

## Reablement: supporting older people towards independence

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### Abstract

As the overwhelming majority of older people prefer to remain in their own homes and communities, innovative service provisions aim to promote independence of older people despite incremental age associated frailty. Reablement is one such service intervention that is rapidly being adopted across high-income countries and projected to result in significant cost-savings in public health expenditure by decreasing premature admission to acute care settings and long-term institutionalisation. It is an intensive, time-limited intervention provided in people's homes or in community settings, often multi-disciplinary in nature, focussing on supporting people to regain skills around daily activities. It is goal-orientated, holistic and person-centred irrespective of diagnosis, age and individual capacities. Reablement is an inclusive approach that seeks to work with all kinds of frail people but requires skilled professionals who are willing to adapt their practise, as well as receptive older people, families and care staff. Although reablement may just seem the right thing to do, studies on the outcomes of this knowledge-based practice are inconsistent, yet there is an emerging evidence and practice base supporting that this provision improves performance in daily activities. This innovative service however may lead to hidden side effects such as social isolation and a paradoxical increase in hospital admissions. Some of the necessary evaluative research is already underway, the results of which will help fill some of the evidence gaps outlined here.

**Keywords:** restorative care, older people, independence, goal-oriented, home-based rehabilitation

### Introduction

Rapidly ageing populations in countries around the world [1] have led to an increase in the number of older people living with long-term conditions [2]. At the same time, evidence suggests that the great majority of people prefer to remain in their own homes and communities as they age [3]. Novel technologies and innovative service provisions aim to maximise the ability to live independently, prevent hospital admissions [4] and address the demand for a more efficient health and social care support. Reablement—termed 'restorative care' in Australia, New Zealand and the USA—is one such service intervention that is being adopted across high-income countries [5–9] as an alternative to more costly institutional care. It aims to promote independence and help older people to remain in their own home for as long as possible.

Reablement is a time-limited, person-centred, home-based intervention for older people who are at risk of functional decline, sometimes after an accident or period of illness [6]. It aims to help older people to retain, regain or gain skills so that they can manage everyday living skills as independently as possible. This concept has penetrated policy at a local, national and international level, offering in general ‘the possibility of raising the overall quality of protection against long-term care risks’ [10, p. 19] and offering governments a feasible approach to addressing the societal implication of ageing. Although different countries and, indeed different localities within the same country, implement reablement in different ways, policy and practice directives emphasise ‘doing with’ older people rather than ‘doing for’ or ‘doing to’ them. Despite this international interest in implementing reablement, there is currently limited, albeit increasing, evidence on the effectiveness and cost-effectiveness of this intervention.

In April 2016 the International Federation of Aging organised a summit in Copenhagen, Denmark, bringing together thought leaders, academics and practitioners to review and discuss reablement as a value-added investment of frail older people. Here, we present the key policy drivers in the international context, summarise the terminology and the key features of this emerging service model, before focusing in more detail on the nature of the evidence base associated with reablement policy in practice.

## **Policy drivers**

Several distinct but inter-related trends across developed countries are captured by the UNECE’s 2012 Vienna Ministerial Declaration which requires that UNECE member States ‘are committed to raising awareness about and enhancing the potential of older persons for the benefit of our societies and to increasing their quality of life by enabling their personal fulfilment in later years, as well as their participation in social and economic development.’ [1, s3]. ‘Reablement’ has emerged as a key aspect of government reforms as a means of addressing these trends within policy (and practice) debates.

### **Promoting independence**

There is growing recognition that health and social services might not intervene early enough to prevent ill health and/or functional decline, and that preventative services do not necessarily focus on ‘repairing’ situations that can minimise the impact of ill health including loss of independence. At the same time, it is also recognised that health and social care services can sometimes make premature decisions about older people’s long-term destinations, such as presuming that long-term institutional care is the only feasible option for them. In contrast, reablement aims to invest time and expertise in helping older people to be the best they can be before making decisions about the future including place of residence and care needs.

### **Promoting participation in daily activities that matters**

Alongside the importance placed on independence, are increased calls for promoting active participation in a wide range of activities perceived as important by the older person themselves. Reablement practice responds to this debate by focusing on improving individuals’ full or partial independence in activities of daily living inside the home, but also focuses also on helping people to access their local community and to reconnect with their preferred social, leisure, and physical activities.

### **Citizen-centred approach**

For some years, older people's movements have been drawing attention to structural and cultural ageism that older people experience and that affect older people's rights [11]. These groups have called for a more inclusive and human rights approach to be incorporated into policy so that an individual's rights and responsibilities (full citizenship), irrespective of age, can be realised. Moreover, instead of looking to older adults primarily in terms of frailty, there is a need to emphasise the resilience and the ability of older people to overcome losses, adapt and regain independence.

