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Introduction

The concept, rationale, and implications of reablement

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1

Introduction: The concept, rationale, and implications of reablement

Tine Rostgaard, Hanne Tuntland, and John Parsons

The aim of the book

With ageing societies, we need to identify sustainable and person-centred solutions for supporting frail older people at home and in ways that improve their quality of life and longevity. There is also a need for innovative and integrative approaches to health and long-term care that are cost-effective and ensure the ageing individual receives individually tailored assistance. Reablement may be an appropriate response to these challenges. It is a radically different approach to home care for older people, seeking to help them to regain and maintain their functional ability and independence, in contrast to more passively providing help and assistance, which has been the traditional approach in compensatory home care (Aspinal et al, 2016; Cochrane et al, 2016). Thus, reablement may be a more sustainable solution for nation-states, municipalities, and service providers to address the needs of an ageing population. Reablement's integrative approach may also help counter the expected increase in public spending on health and long-term care, which is expected to double in the OECD countries by 2060 (de la Maisonneuve and Martins, 2015). However, reablement also implies a new approach to ageing and the provision of social care, which has implications for individuals and their families, as well as for practitioners with regards to new roles, collaborations, needs fulfillment, and obligations. This is why a critical investigation of reablement is needed.

There is already wide and global interest in reablement from policy makers, practitioners, and the academic community. However, since reablement is a relatively new and unexplored approach, research into reablement models and their outcomes has been scarce, uncoordinated, and lacking focus, both nationally and internationally (Legg et al, 2016; Pettersson and Iwarsson, 2017; Clotworthy et al, 2021). In order to bring the research forward and to facilitate theorisation and learning across countries, this book provides an interdisciplinary, comparative, and critical investigation of reablement. Based on collaborations within an international and interdisciplinary research

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network of reablement researchers, ReAble (https://reable.auckland.ac.nz/), we now take the opportunity to coherently address what reablement is, and what its implications may be on both an individual and societal level.

Our aim with this book is to critically investigate and advance knowledge about reablement in an interdisciplinary and international context: what is the idea behind reablement, which different models exist in different countries, how do they work, and what are the overall consequences for clients and their families, care providers, and societies overall? The research gathered in this book presents empirical evidence on reablement from different Western world countries and with a particular focus on seven countries: Australia,[1] Denmark, England, the Netherlands, New Zealand, Norway, and Sweden, and considers the theoretical implications of the practice. As such, we hope it will be relevant and provide inspiration to academics and practitioners, and that it can be used in the development of international, national, and local policy making.

Why reablement?

Reablement is a response to the need for adapting the health and social care systems to expected changes in the demographic composition of populations in many Western countries. Societies around the world are ageing; in some countries, faster than in others. Population ageing is the fortunate consequence of longer life expectancy but also of declining fertility rates; combined, it means that many countries will have an increasing share of populations aged 65 or over in the years to come. Within less than a century, across OECD countries, older populations aged 65+ will increase on average from less than 9 per cent of the population in 1960 to 27 per cent in 2050. They will make up nearly 40 per cent in countries like Greece, Japan, Portugal, South Korea, and Spain. Population ageing is taking place more rapidly in particular countries and will therefore require more immediate societal adaptions, such as in China where the population aged 65+ will nearly triple between 2015 and 2050, reaching a level just below the OECD average (OECD, 2019).

On average, people around age 65 are well functioning and can manage their daily activities; thus, they are not likely to require any support from health and social care within the subsequent years of their life. However, this is less likely once they reach age 80 and over. There are varied interpretations of the impact of ageing over disability, but some research indicates that there will be an increasing incidence of disability as populations aged 80 and over increase in the OECD countries (Lafortune and Balestat, 2007).

