

# Reablement through time and space: A scoping review of how the concept of 'reablement' for older people has been defined and operationalised

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## Research article

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# Abstract

**Background:** While the field of rehabilitation has determined a common definition of professional practice, legislators and healthcare professionals in various Western countries have been struggling to reach consensus about how the newer offer of 'reablement' should be organised, operationalised, and understood as a health service for older adults. International research indicates that a great deal of confusion, ambiguity, and disagreement has arisen regarding the terminology and the structure of these programmes, and they may not be adequately supporting older people. Could a clarification of the concept help reablement become more effective in theory *and* in practice?

**Methods:** We conducted a qualitative and quantitative scoping review to determine how reablement has developed through time and space. Eligible articles ( $n=86$ ) had to focus on any of the defined features of current reablement programmes; there were no restrictions on study designs or publication dates. In articles published from 1947–2019, we identified themes and patterns, commonalities, and differences in how various countries described and defined reablement. We also performed an analysis using computer software to construct and visualise term maps based on significant words extracted from the article abstracts.

**Results:** The fundamental principles of reablement have a long history. However, these programmes have undergone a widespread expansion since the early 2000s with an intention to reduce costs related to providing long-term care services and in-home assistance to growing older populations. As reablement programmes have developed internationally, they have begun to overemphasise training older people to (re)gain their skills and confidence in maintaining or improving functional ability related to activities of daily living (ADLs).

**Conclusions:** Reablement programmes are fundamentally intended to be person-centred and should support older people in attaining their self-defined goals to be both more physically independent at home and socially involved in their communities. However, the rapid implementation of these programmes without clear evidence for the full scope of their potential effects and impact means that they may not adequately consider older people's own goals. A continued lack of agreement about what reablement is (and what it should achieve) may lead to ineffective programmes and unclear guidance on which outcomes to measure.

## 1. Introduction

Population ageing raises significant questions about the socio-economic sustainability of increased human longevity, and this demographic shift has resulted in the promotion of 'healthy ageing' in many Western societies. While there is no universally accepted definition for 'healthy ageing' – or active, productive, or successful ageing – such concepts typically refer to individual or collective strategies used to optimise economic, social, and cultural participation throughout the life course (Clotworthy, 2017: 12; Gilieard and Higgs, 2007). The paradigm of 'healthy ageing' is often emphasised in legislation and social

policies that target older people (e.g., Alftberg et al., 2012; Elmelund, 2012; Laliberte Rudman, 2015; Lassen et al., 2014), particularly in high-income, industrialised Western societies that tend to valorise individualism and productivity. For example, during the International Federation on Ageing (IFA) Global Think Tank and Copenhagen Summit 2015/2016, attendees from many of these countries met to discuss ways to develop a solution-driven global public-health agenda that would further promote ‘healthy ageing’. One result of the summit was an agreed intention to advance “improved awareness of the value of a reablement approach and applied technology for an increasing ageing population” (Mishra and Barratt, 2016: 6). Here, reablement for the individual older person is understood as “an active process of (re)gaining skills and confidence in maintaining or improving function, or adapting to the consequences of declining function. It also supports the individual to remain socially engaged within the community context in a safe, culturally sensitive and adaptable way” (Mishra and Barratt, 2016: 7).

However, this approach to reablement may be easier said than done. There currently seems to be a great deal of confusion, ambiguity, and disagreement about the terminology and the structure of such programmes. While physical ‘rehabilitation’ has been formally recognised as a field of professional practice since the aftermath of World War I (Brandt and Pope, 1997: 28–9) – and has subsequently established its own policy governance, regulations, professional organisations, and educational training programmes as well as an agreed-on set of practices, aims, and outcomes – the concept of ‘reablement’ is relatively new and lacks regulation; thus, it is often considered to be “poorly defined, with little understanding of what it looks like when achieved” (Cations et al., 2018: 172–3). Furthermore, while the professional field of rehabilitation has determined a conceptual description to “foster the development of a common understanding of rehabilitation and its professions” (Meyer et al., 2011: 765), it appears that legislators and healthcare professionals both within and across various Western countries have been struggling to reach consensus about how reablement programmes should be defined, described, and structured – let alone how they should function in practice to best support older adults in reaching their own self-identified goals. As such, there is ambiguity about what reablement programmes are, what they offer, and why (e.g., some may not specifically target older people; most are defined as being time-limited and home-based). Could a clarification of the concept help reablement become more effective in both theory *and* in practice to benefit older people?

We performed a quantitative and qualitative exploration of how the concept of ‘reablement’ has developed over time in various countries to examine the common features and differences between these programmes at an international level. With our investigation of the term, this scoping review contributes insights and provides clarity to legislators, health professionals, and older people with regards to how these programmes can be organised, operationalised, and understood in practice – fundamentally, this clarification will enable them to collectively determine what ‘reablement’ looks like when it is achieved.

## 2. Methods

On 25 March 2019, we searched Medline, Embase, CINAHL, and PsycInfo for all articles on reablement. There were no restrictions on publication dates. Due to the exploratory nature of our study and our main

interest in reablement, the search term for all databases was “reablement OR re-ablement”. This resulted in papers published in English by researchers primarily working in high-income Western countries (as defined by the Organisation for Economic Co-operation and Development, International Monetary Fund, World Health Organization, and the United Nations). We examined the full texts of potentially eligible articles, and then used reference tracking to scrutinise reviews, updates, and protocols for additional potentially eligible articles.

### *2.1 Article selection*

Two authors (AC and SK) jointly examined all resulting articles for eligibility. Disagreements were resolved through consultation with a third reviewer (RW). For an article to be eligible, it had to focus on any of the most common aspects of ‘reablement’ as currently defined by most local government officials or health- or aged-care organisations:

- time-limited offer
- home-based intervention
- intervention implemented to improve a person’s functional ability and improve or develop their social participation (i.e., to support them in being more socially active).

The resulting original contribution had to be a complete research article, study protocol, or editorial published in an academic journal or book, and therefore not a conference abstract or poster. We did not apply restrictions on study designs (quantitative or qualitative) or publication dates.

### *2.2 Qualitative analysis of the eligible articles*

Starting with the earliest articles published, we examined the titles and abstracts for themes and patterns, commonalities, and differences in how ‘reablement’ was described and defined. In order to inform our analysis, we aimed to identify several shifts in terms of how reablement programmes have developed, which components they share, how reablement is organised and delivered as a service model, and how/why reablement is offered by healthcare authorities and to whom. This thematic analysis provided flexibility and allowed us to manage a large initial dataset; it was also an efficient way for us to determine the conceptual shifts in how reablement programmes have developed over time. Once we determined these predominant themes and patterns, we reviewed all of the relevant articles in full.