### **Changing the locus of expertise**

Ongoing debates about what constitutes, and who holds, expertise in caring relationships have culminated in services increasingly looking to build equal partnerships between professionals and the person using the service. In this context, professional expertise is ideally limited to clinical/technical aspects of support and knowledge of formal service structures whilst the person is considered an expert in their own life and what works for them.

### **Individuals as resources**

Narratives are increasingly portraying individuals through an economic lens whereby older people are viewed as a major social and economic resource; a resource that cannot be fully harnessed if older people's contribution to society is not maximised. Loss to the economy might also be realised where people of working age leave employment to take on caring responsibilities for older family members who, without this, would be insufficiently supported.

### **Integration**

There is a growing recognition by front-line practitioners that organising services on the basis of professional and organisational silos leads to poor outcomes, fails to make the best use of the skills of the multi-disciplinary team and demotivates staff. Instead, professionals are increasingly interested in integrated care where there is the potential to deliver the kind of inter-disciplinary support they believe older people deserve, increasing job satisfaction and improving recruitment and retention.

### **Cost containment**

Not least because costs for long-term care are expected to double within the next 50 years [10], budget holders at the organisational and at local and national governmental levels aspire to make best use of scarce resources, either to get the best outcomes from existing funding or, where possible, to save money whilst achieving the same outcomes. Although the way that these trends play out in different countries might be different [12], reablement has been adopted internationally as a means of responding to them. Perhaps the inherent flexibility and holistic nature of reablement means that these national, cultural differences can be accommodated within the aims and key features of reablement and thus, might explain the international interest in this policy and practice initiative.

### **Terminology and key features**

As the structure of reablement services differs across, and even within, countries and it being a person-centred intervention, providing a definitive description of what reablement looks like, is impossible. However, the large range of reablement provisions shares several key features.

Reablement is an inclusive approach that seeks to work with all people who could benefit from this kind of support, irrespective of diagnosis, age and capacity—although they may be targeted at those for whom reablement is considered most likely to lead to improvement. It is a focused, time-limited (typically 4–12 weeks) intervention provided in people's homes or in community settings, often multi-

disciplinary in nature and integrated across social care and health sectors, that aims to help people regain as much functional independence as possible following a period of ill health, an admission to hospital or a decline in function. Services tend to focus on supporting people to regain skills around daily activities and should be goal-orientated, holistic and person-centred— working to achieve participation in daily activities that matter to the individual, supporting them to lead chosen lifestyles and working with them in their family and local context. Despite being time-limited, reablement requires working at the pace of the individual and adapting[8] input depending on the capacity and needs of the individual and is thus self-anchored. Crucially, this way of working requires skilled professionals who are willing to adapt their practice (in potentially very new ways) as well as receptive older people, families and care staff.

Part of the difficulty in defining reablement definitively is that many services and professions would already claim to use a 'reabling approach'—but arguably do not really deliver reablement in practice. Thus, it is easy for existing services to re-badge themselves as delivering reablement (often to attract new funding), or for individual professions to claim that they are the true guardians of this agenda [6]. However, our experience is that some services which claim to offer 'reablement' do not offer the quintessential elements of reablement set out above. Thus, a more coherent and consensual understanding of what reablement entails in practice is essential.

### Nature of the evidence

Although reablement is being adopted and promoted internationally, the evidence base for reablement is more limited than is often imagined by policy makers and practitioners. This is partly because reablement is relatively new in a number of countries, but also because, as outlined above, very different service models can be adopted in different countries and localities meaning that larger studies may not be comparing like with like. As with all interventions that are quickly rolled out, the pace at which reablement has been adopted and implemented means that it can be difficult, to find service or person-level comparators to enable rigorous effectiveness and cost-effectiveness evaluations. Although there is an increasing RCT evidence base, up to date 'evaluations' of reablement in some countries are often built on small-scale service experiments and/or of limited scientific quality. Aside from the available evidence reported below, most research focuses on fairly small timeframes, so we still know relatively little about the longer-term impact of reablement. For instance, does it increase quality of life, ensure greater independence and control over daily life, or does the client suffer from hidden side effects such as isolation and loneliness? Does it reduce the need for conventional care or does it lead to a paradoxical increase of hospital admissions? And if beneficial, which reablement models are most effective for which individual user?

The available evidence about reablement, tends to focus on four different types of outcomes: outcomes for individuals, effects for service providers, effects in service utilisation, and cost-effectiveness. Two systematic reviews of reablement-type interventions indicate that there is limited evidence that reablement can help to improve individual's performance in personal activities of daily living [13, 14] and other studies show conflicting results about the impact of reablement. For example, one study shows that physical activity improves [15]; whilst others show no significant improvements [16,17], some studies show that reablement have a significant improvement on daily activities [8, 18–20], while one study shows only minor improvements [16]. Studies about the impact of reablement on safety [16,18] and health-related quality of life [8,16, 18, 21] were also contradictory. Hence, the results from primary studies are inconsistent, although there is an emerging evidence base supporting that reablement improves performance in daily activities.