Countries worldwide are therefore facing demographic changes that require societal adaption. An ageing population does not only require an increase in the need for social and healthcare services; it also points to a potential decline in the labour supply, which has implications for the

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economy. Population ageing will result in fewer taxable incomes, as well as a reduction in workers in the long-term care (LTC) sector, which is already suffering from understaffing and problems with recruitment and retention (OECD, 2020). Therefore, many countries apply a focus on cost-effective approaches that enable redistribution of resources to those who require the most care, often prioritising resources to the degree that LTC needs are unmet and care poverty is created, even in the typically generous Nordic countries (Kröger et al, 2019). As often argued politically as a combined rationale, reablement may instead offer an approach that reduces the need for LTC by actually reducing need for care, as well as enabling a person-centred approach that focuses on what matters to the individual and their quality of life. In other words, reablement has the potential to change the way societies approach LTC policies and implement them into practice.

Reablement can thus be seen as a risk-minimisation strategy that helps older individuals adapt to age-related changes, and may help to prevent certain dependencies. It can also be seen as a policy tool that offers welfare states a new capacity for more dynamically managing and addressing the societal risks associated with population ageing (Rostgaard, 2015). Therefore, one aim of the book is to critically test these rationales and investigate the implications for individuals and societies. The book also seeks to advance the knowledge about reablement in an interdisciplinary and international context.

What is reablement and how is it related to rehabilitation?

Reablement is part of the more inclusive concept of rehabilitation. The World Health Organization defines rehabilitation as 'a set of interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment' (World Health Organization, 2017: 1). In this book, we consider 'rehabilitation' to be an umbrella term for many kinds of specific interventions, such as community-based rehabilitation and stroke rehabilitation; reablement is also a rehabilitation intervention under this umbrella.

Ideally, reablement implies the provision of active, person-centred, and goal-oriented support; it should be seen as an alternative to other types of support that merely compensate for care needs and thereby increase the risk of the client becoming passive. The different national – and indeed local – approaches are similar in that reablement is a short-term and intensive intervention that typically lasts 4–6 weeks (Rostgaard, 2015; Tuntland et al, 2015; Legg et al, 2016; Pettersson and Iwarsson, 2017). During this time, an interdisciplinary team composed of social-care workers, nurses, occupational therapists, and physiotherapists cooperate with the older person to identify and work towards a specific outcome goal. The goal is often related to improving functional ability and gaining independence in daily

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activities, such as shopping, cleaning, or general physical mobility – with an aim to delay or prevent the need for health and social care services – and to increase quality of life (Aspinal et al, 2016; Tuntland et al, 2019). The goal may also be related to social engagement and participation in meaningful social activities. The reablement intervention typically takes place in both the home and local community and is based on training and adaptations in daily activities, physical training, home modifications, and assistive devices. It may also include the involvement of social networks.

Reablement is an active process that involves working alongside the older individual and their family/carers to identify goals for the reablement episode (Parsons et al, 2014). Reablement may also empower the individual and their family/carers within the process (defined as control over one's life, enabling decision-making and self-determination) (Hurst, 2003). In fact, understanding the client's own priorities and concepts of independence is considered to be key to the potential for enhanced effectiveness (Wilde and Glendinning, 2012; Clotworthy, 2020). Also, there is a focus on maximising/optimising function.

Reablement may include a focus on compensatory strategies, defined by the World Health Organization (2012) as adaptive behaviours or alternative ways of performing tasks that enable the individual to optimise their independence despite the impairments and limitations. In many cases, reablement services seek to improve the older individual's social participation (Meyer et al, 2014). Maintaining physical function allows older people to continue in meaningful activities and roles within their communities. Interpreting healthy ageing in this way allows for a refocus from merely the absence of disability to a consideration of wellbeing, participation, and values (Stephens et al, 2015; Stephens and Breheny, 2018).