### *2.3 Quantitative analysis of the eligible articles*

To validate the findings from our qualitative analysis, we also performed a quantitative analysis of the eligible articles using VOS viewer software version 1.6.11 (“VOSviewer - Visualizing scientific landscapes,” n.d.). Here, we used the software’s text-mining functions to construct and visualise term maps based on scientific terms extracted from the eligible abstracts. A term map is a two-dimensional visualisation that represents networks of concurrent relations between scientific terms. The relatedness of terms is determined based on two or more terms occurring together in the abstracts. The smaller the distance

between two terms, the stronger the terms are correlated with each other. Multiple terms with high co-occurrence are grouped together into clusters, and each cluster can therefore be seen as a confined intellectual topic. We used a full counting method, meaning that the number of occurrences of a term in a document was taken into account instead of only looking at the presence or absence of a term. Parts of the texts were tagged to identify verbs, nouns, adjectives, etc., and thereafter a filter selected all word sequences that consist exclusively of nouns and adjectives. We also set a threshold of minimum five occurrences for a term to be included in our analysis. Out of all of the terms included, a relevance score was calculated and, based on this score, the most relevant terms were selected. The top 60% of the most relevant terms were visualised and coloured according to publication year. It is likely that some of the terms may appear across multiple time periods. However, each term is only visualised once, depending on the average publication year of articles in which the term was mentioned.

### 3. Results

Figure 1 presents a flow chart describing the selection of articles. Out of the 120 articles identified in our initial search in Medline, Embase, CINAHL, and PsycInfo databases, 14 were conference abstracts, 14 were beyond the scope and therefore irrelevant (e.g., articles on postnatal wards, homeless people, non-humans, etc.), and 18 were hospital-based post-disease/ -injury, which resulted in 74 relevant articles from the database search. We added 12 relevant articles from reference tracking, which amounted to a total of 86 final eligible articles that were appropriate for the next stage of quantitative and qualitative analysis.

#### 3.1 Qualitative Analysis

Based on the collected literature, we divided the conceptual shifts about reablement into the following categories: historical focus (pre-2000); the emergence of 'restorative care' for older people (2001–2005); the transition from 'restorative care' to 'reablement' (2006–2014); and the boom of reablement services (2015–present).

##### 3.1.1 Historical focus (pre-2000)

From the literature search, we learned that the meaning and conceptualisation of 'reablement' has changed since the beginning of the 20th century; in practice, it has both run parallel to and deviated from its sister practice, rehabilitation. After World War I ended in 1918, German surgeons and engineers (notably Ferdinand Sauerbruch and Aurel Stodola) made significant advances to develop and formalise physical rehabilitation, especially with regards to the technical design and engineering of prosthetics (Brandt and Pope, 1997: 28). The injuries that soldiers experienced during the Great War also prompted an interest in developing rehabilitation services in the United States "as veterans with disabilities needed to be reintegrated into society and the workforce" (Brandt and Pope, 1997: 28). As science and engineering made rapid post-war technical advances, occupational and physical therapists were able to achieve further professional progress in their work with war veterans. After World War II, however, the emphasis of clinical rehabilitation began to broaden from a patient's recovery of ambulation to a focus

on “the **comprehensive restoration** of an individual’s physical, mental, emotional, vocational, and social capacities” (Kottke and Knapp, 1988 in Brandt and Pope, 1997: 31; *emphasis added*).

Based on our search, the word ‘reablement’ first entered the scholarly lexicon in a 1947 editorial simply titled “Disablement and reablement”, which was published in *Physiotherapy* (Nixon, 1947). The author argued that the word ‘rehabilitation’ must be discarded in favour of ‘reablement’, which should focus on “making a disabled person able-bodied again”, and that an “expert medical supervisor” should know “what can be done to overcome disability and restore a man to capacity for his former work, or, alternatively, what particular work he can be trained for” (Nixon, 1947: 173). The publication of this article at the end of World War II suggests that the author’s conceptualisation of ‘reablement’ was inspired by the need to support and train ‘dis-abled’ patients – most likely injured soldiers returning from the frontlines – in restoring their functional abilities and ‘re-settling’ them both at home and in the workplace. At the same time, the term ‘reablement’ was also being used to describe physiotherapeutic training for patients suffering from specific health conditions or diseases, such as cerebral palsy and rheumatoid arthritis (Collis, 1947; Grenville-Mathers, 1949). The first mention of reablement associated with “the heavily handicapped patient” was found in the title of a British journal article on the principles of rehabilitation in 1962 (Grant, 1962), and an article from 1975 discussed reablement in relation to functional activities and “resettlement in work and home” (Nichols, 1975 :113).

An emphasis on the restoration of functional ability and “resettlement in work and home” appeared to continue throughout the 1960s and 1970s (Leplaideur et al., 1977); (Dupontreuve, 1977); (Cooper, 1977). During this time period, there also seems to be an emphasis on ‘re-abling’ patients suffering from arthritis and other rheumatic diseases, with a paper in the *Ulster Medical Journal* (Northern Ireland) stating that, “A patient’s total care should begin and end in the community of which he is an active member, whether at home or at work. Regardless of the degree of disability, if satisfactory integration is not being achieved the system is at fault” (Newton, 1978: 49).

Our literature search found very few scholarly articles published in the 1980s and 1990s that mention the term ‘reablement’. However, a 1994 editorial in *Reviews in Clinical Gerontology* began, “We are trying to improve this patient’s quality of life’ is the often stated goal of much therapeutic effort made for elderly people” (Ebrahim, 1994: 93) and continued to say that “the criteria for successful **rehabilitation** are often limited to independence in a limited range of basic activities of daily living. **Reablement** is most obviously concerned with reducing disability and the appropriate outcomes must be disability measures. **Resettlement** is a more complex goal and implies the restoration of people to their own, or sometimes a new, environment” (Ebrahim, 1994: 93–94; *emphasis added*). This article suggests that the term ‘reablement’ was still linked to ‘rehabilitation’ while ‘resettlement’ was understood as a different approach that included a focus on the environmental ‘restoration’ of older people.

### 3.1.2 The emergence of ‘restorative care’ for older people (2001–2005).

By the turn of the millennium, this idea of ‘resettlement’ and ‘restoration’ as a specific intervention for older people receiving home care had transitioned into ‘restorative care’. For example, in 2002, Tinetti et

al. published what could be considered a landmark paper in the *Journal of the American Medical Association* (JAMA) titled: "Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care". In this article, the authors suggest that "a primary goal of health care for older, particularly multiply and chronically ill, persons should be to optimize function and comfort rather than solely to treat individual diseases" (Tinetti et al., 2002: 2098), and they state that both broad and disease-specific home-based clinical strategies have been performed and studied with mixed results (Tinetti et al., 2002: 2098). The U.S.-based trial examined the benefits of a 'restorative care model' in relation to older patients' ability to remain at home as well as "the duration and intensity of the home care episode, emergency visits to a physician, emergency department (ED) visits, and pain" (Tinetti et al., 2002: 2098). The restorative-care model that the authors described was based on principles adapted from geriatric medicine, nursing, rehabilitation, and goal attainment, which refers to the belief that people "are more likely to adhere to treatment plans if they are involved in setting goals and in determining the process for meeting these goals" (Tinetti et al., 2002: 2100).