Studies indicate that providing reablement can have positive impact on practitioners. Research [17,22] had shown that home care assistants reabling participants had greater job satisfaction and significantly reduced turnover compared to those working with participants in the usual care way.

Studies indicate that reablement services can affect care service utilisation. An Australian study showed that participants receiving reablement required fewer home care hours, were less likely to need nursing home and emergency department treatment compared to participants in the control group [23]. The lower utilisation of emergency departments has also been shown in another study [20]. Studies also show that people who received reablement were less likely to need personal care service [9,16] and to be readmitted to hospital [24]. The results thereby indicate that reablement may reduce the need for homecare services, as well as for other healthcare services.

Studies exploring the cost-effectiveness of reablement are inconclusive. The national evaluation of reablement in the UK [6] showed that costs were similar between reablement and usual care but that individual outcomes were better for up to 10 months post-reablement. More recent studies showed that health and homecare costs of reablement were lower than the costs of the conventional home care provision [9,23].

Overall, therefore, although there is evidence about the effectiveness and cost-effectiveness of reablement, ambiguity remains about whether reablement can:

- affect individual outcomes other than daily activities;
- reduce the long-term need for social and health care services;
- be more cost-effective than providing conventional home care.

Furthermore, little is currently known about how reablement is actually configured and operates in practice, optimal timing and intensity of the intervention and which client groups are likely to benefit most and in what ways.

## Reflection

Despite the limited evidence base that currently exists, the sometimes contradictory nature of policy and the national and international flexibility in interpretation of what reablement is and what it should be in practice, reablement is a service that seems here to stay. Perhaps it is precisely this flexibility that means reablement can be incorporated into different policy and cultural contexts. For example, the way that the policy trends outlined here play out in different countries might be different. The way that 'ageing in place' [25] is experienced in different cultural environments might require a non-uniform policy and practice response [12]. The flexibility and holistic nature of reablement means that these differences are able to be accommodated in different contexts whilst the primary aims and key features of reablement remain intact.

At present, there is growing experience of trying to deliver these different aims in practice, and there are some promising signs from the emerging evidence base. However, some of the individual arguments and motives above may sometimes be in conflict with each other. Thus, a series of key questions remain for national policy makers, local leaders, front-line practitioners and older people themselves.

Underpinning all this is a broader debate about what constitutes valid evidence in the first place and how much evidence we need before we make changes to our services. Often, health care in particular is

focused on a form of ‘evidence-based policy and practice’—focusing on formal evidence of what might work and often relying primarily on particular forms of research—such as systematic reviews and randomised controlled trials. However, policy and practice in this area is typically a long way ahead of the formal evidence and is waiting impatiently for the research to catch up. In such a situation, we cannot always wait for evidence of what works before we do something new. Instead we have to look also for evidence of what is not currently working, then thinking through new ways of doing things and learning by doing and reflecting as we go along, i.e. a form of ‘knowledge-based practice’ [26,27].

In the case of reablement, we are firmly in the realm of ‘knowledge-based practice’, with different local and national services trying to pioneer new and better responses to longstanding policy challenges. In the process, they are having to draw on the emerging research evidence, but are also having to make decisions about future services based on intuition, professional experience and the lived experience of older people. This is often contested and ‘messy’—and there is a strong sense of having to learn as we go along. However, reablement has a positive role to play and needs to be a core part of the spectrum of services available to older people. Although the evidence is still emerging, reablement seems simply ‘the right thing to do’—not trying to support people back to optimal independence would be bad for the individual as well as a poor use of scarce resources.

As outlined here, there is a lack of evidence about reablement. More research is needed in order to reduce the knowledge gaps concerning the effects of reablement, in particular with regards to individual health outcomes and more high quality research with large samples is required for all types of outcomes. Some of this research is already underway, including the forthcoming Cochrane review on reablement [28] and service evaluations in, for example, the UK [5], Norway [29] and in Denmark [30], the results of which will help fill some of the evidence gaps outlined here.

## Keypoints

- Policies in many countries are increasingly promoting short and intensive reablement services to replace conventional care provision which is often long-term or even permanent;
- Reablement is an individualised care provision supporting independent living;
- Focus is on to help clients relearn how to do things for themselves rather than the conventional home care approach of doing things for people
- There is limited evidence about the effectiveness and cost effectiveness of reablement;
- Yet, current empirical and practice evidence suggests that reablement is a promising intervention and ‘simply the right thing to do’;
- Further research is needed to assess the short- as well as longer-term impacts of reablement for clients, carers, services and systems.

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