A common definition of reablement

In order to advance a common understanding and definition of what reablement is across national and disciplinary contexts, the ReAble Network conducted a Delphi study in 2018–19 that aimed to reach agreement on the characteristics, components, goals, and target groups of reablement. The Delphi technique is a widely used consultation process that surveys a panel of experts in order to arrive at a group opinion (Hasson et al, 2000). In this case, our aim was to develop agreement on a generic definition that could simultaneously incorporate the national and indeed local variations in reablement models. In 2020, an internationally accepted definition of reablement was published, based on four web-based rounds of the survey that had been sent to a total of 112 academics and practitioners (Metzelthin et al, 2020). The chapters in this book all relate to the final definition of reablement, which is as follows:

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> Reablement is a person-centred, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Reablement consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Reablement supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as involvement of their social network. Reablement is an inclusive approach irrespective of age, capacity, diagnosis or setting. (Metzelthin et al, 2020: 11)

Chapter 2 by Tuntland et al further investigates these model features of reablement and how they are applied in the seven countries/jurisdictions covered in the book.

Support of new professional and organisational roles, relationships, and power positions

As indicated in the Delphi definition, the application of reablement implies a new perspective. Reablement challenges us not only in our theoretical understanding of what the problem is and how we are going to solve it, but also with what means. It both requires and supports new roles and relationships across clients, their families, and professionals (Rostgaard and Graff, 2016; Clotworthy, 2020). Ideally, with a person-centred and goal-oriented approach, the individual client is expected to engage in identifying and stating their preferences for independent daily living. It is an invitation but also a requirement to continuously reflect on 'what is important to me', in contrast to traditional home care, which is often based on a one-time professional assessment of need followed by fixed times and tasks over the longer term. Another contrast is that the individual works more closely with the professions in a regular conversation to identify how the reablement intervention may support independent living.

Whether the provider is a nurse assistant, a social care worker, an occupational therapist, or a physiotherapist, an important role for the reablement provider is, therefore, to identify the client's potential and motivation for change and to facilitate such change. Often the daily training is provided by a relatively low-skilled support worker. In the book, we apply the term 'reablement care worker' for this function and skill-level. In basing the daily intervention on the interpretation of the older person's capabilities and resources, the reablement care worker may apply more professional

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independence and autonomy than is the case for regular home care (as elaborated on in Chapter 9 by Rostgaard and Graff). Also, the reablement care worker engages in an ongoing relationship with professional peers as they are expected to participate in and learn from an interdisciplinary collaboration with other professional groups. This implies a new shared power position of the different professions, where, in particular, occupational therapists and physiotherapists seem to have contributed to the professional perspective of maximising independence in daily activities. Yet, reablement seems generally to be adopted and accepted across professional groups. In a qualitative study regarding task-shifting practices in reablement, in this case task-shifting from physiotherapist to auxiliary nurse, two different practices were identified. The first practice, called boundary-making, was found to generate asymmetric power relations that may limit autonomous work and job satisfaction in teams, while the second practice, boundary-blurring, was found to support collaborative practices that endorse holistic approaches and joint learning (Eliassen and Moholt, 2022). Although the boundary-blurring practice seems to be favourable from both a client and a team perspective, asymmetric power relations also exist in many reablement teams.

The support of the older individual's family members is also an important part of a successful outcome in reablement, and informal carers such as partners may influence a successful outcome (Lauritzen et al, 2017). Finally, provider organisations must adapt culturally and change their organisational set-up approach by introducing new overall aims, and by care managers supporting individuals and teams of reablement care workers. When services are procured, special consideration must go into the creation of incentives for non- and for-profit providers for assisting individuals in gaining more independence. Generally, it is cheaper to do things for people than setting time aside to help them do things themselves. Therefore, funders must accept greater provider flexibility where the aim is the outcome and the input may be adjusted along the way according to the individual's abilities and confidence (Francis et al, 2011) (for more information on funding models, see Chapter 2 by Tuntland et al and Chapter 4 by Parsons et al).

The target group

Reablement also poses challenges with regards to who is the target group. The assumption of active participation and involvement of the client raises the question of whether reablement is for everyone, especially if the belief is that a reablement intervention increases quality of life and leads to more independent living, then it is important to not be too restrictive in who is included as a target group. In fact, according to the Delphi definition, reablement is an inclusive approach irrespective of age, capacity, diagnosis, or setting (Metzelthin et al, 2020). Regardless, and presented in more

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detail in Chapter 2, it has primarily been home-dwelling older adults with physical health conditions and functional limitations who have been offered reablement. As Chapter 8 by Rahja and Thuesen argues, people with dementia are increasingly considered to be a relevant target group also.