The intervention included training relevant health professionals (i.e., home care nurses, therapists, and home health aides) as well as reorganising this home-care staff "from individual care providers into an integrated, coordinated, interdisciplinary team with shared goals", which required a "reorientation of the focus of the home care team from primarily treating diseases and 'taking care of' patients toward working together to maximize function and comfort" (Tinetti et al., 2002: 2100). Furthermore, it was built upon "the establishment of goals based on input from the patient, family, and home care staff, and agreement among this group on the process for reaching these goals" (Tinetti et al., 2002: 2100). Although the authors cite several studies from the 1990s that focused on goal-setting in clinical medicine for the so-called 'frail elderly', their intervention appears to be the first well-defined programme that closely resembles the reablement initiatives that are presently being operationalised and implemented worldwide. This research also built its findings on the authors' earlier study, "The design and implementation of a restorative care model for home care" (Baker et al., 2001) as well as several previous articles that examined older people's self-care and functionality with regards to performing ADLs in both hospital and home settings.

Around the same time, a report was published in the United Kingdom that described 33 services that were part of the NHS Modernisation Agency's Changing Workforce Programme project, called the Accelerated Development Programme for Support Workers in Intermediate Care in England (Nancarrow et al., 2005). These services were "designed to prevent inappropriate hospital admissions, facilitate hospital discharge, and prevent premature or avoidable admissions to long-term care" (Nancarrow et al., 2005: 338) – and this included what was called 'reablement services'. The summary of care roles outlines that it focuses on providing "personal care, daily living skills, mobility and financial management (...); enablement rather than 'doing' for their services users; dedicated home workers providing personal care from an enabling perspective with rehabilitation skills; reablement to promote independence" (Nancarrow et al., 2005: 343). This brief description indicates that 'reablement' and 'restorative care' were two similar approaches that were being implemented in two different geographical contexts; i.e., 'reablement' was beginning to be operationalised in the United Kingdom at nearly the same time that the similar 'restorative care model'

was being developed in the United States. However, with their shared focus on older people's specific goals and needs, both of these approaches were meant to be something other than traditional (conventional) forms of physical 'rehabilitation'.

### 3.1.3 The transition from 'restorative care' to 'reablement' (2006–2014).

The general concept of 'restorative care' services for older people seems to have transitioned to being called 'reablement' in the late-2000s, and our search identified 24 relevant articles from this time period. As mentioned earlier, the term reablement or re-ablement was first adopted in the United Kingdom; this transition was reinforced by a retrospective longitudinal study of 'homecare re-ablement', "Research into the longer-term effects of reablement services" (Newbronner et al., 2007), which was undertaken for the Care Services Efficiency Delivery (CSED) Programme at the Department of Health. In the *Journal of Integrated Care*, it was stated that homecare reablement had been widely accepted in the UK to refer to "services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living" (Petch, 2008: 38).

Other researchers emphasised progress in developing "outcomes-focused services for older people and the factors that help and hinder this" (Glendinning et al., 2008: 54). The authors also described two small-scale, exploratory studies that examined the impact of home-care reablement on subsequent service use (Glendinning and Newbronner, 2008). These articles present the first definitive definition that distinguishes 'reablement' as its own unique approach: i.e., "Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning skills necessary for daily living" (Glendinning and Newbronner, 2008: 33, Table 1). The authors continued to describe reablement as a service that "aims to help people 'do things for themselves', rather than 'having things done for them'. Home care reablement services therefore provide personal care, help with mobility and other practical tasks for a time-limited period" (Glendinning and Newbronner, 2008: 33). The authors further stated that user-identified outcomes are central to the reablement process, particularly with regards to personal care, daily living tasks, or social activities. They also pointed out that reablement services can be offered to adults of all ages in the UK; their studies did not focus on recipients of a particular age, although they suggested that "even very elderly...users may regain skills and attitudes to help sustain them for a relatively long period" (Glendinning and Newbronner, 2008: 36–7). The same authors published a prospective longitudinal study and working paper that investigated the longer-term impacts of "home care re-ablement services" (Glendinning et al., 2010).

During this time period, a greater focus on professional practice was beginning to develop, as evidenced by a short blog post in *Community Care* in which the author wrote, "Providing personal care, help with daily living activities and other practical tasks, usually for up to six weeks, reablement encourages service users to develop the confidence and skills to carry out these activities themselves and continue to live at home" (Samuel, 2010: para 2), and a professional column in *British Journal of Community Nursing* stated that reablement is "generally provided by local authorities as part of adult social care provision with a focus upon promoting self-care skills and rebuilding confidence" (While, 2011: 102). The concept

of reablement targeted specifically at older people was also beginning to emerge in northern Europe – particularly, Finland. However, such programmes were termed “geriatric rehabilitation’ (Wallin et al., 2009) and did not take place within the home setting. But other than this difference, the Finnish intervention seems to contain many aspects that are similar to other reablement programmes; e.g., the goal was “to achieve and maintain functional independence, and to enable older people to remain community-dwelling” (Wallin et al., 2009: 145).

By 2011, British experts reiterated the burgeoning ‘reablement philosophy’, which states that “the focus is on restoring independent functioning rather than resolving health care issues, and on helping people to do things for themselves rather than the traditional home care approach of doing things for people that they cannot do for themselves” (Francis et al., 2011: 2). This briefing also mentioned that there was renewed political emphasis “on the need to ‘keep people as independent as possible, for as long as possible’”, and restated both that care workers require specific training in reablement and that no leading service model had been identified (Francis et al., 2011). Other researchers claimed that “home-care reablement or ‘restorative’ services had become a cornerstone of preventive service initiatives in many countries” (Rabiee and Glendinning, 2011: 495), and that such services should enable older people to live independently in the community. The authors wrote that “the assumption underlying re-ablement is that enhancing independence and practical skills reduces needs for ongoing service support” (Rabiee and Glendinning, 2011: 496).

However, there remained a lack of consensus about the definition, organisation, and practices related to the concept of reablement. For example, our search also identified a 2011 Taiwanese article that discussed community hospital-based post-acute care (PAC) to improve functional ability amongst frail older patients (Lee et al., 2011), which is the first time the term is mentioned by East Asian researchers; the authors concluded that “a short-term, inpatient physical re-ablement program conducted by an interdisciplinary geriatric team in a community hospital can successfully improve the physical function and cognitive, psychological, ambulatory, and nutritional conditions of postacute elderly patients” (Lee et al., 2011: 32).

A 2012 British article – which claimed to be the first in-depth study of the experiences of home-care reablement service users and carers – described reablement as “a short-term, intensive service that helps people to (re-)establish their capacity and confidence in performing basic personal care and domestic tasks at home, thereby reducing needs for longer term help” (Wilde et al., 2012: 583). The authors noted that similar programmes were also being implemented in Australia and New Zealand. In Australia, the term ‘restorative care’ was being used to describe programmes that were similar to the current understanding of reablement (Ryburn et al., 2009). Here, the authors described how the provision and nature of home-care services had recently developed a “new focus on activity, independence and successful ageing” and concluded that “a restorative approach to home care has significant advantages over the traditional approach aimed at maintenance and support only” (Ryburn et al., 2009: 232). At the same time, the National Development Manager–Care and Communities for Age UK argued that reablement is “nowhere near as effective as it could be” because it lacks personalisation and “fails to

appreciate what motivates people to make the substantial effort involved in regaining lost skills and abilities” (Newton, 2012: 117).

