



Shared Decision Aids for Rehabilitation Goal Setting

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Abstract

Goal setting is a central component of rehabilitation because it translates broad aspirations for recovery into priorities that can organize assessment, therapy, interdisciplinary coordination, and evaluation of progress. Yet a rehabilitation goal is not genuinely patient-centered merely because it is written in measurable language. Meaningful goal setting also requires patients and rehabilitation professionals to exchange information, clarify expectations, consider feasible alternatives, and determine which outcomes matter most to the individual. A systematic review by Rose, Rosewilliam, and Soundy found substantial variation in patient involvement within rehabilitation goal setting and relatively few examples of fully patient-centered shared decision-making. The present study develops a simulation-based framework for evaluating shared decision aids for rehabilitation goal setting. The proposed decision aid is not designed to generate goals automatically. Instead, it prepares patients and clinicians for collaborative discussion by presenting possible rehabilitation domains, eliciting patient priorities, clarifying trade-offs, identifying expected functional outcomes, and documenting areas in which patient and professional priorities converge or differ. Because no original rehabilitation dataset was provided, 600 synthetic patient profiles were modeled across three conditions: usual rehabilitation goal setting, a structured goal-setting conversation, and a shared decision aid combined with clinician facilitation.

The simulated mean patient-clinician goal-concordance score increased from 56.5 under usual goal setting to 69.0 following a structured goal-setting conversation and 82.0 when the shared decision aid was combined with clinician facilitation. The proportion of simulated cases achieving goal-concordance scores of at least 75 increased from 12.0% to 31.5% and 77.5%, respectively. Modeled decisional conflict decreased while perceived involvement, goal clarity, and rehabilitation engagement increased. These values are synthetic and should not be interpreted as measured intervention effects. The conceptual interpretation is supported by established shared-decision-making evidence. Patient decision aids generally improve knowledge, clarify values, and encourage more active participation in health decisions, while rehabilitation-specific research suggests that shared decision-making has considerable potential but remains inconsistently embedded in goal-setting practice. Community rehabilitation research also indicates that patients and providers can perceive goal-setting participation differently, emphasizing the importance of measuring the patient's experience rather than assuming that professional intention proves collaboration.

Keywords: shared decision making; rehabilitation goal setting; patient decision aids; patient-centered rehabilitation; goal concordance; rehabilitation engagement; collaborative care; functional recovery



1. Introduction

Goal setting has long been treated as an organizing principle of rehabilitation. Rehabilitation rarely involves a single standardized outcome because individuals may value mobility, self-care, communication, employment, pain reduction, parenting, community participation, independence, recreation, or return to personally meaningful roles differently. A formal goal-setting process can help transform these broad priorities into targets that guide rehabilitation planning and progress review. The Cochrane review by Levack and colleagues found some evidence that goal-setting strategies may improve engagement, self-efficacy, and satisfaction with service delivery, although evidence for several health and functional outcomes was heterogeneous and methodologically limited. Goal setting should therefore be viewed as a potentially valuable process whose effectiveness depends substantially on how goals are selected and pursued.

Patient-centered rehabilitation requires more than presenting patients with professionally selected goals and requesting agreement. Shared decision-making involves clinicians and patients exchanging relevant evidence and experience, discussing options, identifying patient values and preferences, and reaching a decision appropriate to the person's circumstances. Van Til and colleagues argued more than a decade ago that rehabilitation contains substantial potential for shared decision-making and that decision aids could contribute to its implementation. This is particularly relevant because many rehabilitation decisions are preference-sensitive: several clinically reasonable pathways may exist, but their relative value depends on what the patient hopes to regain, tolerate, prioritize, or postpone.

Evidence indicates, however, that actual rehabilitation goal setting is not consistently shared. Rose, Rosewilliam, and Soundy's systematic review identified varying levels of patient involvement and found that relatively few rehabilitation teams demonstrated fully patient-centered shared decision-making within goal setting. Their later mixed-methods study similarly examined the degree of shared decision-making occurring in rehabilitation goal-setting meetings and the factors influencing patient participation. Community-rehabilitation research by Manhas and colleagues further demonstrated that the experiences and perceptions of patients and providers require explicit measurement rather than assumption. A clinician may believe a meeting was collaborative because the patient was present, while the patient may still feel that meaningful options were never actually offered.