However, reablement has been criticised for being a 'one size fits all' intervention (Legg et al, 2016). Indeed, when setting the criteria for inclusion, it is at times recommended that practitioners should not be guided by preconceived notions of who may benefit; rather, they should go beyond such notions and include those who may at first seem to be too frail (Rabiee and Glendinning, 2011). It is reasonable to assume, however, that not all target groups benefit equally from reablement. Some research has found that people who have bone fractures as their main health condition benefit the most with regards to functioning again in daily activities, while having a neurological disease (other than stroke), dizziness/balance problems, and pain/discomfort may lead to poorer outcomes (Tuntland et al, 2017). One explanation for this may be mindset, motivation, and natural healing. Also, a bone fracture occurs as an acute event with a sudden limitation in daily functioning, and where improvements are expected as the fracture heals.

Gender is also an important factor regarding who benefits from reablement, as women seem to benefit more than men. On the other hand, age seems to be a less relevant factor, as adults aged 18–64 tend to benefit as much as adults aged 65+ (Tuntland et al, 2017). In a large cohort study, effects varied among older adults with different levels of care needs. It was found that older adults who have low care needs at baseline, benefit most from reablement when it comes to improvements in ADL (Yu et al, 2022). Hence, although reablement in theory might be offered to everyone, the benefit is not irrespective of diagnosis, capacity or gender. This suggests that some target groups may need more intensive reablement than others to achieve improvements.

Effect of reablement on outcomes

An important question to consider is whether reablement works more overall in improving healthy lives, and has a cost-saving potential compared to traditional home care. Determining the impact of reablement services on outcomes is an imperative need to create sustainable models that meet the needs of the target group for the service and other key stakeholders such as policy makers and funders of health and social care. But before determining whether reablement works, it is necessary to determine by which standard we measure its effect. Common frameworks to evaluate and measure the effect of complex health interventions that support older people (such as reablement) have a number of key domains. These can consider outcomes for the person receiving the service, outcomes for their family, clinical outcomes

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(such as physical function), and health and social care outcomes, including cost and service usage (Kozma et al, 1993; Porter, 2010).

Chapter 5 by Lewin et al considers the evidence relating to client-level outcomes of older people who received reablement services. These outcomes commonly measure health and wellbeing at an individual level, based on whether they rate their experience positively and value the outcomes achieved. The most common outcomes considered at the client-level in these studies were daily functioning, physical function and quality of life, which is in line with findings in Chapter 6 by Tuntland et al Lewin et al conclude that the overall evidence is still weak regarding showing that individuals have greater improvement in client-level outcomes following reablement than traditional home care. A number of contributing factors are at play: there is the complexity in combining a very personalised intervention with gold-standard randomised controlled trials, as well as the diversity of outcomes measures which have been used in the different studies. Also, as argued in several chapters of the book, reablement is a very context-driven approach with different agendas and variation in actual reablement models across countries. However, in relation to specific outcomes such as performance of daily activities and quality of life or wellbeing, Lewin et al find the overall evidence seems to be promising. Also, there is a reduced service use and user satisfaction generally seems high. Moreover, in a systematic review and qualitative evidence synthesis of older adults' experiences of reablement including 19 studies, reablement was found to improve older adults' health and wellbeing (Mulquiny and Oakman, 2022). So as argued by Lewin et al in their chapter, in the times of ageing populations it seems a good use of public money to apply an approach that reduces the demand for aged care services and does not negatively impact on individuals' health, function, and wellbeing.