By 2013, Australian researchers began to describe restorative homecare services as “short-term and aimed at maximizing a person’s ability to live independently. They are multidimensional and often include an exercise program to improve strength, mobility, and balance” (Burton et al., 2013: 1591). Although the emphasis is on a physical activity/exercise programme delivered by an interdisciplinary team consisting of occupational therapists, physiotherapists, and registered nurses, the authors wrote that the intervention should ultimately “create independence, improve self-image and self-esteem, and reduce the level of care required through the delivery of an individualized program” (Burton et al., 2013: 1591–2). The linguistic transition from ‘restorative care’ to ‘reablement’ in Australia is clearly seen in a study that aimed “to determine whether older individuals who participated in a **reablement (restorative) program** rather than immediately receiving conventional home care services had a reduced need for ongoing support and lower home care costs” (Lewin et al., 2013: 1273; *emphasis added*). The authors also mentioned the country’s upcoming (2015) Living Longer Living Better aged-care reform package, and the government’s interest in the “effectiveness of **reablement/restorative** home care services in assisting older people to improve their ability to function and reduce their need for ongoing services” (Lewin et al., 2013: 1273; *emphasis added*). The authors provided a straightforward definition for reablement in Australia, which includes “an emphasis on capacity building (...) to maintain or promote a client’s capacity to live as independently as possible, with an aim of improving functional independence, quality of life, and social participation, (...and) an emphasis on a holistic, person-centered approach to care, which promotes clients’ wellness and active participation in decisions about care” (Lewin et al., 2013: 1274).

At this time, it appears that a semantic debate was still occurring in Ireland and the UK as well. This can be seen in an Irish intervention protocol that aimed “to assess the effects of home-care ‘re-ablement’ services compared to usual care, or to a wait list control group, in terms of maintaining and improving the functional independence of older adults” (Cochrane et al., 2013: 1), and which described reablement (in scare-quotes) as “an innovative approach to improving home-care services for older adults in need of care and support or at risk of functional decline” (Cochrane et al., 2013: 2). In this protocol, the authors identified five essential defining criteria for an intervention to be called ‘reablement’: 1. participants must have an identified need for formal care and support, or are at risk of functional decline; 2. the intervention must be time-limited (typically 6–12 weeks) and intensive (e.g., multiple home visits); 3. the intervention must be delivered in the older person’s own home; 4. the intervention must focus on maximising independence; and 5. the intervention must be person-centred and goal-directed (Cochrane et al., 2013: 3–4). A 2013 British article described such programmes as “**re-ablement or restorative** homecare services that provide time-limited input aimed at reducing dependency in personal activities of daily living, and preventing or delaying the need for further homecare support” (Whitehead et al., 2013: 1; *emphasis added*) while a 2014 Australian paper made the distinction between terminology in the different countries: “Restorative home-care services, or re-ablement home-care services as they are now known in the UK, aim to assist older individuals who are experiencing difficulties in everyday living to optimise their functioning and reduce their need for ongoing home care” (Lewin et al., 2014: 328).

Nearly all of the articles during this time period also cite a growing political interest in cost-savings. In particular, the Department of Health in the United Kingdom highlighted its commitment to reablement services in a white paper, *Caring for Our Future: Reforming Care and Support*. This document “outlines the government’s vision that the provision of these services should support people to remain living independently in their homes after a crisis event” (Whitehead et al., 2014: 1). Although the emphasis in the UK remained on providing services to adults of all ages (not specifically older adults), this paper provides a definition of reablement in which “users receive home-care but are supported to increase their ability to manage tasks independently, in order to reduce the amount of homecare they will require in the longer term” (Whitehead et al., 2014: 2), and further distinguishes reablement from rehabilitation, stating that reablement services “adopt a social model of recovery rather than a medical model” (Whitehead et al., 2014: 2). During this time, there is also increased emphasis on developing professional practice; e.g., a 2013 critical literature review analysed evidence on the effectiveness and cost-effectiveness of occupational therapy interventions for older people in social-care services. The authors determined that, although occupational therapists are increasingly involved in rehabilitation and reablement, there is a continuing focus on equipment and adaptations provision (Boniface et al., 2013).

In Scandinavia, reablement programmes started to be offered in the 2000s; the first was established in Östersund Municipality, Sweden, in 1999 and – based on the Swedes’ positive experiences – soon began to develop in neighbouring Denmark (2008) and Norway (2012) under different names. The study protocol for a randomised controlled trial (RCT) of reablement in community-dwelling adults positioned reablement within the discourse of cost-savings related to an increased ageing population, describing it as “an approach to improve home-care services for older people needing care or experiencing functional decline. It is a goal-directed and intensive intervention, which takes place in the person’s home and local surroundings with a focus on enhancing performance of everyday activities defined as important by the person” (Tuntland et al., 2014: 1). The authors further emphasised that the intention is “to increase independence in daily activities, and enable people to age in place, be active and participate socially and societally” (Tuntland et al., 2014: 2). A subsequent Danish article referred to the Nordic concept of ‘help to self-help’, which is based on “ways of providing help that involves the activation of older people, the aim being to enable them to manage as much as possible themselves”. It also stated that, in the UK, “the comparable principle of ‘re-ablement’, which has recently been introduced, seems a more ambitious principle” (Dahl et al., 2015: 287).

#### 3.1.4 The boom of reablement services (2015–2019)

In recent years, differences in each country’s reablement offer have become more apparent, and there is a continuing lack of consensus about what reablement programmes are, how they are organised, and what they should achieve. Our search identified 56 articles from this time period; the majority were published by researchers from Norway (n=17) and the United Kingdom (n=14), and they include both quantitative and qualitative studies conducted in these countries as well as several collaborative studies conducted by researchers from different countries. There are no articles from Asia, South/Central America, or Russia and only one from continental Europe. If reablement-like programmes have been or are currently being

offered in these regions, they are most likely called another name. We have summarised the regional variations and organised these results alphabetically by region in Table 1.

### 3.2 Quantitative Analysis

We created a term map based on text mining the abstracts of the final eligible articles. Figure 2 shows a term map based on the most relevant terms from the abstracts of all 86 final eligible articles. Out of 2,238 terms, 220 met the threshold of five occurrences. Here, we visualised 60% of the most relevant terms, which amounted to 132 terms with 3,315 links between the terms. Each circle represents a term from the various abstracts, and the lines connecting the circles represent the interrelatedness of different terms. The size of the circle represents the number of occurrences of the term. The closer the circles are to each other indicates a high co-occurrence of terms representing a topic. The term map is coloured according to publication year, with dark blue/purple circles indicating terms from the earliest publication in 1947 until 2012 transitioning to teal in year 2013–2014, then turquoise/green in 2015–2017, and thereafter yellow indicating terms from the most recent publications in year 2018–2019.