Decision aids provide one possible response to this implementation gap. Established patient decision aids do more than present information: they make a decision explicit, provide information about relevant options, and help users clarify which features of those options matter personally. The 2017 Cochrane review of patient decision aids found that such tools improve knowledge, risk perception, clarity regarding personal values, and participation in decision-making across diverse health decisions. Rehabilitation goal-setting aids require adaptation because rehabilitation goals are not equivalent to choosing between two treatments. Goals often develop iteratively, depend on functional prognosis, interact with one another, and may change as patients experience recovery, fatigue, pain, environmental barriers, or changes in personal identity. A rehabilitation decision aid must therefore support a conversation rather than reduce goal selection to an algorithmic ranking exercise.



2. Objectives of the Study

2.1 To Examine the Effect of Shared Decision Support on Goal Concordance

The first objective is to examine whether structured decision support could strengthen agreement between patient priorities and formally documented rehabilitation goals. Goal concordance is conceptualized as the extent to which selected rehabilitation goals reflect both what the patient regards as personally important and what the clinical team considers feasible, safe, and therapeutically relevant.

This outcome is deliberately distinguished from simple agreement. A patient who accepts a clinician-defined goal because no alternative was discussed may produce nominal agreement without genuine concordance. Rose and colleagues' systematic review identified precisely this broader challenge: patient involvement varied considerably within rehabilitation goal-setting processes. The proposed aid therefore evaluates whether patients recognize their own priorities within the final goals and understand why specific goals were selected.

2.2 To Assess Goal Clarity, Participation, and Decisional Conflict

The second objective is to examine whether shared decision aids improve the clarity of rehabilitation priorities and reduce uncertainty during goal selection. Patient decision-aid evidence demonstrates that structured decision support can improve knowledge, values clarification, and active involvement across healthcare decisions. The present model extends these mechanisms to rehabilitation goal selection rather than assuming that the same effect size applies.

Decisional conflict is particularly relevant when patients face several competing rehabilitation priorities. A patient may simultaneously want to walk independently, return to work, improve hand function, decrease pain, and resume driving, while available rehabilitation intensity or prognosis requires short-term prioritization. Decision support may make these trade-offs explicit instead of allowing professional assumptions to determine priorities invisibly.

2.3 To Develop an Accessible Model for Diverse Rehabilitation Populations

The third objective is to develop a shared decision-support model that remains usable when patients have communication, cognitive, sensory, or health-literacy barriers. Dörfler and Kulnik showed that person-centered goal setting can remain relevant after stroke despite communication or cognitive impairment, but appropriate strategies are needed to support involvement. Patients undergoing inpatient rehabilitation after spinal cord injury have also described restoration of decision-making capacity as an important dimension of rehabilitation participation.

An equitable decision aid should therefore permit pictorial choices, simplified language, supported communication, caregiver involvement where desired and appropriate, repeated discussion, and flexible pacing. Accessibility should expand participation rather than become a reason to substitute family or professional preferences automatically for the patient's own priorities.

3. Review of Literature

3.1 Goal Setting as a Core but Methodologically Complex Rehabilitation Process

Rehabilitation goal setting has been studied for several decades, yet the evidence does not support a simplistic conclusion that formally setting goals automatically improves every rehabilitation outcome.



Levack and colleagues' Cochrane review found evidence favoring goal-setting strategies for selected outcomes including engagement, self-efficacy, and satisfaction, but evidence regarding health-related quality of life and functional outcomes was less certain. A related systematic review and meta-analysis likewise emphasized heterogeneity across rehabilitation populations and intervention formats.

This methodological variability is understandable because “goal setting” can describe very different processes. At one extreme, clinicians may write professionally determined SMART goals into the rehabilitation record. At another, patients and clinicians may explore personal priorities, negotiate trade-offs, identify intermediate goals, agree on action plans, and repeatedly review progress. Leach and colleagues' work on patient-centered goal setting and Scobbie and colleagues' implementation of a structured goal-setting framework in community stroke rehabilitation demonstrate attempts to operationalize more collaborative approaches.

The population also matters. Smit and colleagues' systematic review in geriatric rehabilitation found low-quality evidence and did not establish clear improvement in physical functioning from goal setting compared with usual care. These findings caution against treating goal setting as a universally effective therapeutic ingredient independent of how it is implemented. The more defensible conclusion is that structured goal processes may help organize rehabilitation, but the mechanism, patient involvement, and outcome measured need to be made explicit.

3.2 Shared Decision-Making Within Rehabilitation Goal Setting

The systematic review by Rose, Rosewilliam, and Soundy is especially relevant because it examined shared decision-making directly within rehabilitation goal setting. The authors identified variable patient involvement and relatively few rehabilitation environments that adopted fully patient-centered shared decision-making. Their findings imply that recording a patient goal is not sufficient evidence that a shared decision process occurred.