There is also developing evidence of reablement being less costly than traditional home care. Chapter 7 by Zingmark et al presents the available evidence relating to the cost-effectiveness of reablement services, and discusses the health economic perspectives of reablement both from a clinical and future research perspective. The authors also point to the need for considering societal costs, such as the cost for healthcare as well as for informal care, and not only the direct cost for the provider. Again, there are few high-quality studies of cost-effectiveness. The authors conclude that health economic perspectives on reablement are limited to studies conducted in Australia, Scandinavia, and the UK. However, when these studies evaluate reablement in relation to usual care, in all studies except one, reablement resulted in lower costs. Reablement is also found to be a cost-effective intervention in a systematic review (Flemming et al, 2021). In other words, there are indications that reablement has the potential to improve lives without straining the public purse – as well as the potential to enable control over one's life and self-determination.

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However, it may be discussed whether this focus on ordinary outcomes such as improvement in daily activities and saving money may mislead us. Chapter 10 by Clotworthy and Westendorp provides an alternative view to the measurement of effectiveness of reablement by proposing that a focus on cost-effectiveness, service use, and clinical outcomes results in reablement service models that do not meet the needs of older people, such as the need for social connectedness. Together, the three chapters highlight the need to understand the important outcomes that can be used to measure the impact when planning and designing reablement services.

The wider implications of reablement

Overall, the introduction of reablement must be considered a 'game changer' in the care of older adults, as the aim is to move from compensating for a loss of functional ability to sustained independence in daily activities. There is a direct line from reablement to the influential Indian philosopher and economist Amartya Sen and his moral framework on the need for the development of individual capabilities in order to sustain what he has called our "individual functionings"; what we as humans do and are, and what makes sense to us too (Sen, 2010). The core idea of reablement is therefore that the client participates in determining and deciding which individual functionings are important, and that upholding such functionings ensures a high quality of life. However, the idea of such individual involvement falls short if the functionings conflict with the person's capabilities and resources, or even with the overall aim of and norms for the provision of health and social care, which tend to be focused on physical functioning. For instance, the person's aim may not be to be functionally independent in housework and cleaning, but rather to gain physical mobility in order to participate in social activities. There may therefore be varied assumptions regarding what a 'successful' intervention is, depending on the individual's goals and whether they match the service levels of the provider organisation.

From a critical perspective, the introduction of reablement also suggests that we adopt a new perspective on LTC as the production of outcomes; that is, the able-bodied and functionally independent client. The intersections of active and successful ageing discourses and the neoliberal agenda of activation, responsibilisation, and individualisation imply that, in order to receive care, the individual is expected to aim for change and accept becoming changed (Clotworthy, 2020). The neoliberal rationality of attending to the body as an individual responsibility in this way becomes embodied with the individual (Rudman, 2015). And it may also become embodied in the organisational practice, if individuals who choose not to become 'reabled' are denied regular services. Therefore, any restructuring of LTC services towards reablement

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must also consider how those who will not or cannot be part of a reablement intervention have their needs met.

Also, reablement services have become widespread in many Western world countries but the evidence of the effectiveness to date lacks a specific consideration of the impact of cultural factors in considering majority populations only. Little of the published research considers the ethnicity of the participants in studies of reablement, but when described, it is clear that the majority of participants are older people of European descent (see for example, Parsons et al, 2018; Parsons et al, 2019). As a result, it is difficult to determine the effect of reablement services among older people from ethnic minorities within a country or in countries outside of Europe, North America, and Australasia.

The development of a more focused and culturally safe practice that aims to reduce issues of health equity should also be considered, particularly as reablement models spread to other countries. Reablement should be more focused on addressing the needs of culturally diverse groups with potentially marked differences in their views towards rehabilitation, reablement, and wider delivery of health and social care services. This is a key issue that points to the importance of considering the cultural context alongside other major contextual factors when designing and implementing reablement-service delivery models. Such an approach may extend beyond having clinical and functional attributes in disease management with a requirement for an alignment in emotional, cultural, and familial understandings (Sheridan et al, 2017; Kuluski et al, 2019).