Based on the number of occurrences of terms emerging in Figure 2, we can see the central concepts that have been emphasised in the literature throughout the years as listed in Table 1. In the earlier papers from 1947 until 2012, the core principles of reablement had already been conceptualised as a form of rehabilitation for hospitalised patients with disabilities and/or a need for home care and social care services. In 2013–2014, there appears to be a shift of the target group from ‘patients’ to ‘users’. There was also an emphasis on developing specialised staff training that could create an impact by improving cost-effectiveness, and these programmes were offered as an alternative treatment to usual care. In 2015–2017, there appears to be another shift from ‘users’ to ‘participants’, with special attention to their goals and satisfaction with the programmes. This period also underlined the importance of assessing the performance of reablement services, particularly regarding the health professionals’ and carers’ roles, skills, knowledge, and experience (specifically, nurses and occupational therapists). In the most recent publications from 2018–2019, the focus shifted towards how to organise reablement teams and the programme’s overall approach, particularly by focusing on improving user involvement and collaboration between healthcare professionals, home care personnel, and family members. The literature also highlighted an increased interest in making reablement programmes more inclusive to accommodate participants with dementia.

## 4. Discussion

In order to examine how the concept of ‘reablement’ has been defined and operationalised through time and space, we conducted an exploratory qualitative literature review and quantitative analysis. As stated in several of the recent cross-national studies and systematic reviews that we examined, reablement is often described as a “time-intensive, time-limited intervention provided in people’s homes or in community settings, often multi-disciplinary in nature, focusing on supporting people to regain skills around daily activities” (Aspinal et al., 2016: 574; *also* Cochrane et al., 2016; Tessier et al., 2016), which is very similar

to the standard definitions of physical rehabilitation. However, our scoping review shows that, in the earliest articles dating back to 1947, reablement was understood as a very specific and specialised form of rehabilitation that emphasised 'resettling' or 'restoring' a person in their local community; i.e., a social model rather than a medical model of recovery. As reablement programmes have developed over the years, the target population has typically become "older patients with diverse mortality and morbidity risks, multimorbidity, prognostic outcomes, symptoms, and disability" (Legg et al., 2016: 746) – a set of circumstances that has long presented significant challenges to healthcare professionals working with more traditional forms of rehabilitation.

The literature that we reviewed also indicates that the practice of reablement is a strategy that (thus far) is only being implemented in Western countries with neoliberal political and economic frameworks, and which tend to valorise individualism and productivity. As such, reablement programmes have primarily developed into a cost-savings measure that focuses on maintaining and improving an older individual's functional (i.e., physical) ability in relation to activities of daily living (ADLs). This is being done to promote greater independence and self-sufficiency in the home but also to reduce an older person's need for costly welfare/support services. Thus, rather than attempting to carefully and methodically implement the first contemporary restorative-care model from 2002 (which was based on principles adapted from geriatric medicine, nursing, rehabilitation, and goal attainment), the sheer volume of papers from 2015 to 2019 suggests that reablement programmes are being rapidly implemented by Western governments without clear evidence for the full scope of the potential effects and outcomes.

Our review also indicates that very few countries have been able to implement person-centred and goal-directed reablement in practice – rather than supporting an older person's social involvement or participation in their local community, the emphasis is instead on improving their physical ability/function within the home to reduce the costs related to providing home-care and other eldercare services. In this respect, the literature offered unsubstantial evidence to suggest that older people's participation in a reablement programme could consistently reduce costs over the long term, prevent inappropriate hospital admissions, facilitate hospital discharge, and prevent premature or avoidable admissions to long-term care (Nancarrow et al., 2005) or improve death rates (Cochrane et al., 2016). Although Norwegian researchers concluded that, after six months, "reablement is a more effective rehabilitation service than traditional home-based services" for people with functional decline (Langeland et al., 2019: 1), the evidence for the long-term efficacy of reablement still remains weak and inconsistent. Our review shows that part of the problem is that the concept of reablement has become interchangeable with standard forms of physical rehabilitation. Frequently, this is due to a lack of infrastructure, professional guidelines, training, and/or resources. Many of the articles we reviewed also suggested that, despite already being implemented by national governments, there is a lack of capacity, training, and coordination/cohesion between professional groups to properly implement reablement programmes; in particular, professional training, coordination, and compliance remain problematic.

More to the point, it seems likely that reablement is "nowhere near as effective as it could be" because it lacks personalisation and "fails to appreciate what motivates people to make the substantial effort

involved in regaining lost skills and abilities” (Newton, 2012: 117). Overall, most of the literature in our review states that, since formalised, community-based reablement services for older people first began to be widely implemented in the early 2000s, these programmes lack clear evidence of efficacy, there are inconsistencies in how the programmes are designed and offered in practice, and there is fundamentally a lack of research-based knowledge as well as “an agreed understanding of the nature of reablement” (Legg et al., 2016: 741). This lack of shared understanding and consensus about what reablement *is* or *should be* is reflected in the multitude of terms used to describe nearly identical programmes in different geographical regions. Even in English-speaking countries with similar service models, programmes with similar components have different names: e.g., *reablement* or *re-ablement* (United Kingdom) and the *active service model* or *restorative home support* (Australia, New Zealand, and USA). In Scandinavia, the Swedish version is called *hemrehabilitering* (home rehabilitation), while the term *hverdagsrehabilitering* (everyday rehabilitation) is used in both Norway and Denmark, and the terms *reactivation*, *geriatric rehabilitation*, or *restorative intervention* are sometimes (inconsistently) used in other countries. Moreover, some countries have recently begun to merge the terms *reablement*, *reactivation*, *rehabilitation*, and *restorative intervention* into the overarching concept of “4R interventions” to define healthcare services for older adults who need support to continue to live at home (Eliassen et al., 2018b; Sims-Gould et al., 2017). By bundling these programmes together under an umbrella term, the implication is that each of these interventions has common features and goals that are relevant to a specific target group; however, the lack of an agreed set of specific “clinical and demographic characteristics makes the target population highly heterogeneous and difficult to define” (Legg et al., 2016 in Eliassen et al., 2018b: 1).

#### 4.1 Limitations

Due to the exploratory nature of our study and our main interest in reablement, the search term for all databases was “reablement OR re-ablement”, which resulted in papers published in English by researchers primarily working in Western countries. While this is clearly a limitation, it would also be difficult to interpret the term-map visualisations if there had been a mix of several languages; this could have resulted in multiple words in different languages with the same meaning. Moreover, this means that many countries are not represented in our search because researchers may have published articles in their native language, or they may use different terminology and/or may not describe ‘reablement’ as the concept is generally understood; i.e., the most common (and specific) features are that participants are age 65+, programmes are of a short duration (typically 6–12 sessions) and are provided by paid health professionals, such as physical/occupational therapists or homecare workers, in the participant’s home. A more precise study of how the etymology of different words relates to their specific geographical and/or cultural contexts would be extremely interesting; however, it is beyond the scope of this review. Rather, we have attempted to describe a particular historical development and trajectory that can be seen in the literature that was identified in our search.