Rose and colleagues' subsequent mixed-methods investigation further examined shared decision-making within goal-setting meetings among rehabilitation patients. Manhas and colleagues extended this work in community rehabilitation, measuring shared decision-making and collaborative goal-setting experiences across multiple sites. Their related qualitative work explored how patients and professionals experience shared decision-making in community rehabilitation. Together, these studies reinforce the importance of measuring participation from both perspectives.

Shared decision-making is also relevant within specific rehabilitation professions. Hoffmann, Lewis, and Maher argued that shared decision-making should be integral to physiotherapy because many rehabilitation decisions involve legitimate alternatives and patient preferences. This principle can be extended across occupational therapy, speech and language therapy, rehabilitation nursing, psychology, prosthetics, rehabilitation medicine, and other disciplines. The core challenge is ensuring that multidisciplinary expertise contributes to the patient's priorities rather than fragmenting the patient's rehabilitation into profession-specific objectives.

3.3 Decision Aids, Values Clarification, and Supported Participation

Patient decision aids have a broader evidence base outside rehabilitation. The 2017 Cochrane review found that decision aids improve knowledge, support more accurate understanding, clarify values, and



reduce passive clinician-controlled decision-making. The mechanisms are highly relevant to rehabilitation even though goal selection differs from treatment choice. A patient may need assistance identifying what matters most, understanding realistic functional pathways, and comparing consequences of prioritizing one goal over another.

Van Til and colleagues specifically considered the potential for shared decision-making and decision aids within rehabilitation medicine and concluded that decision aids could contribute to greater implementation of shared decision-making. More recent pre-2022 work also explored digital forms of rehabilitation decision support. A 2021 study evaluated an iPad-based decision-support application in occupational therapy, illustrating that digital tools can be used to assist collaborative choice within rehabilitation rather than functioning only as educational information repositories.

Nevertheless, a rehabilitation decision aid must be designed carefully. Rehabilitation goals may evolve as recovery progresses, and clinicians hold information regarding prognosis, safety, available therapy intensity, and likely timeframes that patients may not initially possess. Conversely, patients hold information about identity, daily roles, tolerable burden, family obligations, and meaningful activities that clinicians cannot infer reliably. Shared decision support is useful when it brings these forms of expertise together rather than privileging one automatically.

4. Research Methodology

4.1 Research Design and Simulated Population

The study adopts a simulation-based explanatory quantitative design. No rehabilitation patients were recruited, no clinical records were accessed, and no actual decision aid was deployed. Simulation was selected because an original dataset was not supplied and because fabricated rehabilitation outcomes should not be represented as real empirical findings.

A synthetic population of 600 adult rehabilitation cases was generated. Cases were conceptually representative of people receiving rehabilitation after neurological, musculoskeletal, geriatric, orthopedic, or other disabling health conditions. No particular diagnosis, age distribution, institution, or geographic setting is presented as factual participant information.

The synthetic cases were divided equally across three conditions:

- **Usual rehabilitation goal setting** – conventional goal discussion without a dedicated shared decision-support tool.
- **Structured goal-setting conversation** – clinician use of a standardized conversational framework.
- **Shared decision aid + clinician facilitation** – structured patient preparation, values clarification, option comparison, and clinician-supported goal negotiation.

Each condition contained 200 simulated cases.

4.2 Decision-Aid Components and Outcome Measures

The proposed shared decision aid begins before or at the start of the rehabilitation goal-setting consultation. Patients identify activities and life roles they most want rehabilitation to influence. The tool then organizes priorities into relevant domains such as mobility, self-care, communication, cognition, pain management, work, household activity, caregiving, social participation, recreation, and community independence.



Patients indicate which goals matter most and why. The clinician then contributes information regarding feasibility, time horizon, rehabilitation intensity, safety, and interdependence among goals. Areas of disagreement are deliberately highlighted for discussion rather than automatically resolved by the software.