The spread of reablement and future considerations

Reablement has become increasingly popular in high-income Western countries; a tendency that will most likely continue. Our current knowledge of which countries have implemented reablement derives mainly from research publications from the same countries, but also from personal contact with stakeholders in these countries. Chapter 3 by Feiring et al outlines how the idea of reablement as policy and practice has travelled across regions worldwide. Following instead the academic publications, also gives an indication of the spread from country to country. The first countries to publish peer-reviewed publications on reablement/restorative care were, in chronological order, the United Kingdom in 1999, followed by the United States (2001), Italy (2002), Canada (2005), Australia (2009), Taiwan (2011), New Zealand (2012), and Ireland (2013). Reablement was implemented locally in Sweden around 1997, while Denmark and Norway implemented it locally from 2007 and 2011, respectively (see also Chapter 2). Since the first scientific publication in Norway in 2014, substantial research on reablement has been published. The first scientific publication from

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Denmark was from 2016, followed by Sweden in 2017. Other countries that have published research on reablement more recently, from 2017 onwards, are, in chronological order, the Netherlands, South Korea, Japan, Austria, and Finland. However, even if there is an association between a country's scientific publications and implementation of reablement, the relationship is not one-to-one. While some countries like Denmark, New Zealand and the United Kingdom have implemented reablement across more-or-less the whole country, other countries have implemented it in particular geographical regions, home-based care districts or specific settings. Moreover, some countries like Italy, Austria, and South Korea have only one scientific publication and the publication may not reflect actual implementation of reablement in that country. Lastly, there is increasing interest from professional associations, including the Association of Occupational Therapists, in addition to individual OT scholars who, in some countries, have contacted members of the ReAble Network and shown interest in implementing reablement. These countries include Belgium, China, and Iceland. The extent of implementation in these countries is, however, unknown. To conclude, in total, 16 of the 19 aforementioned countries have publications on reablement demonstrating some interest in, or implementation of, the intervention. However, none of these 19 countries are low- or middle-income countries. Furthermore, there are no publications from the countries in the South American and African region.

Finally, some reflections on future considerations regarding application and implementation of reablement. This book highlights a number of issues that need to be addressed in the design, delivery, and evaluation of reablement services. These are relevant for the ongoing refinement and evolution of reablement within countries that have established service-delivery models. However, there is also a need for critical consideration of these issues in regions, jurisdictions, and countries that are planning to introduce reablement. The book chapters provide valuable insights into these considerations, including the need to consider the motivation for implementing reablement. Furthermore, there needs to be an awareness of the need to clearly define the key model features of reablement that will be delivered at a local level, including the composition of the reablement team. Being explicit about the motivation for implementing reablement and describing the key features within a local, regional, or national rollout will allow for more robust comparison across jurisdictions and will also increase the opportunity for successful outcomes for the older people receiving reablement.

A presentation of the book

The motivation for the book has been to apply an interdisciplinary perspective to critically investigate the idea behind reablement, its application,

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and implementation in different geographical and systemic contexts and, among other things, its implications for cost-effectiveness and for individuals' outcomes and reablement care workers' job quality. We hope that this book will reach a variety of readers and make them interested in how reablement could change LTC systems by providing a more sustainable and person-centred approach for supporting older people to improve their independence in daily functioning.

In line with the interdisciplinary approach in reablement, the authors represent a diversity of disciplines, including economics, ethnology, exercise science, health science, medicine, nursing, occupational therapy, physiotherapy, political science, public health, rehabilitation science, social work, and sociology. The book covers national and cross-country experiences with evidence from reablement in seven countries/jurisdictions across the world and with different LTC systems (Australia, Denmark, England, the Netherlands, New Zealand, Norway, and Sweden).

The book is structured within a number of overarching themes as follows. The following three chapters focus on the theme of *reablement in contexts, ideas, and implementation*:

Chapter 2 by Tuntland et al presents a contextual investigation of the seven countries that are included in the book, including country-specific information on demographics and long-term care systems. The institutional characteristics of reablement in the seven countries are also presented in the chapter, as are more generic reablement model features and the theoretical aspects for reablement.

