome criteria. One participant said: '... but for saying if the goal is attained, well, I use observation. No, I've never asked the client. It wouldn't be objective enough'. Even if participants expressed the need to have support to help them phrase goals, they usually did not use available support, preferring to rely on practical experience. They explained that it is partly due to clinical process routines, implemented in work settings.

In summary, the focus groups results showed that although OTs in French-speaking Switzerland mostly had knowledge about the standards of well-formulated goals, they were unable to implement that knowledge into daily practice. The focus-group participants expected they would benefit from more training in defining and formulating goals, in using GAS more efficiently for intervention, in negotiating goals with clients and in communicating goals to their team members and to other stakeholders.

Phase 2: development, adaptation and testing of the CPD course (processes and methods)

Aims for the course were developed, based on phase one's results; these were discussed, modified and adapted by the research team, who included members from the three linguistic regions of Switzerland (German, French and Italian). After a consensus was reached, detailed learning outcomes were developed using participatory methods and techniques (Mayoux & Chambers, 2005) to avoid giving more weight to any one cultural region.

The course was initially developed in French then culturally adapted to German and Italian. A test course was conducted in all three languages with participants recruited through the Swiss OT association with the same inclusion criteria than for the focus groups. The participants were regularly subjected to the quality insurance process implemented in the law. During each step of the development process, the research team was attentive to adapt the course culturally to fit each linguistic region. Instead of constructing the products in one language and then translating them into the other languages, the research team developed everything in parallel, adapting to other languages and specific cultural context, in a local-regional participatory approach (Chambers, 1997). This was possible and specific to Switzerland, because each member of the research team spoke at least three of the four languages used for this process (German, French, Italian and English), and had knowledge of the specific culture of each other's region. After attending the course, a satisfaction questionnaire with open-ended questions on content and teaching style was completed by participants to determine short-term usefulness of the course. A content analysis was then conducted.

Phase 2: development, adaptation and testing of the CPD course

The CPD course has been designed so that it can be offered over two or three days and taught by various OT teachers. The course materials are available in French, German and Italian, and include a teacher's manual with explanations of the main concepts; various exercises for students; a PowerPoint presentation; a reference list and a student handbook. The course, which focuses on the difficulties identified in phase one, is organised into three units.

Unit 1: The first unit covers the role of goal setting in the intervention process. The content and form of goals are discussed and arguments are made for setting goals that are occupation-focused and person-centred. Client feedback is included in the outcome indicators and issues raised by clinicians in focus groups (phase one) are discussed in terms of validity and reliability of outcomes in a person-centred practice.

Unit 2: The second unit describes the various tools available, such as the SMART method, GAS and the COPM (Law et al., 2014), which is widely used in Switzerland and offers a client-centred approach to negotiate goals. Consideration is given to: how the tools and frameworks of other disciplines can be adapted to OT; how goal setting can assist in grading the intervention and in clarifying what OTs do, and the extent to which the tools are occupation-focused and person-centred. The second unit also covers how professional practice models and frameworks can help in formulating goals.

Unit 3: The third unit explains negotiating goals with clients and communicating with stakeholders in the health-care system. It recognises clients' interests and preoccupations, not expecting them to formulate goals by themselves, but rather how to include them in the negotiation process.

Teaching style

Few theoretical explanations are offered in the course. Rather, it is based on an active pedagogy that allows participants to acquire, explore and try out the contents through discussions, exercises and problem solving.

Brainstorming is used at times, allowing the teacher to adapt the content and pace of the course. Participants become progressively more engaged during the learning process, and there is an increase in grading the complexity of the learning demands (Sipos, Battisti, & Grimm, 2008). For example, participants: (a) try to identify goals in a clinical case provided by the teacher; (b) formulate occupation-focused goals for clients they bring anonymously from their own caseloads; (c) reformulate goals from the study database; (d) reformulate goals to make them SMART; (e) explore various ways to measure the outcomes of goals; (f) grade goals using GAS, and finally (g) identify and formulate a complete set of goals with a client in a role-playing exercise.

Results of phase 2

Overall 33 participants attended the test CPD course (15 in German, 10 in French and 8 in Italian) and gave positive feedback on the units as related to writing person-centred and occupation-focused goals. Participants state that discussing the goal-setting process in the course and using of frameworks helps them better understand the need for writing goals that are person-centred and occupation-focused.

However, participants from the three linguistic regions disagreed on the question about the usefulness of having clinical vignettes in the course: the German-speaking OTs deemed the in-course-clinical cases less useful than their French or Italian-speaking counterparts. As the course in German was held in two one-

month distant sessions, participants had the opportunity to apply the course contents in their practice and discuss their own situations/vignettes. Learning the use of the Goal Attainment Scale, since it has been chosen as a quality measure by the Swiss OT association, was frequently cited as motivation for attending the course. For the more experienced participants, they felt the course filled in a need to be updated in their practice with new evidence on goal setting. The need for tools to facilitate goal phrasing also came up as a motivation. In addition, for those acting as fieldwork tutors, they expected improving goal setting would help with supervising students and better mastering what they learned in fieldworks.

Considering the possibility to have a 'recall' of the course sometime later (in a month, 2–3 months or 1 year later), participants were evenly divided. Those who found it interesting believed it would help them check the way they write goals now compared to before with the same client or discuss the change of practice brought by using the content of the course.

Unit 3 helped participants discuss new knowledge and skills, although they stressed the need to have more time for negotiating goals with clients. Participants had difficulties accepting outcome measures based on client's satisfaction and self-assessment of the intervention's success only, as if they could not trust the client's appraisal, saying that 'but it is not objective enough to just listen to the client tell she has reached the goal'. Furthermore, participants had difficulties to accept that evidence provided in the course only stressed the importance of negotiating goals with clients, and that negotiated goals were more often reached than non-negotiated ones, rather than telling them the content of the goals that should be pursued.