Table 1: Proposed Measurement Framework for Shared Rehabilitation Goal Setting

Construct	Operational Definition	Proposed Measure	Analytical Role
Patient–Clinician Goal Concordance	Degree to which documented goals reflect both patient priorities and clinically feasible rehabilitation planning	0–100	Primary outcome
Goal Clarity	Patient understanding of what the rehabilitation goal is and why it was prioritized	0–100	Secondary outcome
Perceived Participation	Extent to which the patient believes their views materially influenced goal selection	0–100	Shared-decision outcome
Decisional Conflict	Uncertainty about which rehabilitation priority should be pursued	0–100	Negative outcome
Values–Goal Alignment	Degree to which formal goals reflect personally meaningful activities or roles	0–100	Proposed mediator
Rehabilitation Engagement	Participation in agreed rehabilitation actions and goal review	0–100	Functional process outcome
Goal Review Flexibility	Capacity to revise goals when recovery, circumstances, or priorities change	0–100	Longitudinal process outcome

The principal outcome is goal concordance because shared decision support should primarily improve alignment rather than guarantee a particular level of physical recovery. Clinical outcome improvement may follow from better engagement or prioritization, but the evidence base does not justify assuming that a decision aid by itself produces superior functional recovery.

4.3 Simulation Procedure and Analytical Strategy

Goal-concordance scores were generated as continuous 0–100 values, allowing substantial overlap between groups. The simulation intentionally permits some usual-care cases to achieve excellent concordance and some decision-aid cases to achieve poorer concordance. This reflects clinical reality: a



highly skilled clinician may conduct excellent shared goal setting without a formal tool, whereas a poorly facilitated decision aid can become a checklist that adds little value.

The shared-decision-aid condition was modeled with the highest average concordance because patient priorities are explicitly elicited and discussed before final goal selection. The structured conversation condition was modeled between usual care and decision-aid support. Additional synthetic variables included perceived participation, goal clarity, decisional conflict, and rehabilitation engagement.

Descriptive statistics were emphasized. Inferential significance testing was not used because artificially generated observations cannot establish population effects. Future empirical research could use a cluster-randomized design with rehabilitation teams allocated to usual practice or decision-aid-supported goal setting. Patient-reported measures should be supplemented by recorded consultation analysis, clinician ratings, goal-attainment outcomes, and follow-up assessments of whether the goals remain meaningful.

5. Analysis

5.1 Comparative Shared-Decision and Goal-Setting Outcomes

The simulation demonstrates progressively stronger collaborative outcomes as decision support becomes more structured.

Table 2: Simulated Outcomes Across Rehabilitation Goal-Setting Conditions

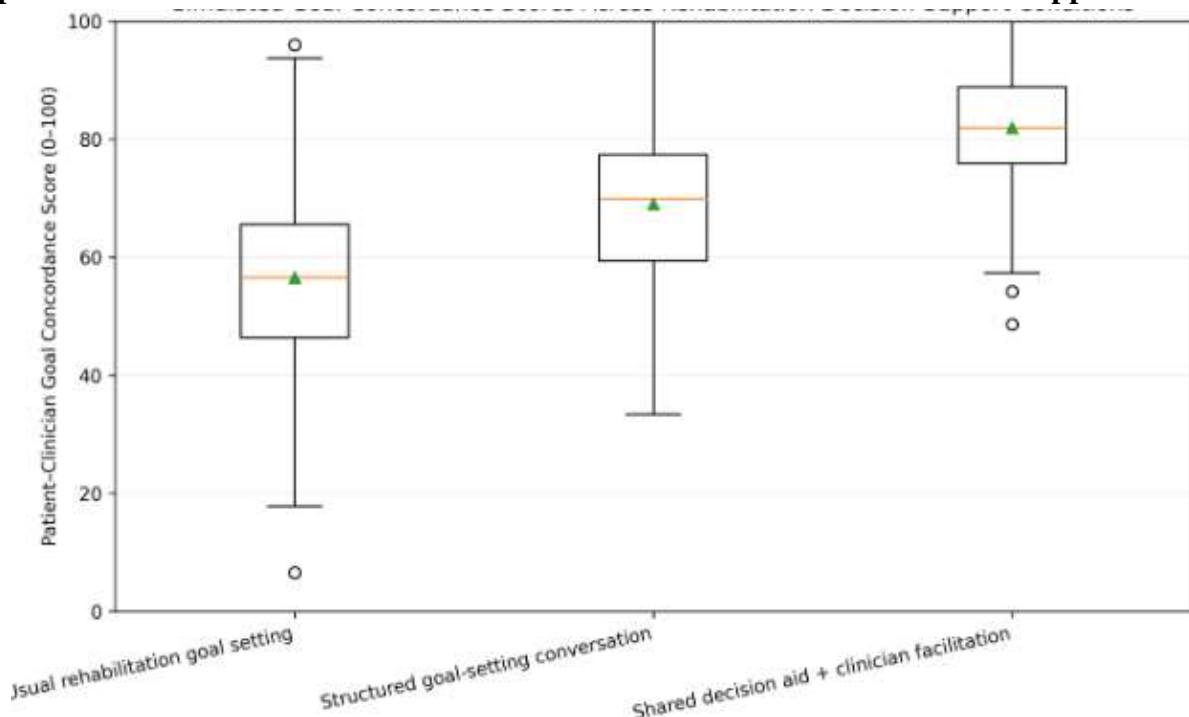
Outcome	Usual Goal Setting	Structured Goal Conversation	Shared Decision Aid + Clinician Facilitation
Simulated Cases	200	200	200
Mean Goal Concordance	56.5	69.0	82.0
Median Goal Concordance	56.5	69.9	81.9
Goal Concordance ≥ 75	12.0%	31.5%	77.5%
Mean Goal Clarity	61	74	87
Mean Perceived Participation	53	70	88
Mean Decisional Conflict	48	35	21
Mean Rehabilitation Engagement	60	71	82