A limitation of the qualitative analysis was its interpretive approach to reviewing the literature. While we attempted to analyse the texts systematically and objectively with a focus on how ‘reablement’ has been/is being described in specific time periods and geographic regions, it is possible that our analysis

reflects certain personal and professional biases. However, we believe that this risk of bias in the qualitative review was mitigated by its overall coherence with the quantitative analysis and term visualisations. Furthermore, our intent with this review was simply to trace the development of 'reablement' as a concept; thus, a more in-depth analysis and discussion about cultural needs for collective enablement or other societal constructions more broadly understood is certainly warranted but beyond the scope of this review.

## 5. Conclusions

In general, this scoping review shows that many Western governments are currently implementing reablement programmes to promote functional independence in older people who have certain physical conditions yet who want to remain self-sufficient. However, a lack of consensus about these services – who they are meant for, and what they should achieve – may lead to ineffective programmes and unclear guidance on which impacts and outcomes to measure; i.e., how long is long enough to make an impact? And is impact measured in terms of increased quality of life and social participation, or improved physical functionality and cost savings? As a result of these inconsistencies, many countries have encountered (and are still encountering) significant challenges with regards to how to define, standardise, and operationalise reablement services at a national level.

Reablement programmes have the potential to challenge negative discourses about ageing and the age-related loss of physical and/or cognitive function. By emphasising the older individual's "continuing ability to participate in, contribute to and be productive and valued in society" (Mishra and Barratt, 2016: 25), the establishment of reablement programmes for older people could be an opportunity for governments to promote a more inclusive and balanced discourse about 'healthy ageing'. Rather than an implied expectation that everyone over age 65 is destined to become an economic burden, a more inclusive discourse with an emphasis on social engagement could promote a belief that people of any age and any level of functional capacity can be non-dependent, valuable, and productive in a variety of ways; old age should not be treated as a disability. However, until legislators, health professionals, and older people can collectively reach consensus about how such a discourse can be most effectively implemented and supported in professional practice, it will be difficult to determine a conceptual description of reablement as a service that is unique, separate, and distinct from more traditional forms of physical rehabilitation.

As we found in our review, reablement programmes are intended to be person-centred and goal-directed, and many articles emphasised the 'reablement philosophy': i.e., helping people 'do things for themselves' rather than 'having things done for them'. Fundamentally, this approach should focus on the older person's own life situation and goals; e.g., "an emphasis on a holistic, person-centered approach to care, which promotes clients' wellness and active participation in decisions about care" (Lewin et al., 2013: 1274). Thus, in terms of how reablement programmes are organised, operationalised, and understood in practice, they should first and foremost recognise the heterogeneity of older people and support them in their self-defined goals to be *both* more physically independent at home and socially involved in their

communities. However, our review leads us to question the sustainability of reablement programmes in their current iteration – particularly with regards to the ongoing and increasing public-health challenge posed by ageing populations in many Western countries.

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## Tables

**Table 1. Concept of Reablement in Various Geographic Regions between 2015–2019**

Region (Country)	Concept of reablement between 2015–2019
Australasia (Australia / New Zealand)	<ul style="list-style-type: none"> <li>• Australian research mentions that ‘reablement’, developed and formalised since the 1990s, has focused on goal-oriented cognitive rehabilitation to improve everyday functioning for people with dementia. Such interventions have been described as a form of reablement (e.g., Cations et al., 2018; Clare et al., 2019a, 2019b; Jeon et al., 2018; Jeon, 2015; Poulos et al., 2017, 2018).</li> <li>• The book <i>“Ageing in Australia”</i> included a chapter “Care and Support for Older People” with a section on the more ‘typical’ reablement, defined as “(short-term) services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living” (Jeon and Kendig, 2017: 250). It was discussed as a person-centred service and emphasised the necessity to develop an aged-care workforce of professionals capable to do things <i>with</i> older persons and find optimal ways to engage family carers.</li> <li>• While restorative home care / reablement services for older adults have been “shown to be effective in reducing functional dependency and increasing functional mobility, confidence in everyday activities, and quality of life” (Lewin et al., 2016: 807), the literature often focuses on support workers and non-health professionals; e.g. to receive better training and improve collaboration (Lewin et al., 2016), to promote health-behaviour change (Lawn et al., 2017a), and to develop the skills to work with complexity in community aged care (Lawn et al., 2017b).</li> <li>• A trend towards developing better collaboration is evident in a paper about the feasibility of LifeFul, a relationship and reablement-focused “culture change program” in residential aged care (Low et al., 2018). However, the authors stated that one of the main challenges to successfully implementing reablement has been compliance by staff.</li> <li>• A critical review described reablement as “an emerging global practice model in community- and home-based care for older people” (Doh et al., 2019: 1) and although it is gaining acceptance worldwide, researchers and policy makers still have questions about what reablement means and how it is used in practice. They found nine essential features, the most predominant being the wish to improve the functionality of clients so they can continue to live in their own homes; the authors concluded that the under-representation of social connectivity for clients was regrettable (Doh et al., 2019: 13).</li> <li>• A New Zealand paper discussed benchmarking to assist the improvement of service quality in home support services for older people and stated that the country “has developed restorative home support services, very close to what in the United Kingdom are called reablement services, involving elements of goal facilitation, functional and repetitive ADL exercises, support worker training and enhanced supervision, health professional training, care management and comprehensive geriatric assessment” (Jacobs et al., 2018: 113).</li> </ul>
Continental Europe (Netherlands)	<ul style="list-style-type: none"> <li>• A Dutch study protocol for a randomised controlled trial (RCT) on the effects, costs, and feasibility of the ‘Stay Active at Home’ reablement training programme for homecare professionals described reablement as home-care services that are “goal-oriented, holistic and person-centred taking into account the capabilities and opportunities of older adults” (Metzelthin et al., 2018: 1).</li> </ul>
North America (Canada / United States)	<ol style="list-style-type: none"> <li>1. • Despite the early implementation of reablement in the United States, our search did not result in any articles from this country during this time period.</li> <li>2. • A Canadian systematic review explored the effectiveness of reablement and factors that contribute to successful implementation (Tessier et al., 2016).</li> <li>3. • Another Canadian systematic review described “the 4R interventions” (reablement, reactivation, rehabilitation, and restorative) with older adults receiving home care to improve</li> </ol>

“functional abilities, strength, gait speed, social support, loneliness, and the execution of activities of daily living (ADL) and instrumental ADL (IADL)” (Sims-Gould et al., 2017: 653).