Communicating goals to other stakeholders continued to be perceived as a problem. Occupation-focused goals were regarded as using ordinary and everyday common language, easily understood by clients; however, the common language was deemed not 'technical' or 'scientific' enough by the participants for explaining how OT intervention contributes to the rehabilitation process, showing that OTs feel insecure in explaining what they do in occupation-based therapy.

Discussion and implication

Frameworks, tools and procedures for setting goals

Findings from the focus groups seemed to match findings from a survey conducted in the UK (Scobbie, Duncan, Brady, & Wyke, 2015), which shows a 'high variability and potential sub-optimal practice' (p. 1296), if goal setting processes are not subjected to reflexion and critique. For this reason, having

frameworks, tools and standardised procedures for setting goals seemed to fit with the clinicians' expectations (focus-group results) and research (Scobbie et al., 2015). GAS and the COPM were, therefore, included in the CPD course, offering a structured and comprehensive approach to goal setting. However, they do not address the whole goal-setting process (Park, 2011) and so, although OTs in Switzerland have identified COPM as offering support in setting goals in an occupation-focused and a person-centred perspective, they still found it challenging. Rather than simply following a standardised procedure, OTs in the course needed to develop their competencies in using an occupation-focused and a person-centred perspective in a reflexive and critical way, in order to feel comfortable, efficient, flexible, and creative with the usually complex situations in which persons live. Accordingly, the CPD course included critical appraisals of tools and procedures, in addition to critical discussions of goal-setting processes. Thus, the course aimed to increase clinicians' familiarity and competencies within a person-centred and occupation-focused perspective, combining the use of client-reported measure (COPM) and therapist-rated measure (GAS) (Doig & Fleming, 2015).

Tension when setting occupation-focused goals

On the one hand, OT practice in Switzerland seems to be closely linked to the medical model (Krieger, 2012), especially for therapists who have experience in clinics-and-hospital-based settings. For many OTs, this seemed to justify goals based on functions and skills. Furthermore, there is an assumption by OTs that the insurance companies paying for OT intervention are following the medical model – even though no evidence for this was found. Therefore, encouraging OTs to formulate occupation-focused goals should help therapists linking body functions and skills to occupational performance.

On the other hand, OT interventions are expected to increase clients' autonomy and independence in everyday activities and to limit health costs in society (Rogers, Bai, Lavin, & Anderson, 2017). In fact, clients themselves often adhere to this expectation, embedded in values of individual independence, which is highly valued in occidental society. Therefore, encouraging OTs to define goals based on occupations and autonomy would facilitate formulation and negotiation of the goals, especially with clients who have cognitive and affective problems. This also enables the participation of caregivers and significant others in defining goals.

It is important to recognise that there is a tension in Switzerland on what should be addressed by goals in OT, between the paradigm shift towards occupation in society and the medical model still present in

hospital-based settings, which leaves OTs unsure how to formulate goals. The assumption that successful and efficient interventions in OT imply an occupation-focused goal-setting process in a person-centred approach is supported by other recent findings and expert position (Doig & Fleming, 2015; Parkinson, Di Bona, Fletcher, Vecsey, & Wheeler, 2015). Therefore, facilitating the use of occupation-focused goals in Switzerland in all settings needs to take this tension into account.

Implementation of the course

The process used in developing and implementing the CPD course has aimed to be close to the clinicians' concerns. Its implementation through the Swiss OT association ensures a close link to professional practice, but also limits the number of clinicians who attend every year, due to its cost, the teacher's availability and the planning of the association's CPD programme.

If the CPD course is translated into other languages or implemented in other countries, there would be a need to adapt the course to the local culture and the constraints of clinicians (Lovarini, 2012). The use of focus groups in the developmental phase, which gives voice to the difficulties, conceptual tensions and needs of therapists, is essential for creating materials that are relevant to practice and should ideally be conducted in every culturally specific region.

The choice of implementing a course was based on the idea that passive dissemination of information is known to be ineffective in changing practitioners' behaviours (Marteau, Sowden, & Armstrong, 2002). An active pedagogy makes it easier for participants to acquire practice skills and competencies in a sustainable way, as there an engagement of the whole person in the learning process (Sipos et al., 2008). Furthermore, it increases the scientific education of clinicians, which will also help them in communicating with stakeholders (Samuelsson & Wressle, 2015; Upton, Stephens, Williams, & Scurlock-Evans, 2014).

Study limitations

This study has a limitation that it did not assess long-term efficacy of the CPD course impact on goal-setting competencies for Swiss OTs. There was no pre-/post-course survey included in the study design due to funding shortage, which is unfortunate as it limits the findings impacts. With additional funding, it would be interesting today to invite OTs who have attended the course through the Swiss OT association these last couple of years and review how they set goals with their clients – in regard with occupational-focus and person-centredness, comparing them to the results of Page and colleagues' study of coding of goals written in year 2008. Generalisation based on this research and

development is also a concern, as it fits a specific context of challenge regarding the quality insurance process implemented in Switzerland.

Conclusion

Although setting goals is an essential part of clinical reasoning in OT (Park, 2009), embedding goal setting in an occupation-based and person-centred approach can be difficult. This research and development provides insight into the challenges faced by clinicians when setting and negotiating intervention goals. Taking into account, the challenges of a CPD course using an active pedagogy, the course offers solutions for updating therapists' knowledge and skills, and transferring them into practice. However, additional research is needed in this field in order to show any lasting effects from a CPD course.

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