The strongest modeled difference concerns perceived participation, increasing from 53 under usual goal setting to 88 when the decision aid is combined with clinician facilitation. Goal clarity also increases substantially, while decisional conflict falls from 48 to 21.

These results illustrate the proposed mechanism rather than proving that real decision aids will produce equivalent changes. The decision aid is modeled as beneficial primarily because it makes patient priorities visible before the final rehabilitation plan is documented.

5.2 Distribution of Goal Concordance

Graph 1: Simulated Goal-Concordance Scores Across Rehabilitation Decision-Support Conditions



The box plot demonstrates both central tendency and variability. The usual-care condition shows the broadest distribution and lowest median goal concordance. The structured-conversation condition shifts the distribution upward, while the shared decision aid plus clinician facilitation produces the highest median and a comparatively concentrated distribution.

The graph is analytically useful because it demonstrates that the intervention is not modeled as universally successful. Some participants in the decision-aid condition retain relatively low concordance, which could arise when prognosis conflicts sharply with patient priorities, communication remains difficult, or the aid itself does not adequately represent the person's circumstances.

Key Finding: Within the simulation, the shared decision aid produces the greatest modeled benefit when it is combined with professional facilitation rather than treated as a standalone questionnaire.



5.3 Interpreting Concordance Without Eliminating Clinical Disagreement

High goal concordance should not be interpreted as requiring clinicians to agree automatically with every patient request. Rehabilitation sometimes involves priorities that are temporarily infeasible, medically unsafe, dependent on earlier functional gains, or outside the realistic scope of a particular service.

The purpose of shared decision support is to make such disagreement explicit and understandable. If a patient prioritizes independent walking while the team believes immediate wheelchair mobility training is essential for safe discharge, a shared process should clarify both the long-term aspiration and the short-term functional requirement. The resulting plan may retain independent walking as an important longer-term aim while agreeing on immediate mobility goals that support safety and participation.

This distinction is compatible with rehabilitation research showing that patient-centered goal setting can generate interactional dilemmas when patient and professional expectations differ. Good shared decision-making therefore does not remove disagreement; it provides a structured way to work through it.

6. Discussion

6.1 Decision Aids Can Make Patient Priorities Visible Before Goals Become Fixed

One of the persistent problems in rehabilitation is that professional assessment can precede meaningful exploration of what the patient actually values. Once discipline-specific treatment goals have been documented, later attempts at patient involvement may occur within a plan that is already substantially determined. A pre-discussion or early-consultation decision aid can reverse that sequence by eliciting personally meaningful activities before the formal goal list becomes fixed.

This possibility is consistent with the wider patient decision-aid literature, which shows that decision aids can strengthen knowledge, values clarification, and active participation. Rehabilitation-specific evidence also suggests that patient involvement in goal setting remains variable and that patients do not always experience the process as fully shared. A decision aid therefore has value when it changes the conversation rather than merely generating additional documentation.

The tool should not ask only, “What goal do you want?” because patients may not know which rehabilitative changes are feasible or how different intermediate targets connect with broader life aims. A stronger design asks what the person wants to be able to do, why it matters, what barriers currently prevent it, how important the goal is relative to other priorities, and what degree of effort or compromise is acceptable. The rehabilitation professional can then translate the aspiration into clinically meaningful and measurable steps without losing its personal meaning.