Scandinavia  
(Denmark /  
Norway /  
Sweden)

1. . Although Denmark and Sweden were the earliest adopters of reablement programmes this region, it was typically referred to as “everyday rehabilitation” or “home rehabilitation”.
2. . The first Scandinavian paper to use the term ‘reablement’ discussed a Danish pilot study on whether a home-based reablement programme influenced the ADL ability of older adults (Winkel et al., 2015).
3. . A Swedish systematic review stated that “re-ablement services are in a period of strong development, but the terms and definitions used remain unclear, and the scientific evidence is still weak” (Pettersson and Iwarsson, 2017: 273).
4. . A Swedish study was conducted to illuminate older adults’ perceptions of a multi-professional team’s caring skills as success factors for health support in short-term goal-directed reablement (Gustafsson et al., 2019), and concluded that health professionals’ caring skills need to be addressed as an evidence base in the area of homecare for older people.
5. A Norwegian RCT on the effectiveness of reablement in home-dwelling older adults (Tuntland et al., 2015) and a study protocol for further investigation of the effects described reablement as “an intensive, multidisciplinary, multicomponent, person-centered, home-based type of rehabilitation, where ordinary activities of daily living are used for rehabilitative purposes” (Langeland et al., 2015: 2).
6. The same authors also investigated potential factors that predict an older person’s “occupational performance and satisfaction with that performance at 10 weeks follow-up” (Tuntland et al., 2017), and later conducted a clinical controlled trial in 47 Norwegian municipalities on the health effects of reablement in home-dwelling adults, writing that “**reablement** is an emerging approach in **rehabilitation services**, but evidence for its efficacy is rather weak and inconsistent” (Langeland et al., 2019: 1); *emphasis added*).
7. A Norwegian qualitative study explored how an integrated multidisciplinary team experiences participation in reablement (Hjelle et al., 2016), followed by another study on how older adults experienced participation in reablement (Hjelle et al., 2017b).
8. Another Norwegian study examined interdisciplinary collaboration (Birkeland et al., 2017), and the same authors also described how relatives in a community setting experienced participation in the reablement process (Hjelle et al., 2017a). They then conducted a qualitative study on interdisciplinary reablement teams’ roles and experiences and described reablement as “a service for home-dwelling older people experiencing a decline in health and function” (Hjelle et al., 2018).
9. Other qualitative research described reablement as an intervention “to provide necessary assistance to the client’s own efforts to achieve the best possible functioning coping ability and participation in social life” (Moe et al., 2017: 2), as “an approach that aims to assist older adults, irrespective of diagnosis, to continue with their desired activities – as well as the activities of daily living – and to increase their independence” (Jakobsen and Vik, 2018: 1), and as “an interprofessional, home-based rehabilitation service that aims to enable senior residents to cope with everyday life and to prevent functional impairments” (Moe and Brinchmann, 2018: 113).
10. Another study wrote “many welfare states offer reablement, also known as restorative care, as an intervention to promote healthy ageing and support older adults in regaining or maintaining their independence in daily life” (Jokstad et al., 2018: 1).
11. The development of professional practice was the focus of a study that presented a cross-sectional descriptive survey of community-working occupational therapists’ involvement in

	<p>research and development projects (Bonsaksen et al., 2018), which included occupational therapy services and reablement. The authors wrote that “reablement is synonymous to the term ‘restorative care’, which is more commonly used in the USA, and describes home-based, goal-oriented intervention provided by a coordinated multidisciplinary team to home-dwelling elderly with functional decline” (Bonsaksen et al., 2018: 2).</p> <p>12. Another study explored the content of physiotherapists’ supervision of ‘home trainers’ in reablement teams (Eliassen et al., 2018a); the lead author also published a paper that discussed variations in physiotherapy practices across reablement settings (Eliassen et al., 2018b).</p> <p>13. In an article that examined the practice of support personnel supervised by physiotherapists (PTs) in Norwegian reablement services, the authors focused on PTs’ work, writing that “the key characteristics of the [reablement] service are the short-term and goal-oriented interventions provided by an interprofessional team” (Eliassen et al., 2019: 2).</p>
<p>United Kingdom (England / Scotland / Wales) and Ireland</p>	<ol style="list-style-type: none"> <li>1. . In discussing a Patient Reported Experience Measure for use by older people in community services, the authors distinguished between social care re-ablement and healthcare hospital-at-home services (Teale and Young, 2015).</li> <li>2. . One article examined ‘re-ablement’ or ‘restorative homecare’ interventions developed as an alternative to reduce dependency in ADLs in homecare to provide “time-limited, intensive input with the specific and explicit aim of enabling people to become independent in personal care activities wherever possible” (Whitehead et al., 2015: 1065).</li> <li>3. . Another article described reablement as a “new paradigm to increase independence in the home amongst the ageing population” (Bond et al., 2015: 30).</li> <li>4. . A systematic review of the evidence on home-care reablement services “found no studies fulfilling our inclusion criteria that assessed the effectiveness of reablement interventions. We did note the lack of an agreed understanding of the nature of reablement” (Legg et al., 2016: 741).</li> <li>5. . In the country’s first RCT of occupational therapy in homecare reablement, the authors state that The Care Act 2014 statutory guidance considers reablement to be “an example of prevention and has been identified as one of the ‘top-ten’ prevention services for older adults” (Whitehead et al., 2016: 1), outlining that these services “aim to assist the person to maximise their ability to carry out activities independently with the aim of reducing the amount of paid care worker input required in the long term” (Whitehead et al., 2016: 1).</li> <li>6. . A formal examination of reablement stated that “there is limited evidence regarding the organisation and delivery of reablement services in England” (Mann et al., 2016: 1).</li> <li>7. . Evaluating three reablement services, researchers found a need for greater investment in research on user engagement (Mayhew et al., 2019).</li> <li>8. . One study examined family-inclusive approaches to reablement in mental health, and defined reablement in terms of empowerment and social participation, particularly with regards to maximising users’ independence, choice, and quality of life (Tew et al., 2017).</li> <li>9. . Another article studied goal-orientated cognitive rehabilitation in early-stage Alzheimer’s disease (Clare et al., 2019a); in a subsequent article, the authors stated that “rehabilitation (or reablement) is grounded in a philosophy of enablement reflecting a positive approach to finding solutions and encouraging optimal functioning. This philosophy emphasises a collaborative approach in service delivery, (...and) translates into specific individualised interventions aimed at optimising functioning” (Clare et al., 2019b: 40).</li> </ol>

	<p>10. In a cost analysis of home care reablement for older people, reablement “actively engages the person in activities of daily living, thus improving their ability to perform those activities, which they might have lost after an episode of illness or other adverse life event” (Bauer et al., 2019: 2).</p>
<p>Cross-national studies</p>	<ul style="list-style-type: none"> <li>• A British-Irish systematic review assessed the effects of time-limited home-care reablement services for maintaining and improving the functional independence of older adults, and stated that “the reablement approach emphasises the active participation of an older person in working towards agreed goals that are designed to maximise independence and confidence” (Cochrane et al., 2016: 6).</li> <li>• A Canadian-Norwegian study on the validity, interpretability, and feasibility of the Canadian Occupational Performance Measure described reablement as a “time limited, person-centered, and goal directed, delivered by a multidisciplinary team” (Tuntland et al., 2016: 411-12).</li> <li>• Norwegian authors followed up with a cost-effectiveness analysis alongside an RCT (Kjerstad and Tuntland, 2015).</li> <li>• British, Danish, Norwegian, and Dutch researchers comprehensively reviewed the reablement approach, describing it as “an intensive, time-limited intervention provided in people’s homes or in community settings, often multi- disciplinary in nature, focusing on supporting people to regain skills around daily activities. It is goal-orientated, holistic and person-centred irrespective of diagnosis, age and individual capacities” (Aspinal et al., 2016: 574).</li> </ul>