6.2 Shared Goal Setting Requires Professional Facilitation, Not Automated Goal Selection

The simulated findings deliberately assign the strongest results to decision aid plus clinician facilitation rather than the decision aid alone. Rehabilitation is too contextual for a generic digital or printed tool to determine goals independently. Functional prognosis, fatigue, comorbid conditions, cognition, environmental accessibility, family resources, equipment availability, and therapy intensity all influence whether a goal is appropriate.

Van Til and colleagues recognized the potential of decision aids in rehabilitation while positioning them within shared decision-making rather than as replacements for professional interaction. Hoffmann and colleagues make a similar point within physiotherapy: shared decision-making requires therapists and patients to consider available options collaboratively rather than merely transfer information in one direction.

Clinician facilitation is also necessary when patient goals appear unrealistic. Simply labeling an aspiration “unrealistic” can undermine trust and prematurely narrow rehabilitation. A skilled shared-decision process separates the underlying valued outcome from the proposed method of achieving it. A person may say, for example, “I need to walk so I can attend my daughter's wedding.” The core value may be attending the event independently and with dignity. Exploring accessible transport, wheelchair mobility, transfer training, fatigue management, or assistive equipment can preserve the meaningful life goal even when independent walking remains uncertain.

Decision aids are therefore most useful as preference-translation tools. They help convert broad hopes into information that an interdisciplinary team can use while ensuring that clinical feasibility does not erase personal meaning.

6.3 Accessibility, Changing Goals, and Longitudinal Rehabilitation

Shared decision support must remain inclusive of people with communication and cognitive difficulties. Dörfler and Kulnik's qualitative research demonstrated that person-centered goal setting remains possible after stroke despite communication or cognitive impairment, provided rehabilitation professionals use appropriate strategies to facilitate involvement. Excluding such patients from shared goal setting simply because conventional verbal discussion is difficult would reproduce precisely the paternalism that shared decision-making is intended to reduce.

Accessible decision aids might therefore include pictorial activity domains, simplified sentences, supported-choice formats, communication boards, repeated presentation of options, slower pacing, and involvement of trusted supporters where the patient wishes. Family involvement should strengthen rather than automatically replace the patient's voice. For some individuals, preferences may need to be explored across several sessions rather than captured in one formal meeting.

Goals also change over time. Rehabilitation is a dynamic process in which recovery trajectory, experience with therapy, discharge circumstances, pain, fatigue, confidence, and personal priorities may alter what feels achievable or worthwhile. A goal agreed during the first week of rehabilitation may no longer be the right goal several weeks later. Shared decision aids should therefore support review and revision, not merely initial documentation.

7. Conclusion

Shared decision aids offer a promising means of strengthening patient participation in rehabilitation goal setting, but their value depends on how they are integrated into clinical conversation. Rehabilitation goals are not ordinary administrative targets. They determine which functional outcomes receive attention, how professional effort is coordinated, how progress is judged, and often what patients come to understand as possible within their recovery. The evidence available through 2021 indicates that goal



setting is important but heterogeneous, and that patient involvement within rehabilitation goal setting remains inconsistent.

The simulation developed in this study illustrates how increasingly structured shared decision support could influence goal concordance. Mean concordance rises from 56.5 under usual rehabilitation goal setting to 69.0 following a structured goal conversation and 82.0 when a shared decision aid is combined with clinician facilitation. The proportion of cases with concordance scores of at least 75 increases from 12.0% to 77.5%. These figures are entirely synthetic and should not be cited as empirical effect estimates.

The most important conceptual implication is that a decision aid should not become a decision maker. Patients contribute knowledge of identity, priorities, daily life, acceptable trade-offs, and valued outcomes. Rehabilitation professionals contribute clinical knowledge, prognosis, treatment options, safety information, and experience concerning feasible pathways. Shared decision support is useful when it creates an explicit space in which these forms of expertise can be compared and integrated.

The model also recognizes that disagreement is not evidence that shared decision-making has failed. Genuine collaboration may expose previously hidden differences between what a patient values and what professionals initially planned. The quality of the process depends on whether those differences are explored respectfully and translated into goals that preserve as much personal meaning as clinical circumstances allow.

Future empirical studies should test shared rehabilitation goal decision aids across inpatient, outpatient, and community settings using objective measures of shared decision-making together with patient-reported involvement, goal concordance, decisional conflict, goal attainment, rehabilitation engagement, quality of life, and service satisfaction. Studies should also evaluate communication accessibility and determine whether decision aids improve participation among people who have traditionally been less able to influence rehabilitation planning. The most meaningful rehabilitation goal is not simply the one that is technically measurable; it is the one that is clinically defensible, personally meaningful, mutually understood, and genuinely shared.

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