**Table 2. Number of Occurrences of Terms Emerging from Figure 2 over Publication Year**

1947 - 2012 Dark Blue - Purple		2013 - 2014 Teal		2015 - 2017 Turquoise - Green		2018 - 2019 Yellow	
Term	N	Term	N	Term	N	Term	N
home care	38	cost	42	participant	50	dementia	25
patient	38	group	39	goal	37	health	14
rehabilitation	37	user	32	role	30	professional	
re ablement	23	team	27	performance	28	reablement team	10
re ablement service	22	impact	24	skill	25	home care	9
social care service	22	staff	18	interview	24	personnel	
hospital	17	training	18	experience	21	kin	9
part	17	cost	17	professional	18	theory	9
disability	15	effectiveness				health care	8
support worker	14	treatment	15	carer	18	professional	
process	13	usual care	15	occupational therapist	17	primary	8
social care	13	development	12	satisfaction	17	outcome	
ablement	10	function	12	knowledge	15	reablement	8
Implication	9	supervision	12	nurse	15	process	
Probability	9	confidence	9	point	15	Hts	7
social care cost	9	efficacy	9	control group	14	reablement	7
Cent	7	organisation	9	municipality	14	approach	
help	7	account	7	context	12	user	7
interaction	7	article	6	task	12	involvement	
local authority	7	bed	6	caregiver	11	family member	6
discharge	6	inclusion	6	participation	11	resident	6
home care episode	6	question	6	daily activity	10	secondary	6
homecare re ablement	6	significant	6	intervention group	10	outcome	
service	6	difference				stroke	6
intermediate care	6	total	6	Norway	10	everyday	5
ablement service	5	semi	5	addition	9	functioning	
conventional home care	5			cognitive rehabilitation	9	mca	5
service	5			physiotherapist	9	mcas	5
end	5			risk	9	medication	5
functional status	5			COPM	8		
relative	5			everyday activity	8		
site	5			goal attainment	8		
				information	8		
				interdisciplinary collaboration	8		
				theme	8		
				way	8		
				Canadian occupational	7		
				performance measure			
				communication	7		
				early stage dementia	7		
				government	7		
				self	7		
				societal cost	7		
				conversation	6		
				evidence base	6		
				focus	6		
				functional ability	6		

medicines reablement	6
pharmacy technician	6
researcher	6
sample	6
bias	5
consumer	5
everyday life	5
focus group discussion	5
Intention	5
main theme	5
Medline	5
own home	5
stakeholder	5

## Figures

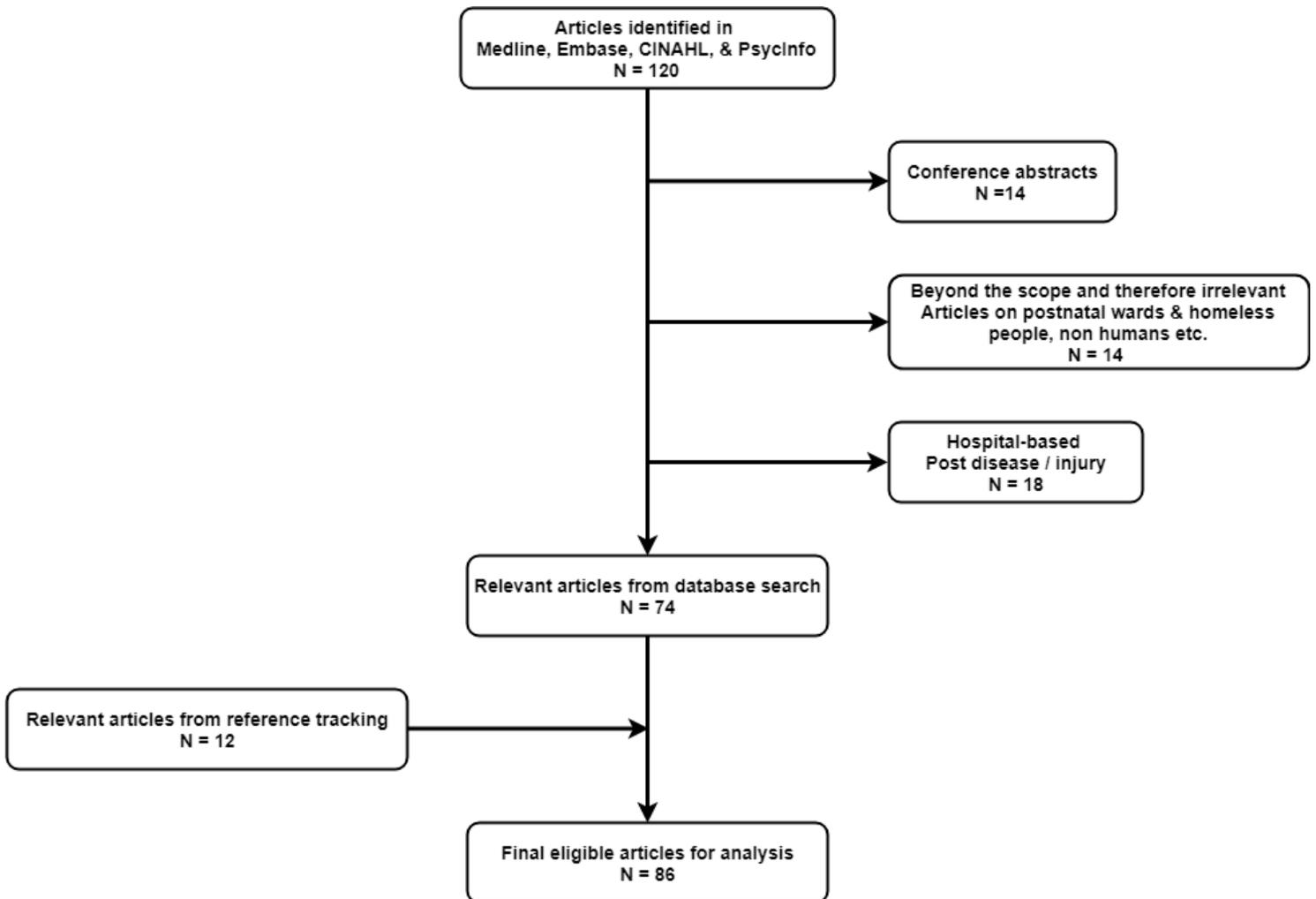


Figure 1

Flow Chart of Article Selection