Chapter 3 by Feiring et al investigates how ideas of reablement have travelled and materialised into similar policies, activities, and institutional practices of reablement within and across different world regions. Data is presented from interviews with key informants and policy documents and online information resources from governing authorities, representing three world regions. The findings illustrate that the travelling of ideas is complex and characterised by circularity rather than linearity. The findings also indicate that transnational ideas of 'successful ageing', 'active and healthy citizens' have travelled to local and national practice, but also from local bottom-up initiatives to the agendas of supranational organisations.

Chapter 4 by Parsons et al explores the related topic of how reablement was implemented across Denmark, the Netherlands, New Zealand, Norway, and Western Australia. Informed by implementation frameworks, the chapter seeks to determine the shared issues for development, refinement, and spread. This allows for consideration of the key features in the composition of reablement across the five countries/regions, together with an illustration of differences in structuring reablement.

In the next part of the book, we focus on the theme of *outcomes* for the individual and in terms of cost-effectiveness.

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Chapter 5 by Lewin et al finds that the available evidence for the effect of reablement on the daily functioning of clients remains weak but nevertheless promising in regard to outcomes such as performance of daily activities, quality of life, wellbeing, and user satisfaction. This aligns well with the content of the next chapter through a summary of the evidence relating to what individuals gain from participating in reablement together with a consideration of why the evidence is still limited and how the situation might be improved.

Chapter 6 by Tuntland et al examines the use of outcomes and instruments to measure the impact of services within reablement research. A comparative analysis of the available literature is utilised to consider the evidence with the authors concluding that there is a lack of consistency regarding client-level outcomes and instruments used in reablement research. They suggest that a core set of client-level outcomes related to performance in activities of daily living, physical functioning, and health-related quality of life should be used to enhance comparison across studies.

Chapter 7 by Zingmark et al is based on a literature review of the health-economic perspectives on reablement, and it provides a summary of existing evidence from both a clinical and future-research perspective. The authors conclude that, compared to usual home-care services, reablement is a cost-effective intervention. However, there is a very low number of publications that include health-economic perspectives on reablement; thus, additional studies are urgently needed.

Following this is a part focusing on the *experience* of reablement. Here, we view the experience of reablement for people with dementia and among reablement care workers.

Chapter 8 by Rahja and Thuesen considers reablement in the context of dementia care and reviews research on reablement intervention programs specifically designed for individuals living with dementia. Reablement in dementia care is a relatively new concept and holds promises for this user group and as applied in nursing homes. Intervention programs consist of strategies to address function-related goals, promote activity engagement, consider behavioural and psychological symptoms related to dementia, and include the individual's social networks. However, several barriers to reablement exist, including stigma attached to the disease and limited health professional knowledge regarding dementia.

Chapter 9 by Rostgaard and Graff describes research conducted in Denmark based on qualitative and quantitative data from two local settings in order to unfold reablement care workers' experiences of how reablement has changed their work. The authors conclude that the implementation of reablement in Denmark indicates that reablement changes the understanding of care work in a way that may eventually result in better retention and recruitment of staff in the health and social care sector.

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In a final part of the book, we look into *future perspectives* and provide a discussion of where the field is and how it should move forward.

Chapter 10 by Clotworthy and Westendorp challenges the contemporary reablement practice that focuses on improving older people's physical functionality, often at the cost of enhancing their social connectivity. The authors propose a change in perspective and a commitment to move beyond current professional protocols – a change that requires a paradigm shift. Here, professionals should 'help people help themselves' instead of focusing on set functional outcomes and economic benefits. The authors' critical examination of certain fundamental assumptions in reablement aligns well with the need identified in this introductory chapter to consider the theoretical frameworks used in the current design and delivery of reablement services.

Chapter 11 by Parsons et al concludes the book. The chapter is based on a facilitated on-line discussion between five members of the ReAble Network and on the basis of reading the chapters. Their reflections focus on the convergence/divergence of reablement tracks, the challenges and learnings, as well as the implications for theory, practice, and policy making. The chapter summarises the key learnings and messages from the book and illustrates the potential implications for reablement practice and research.

Terminology in the book

The book presents the perspectives and experiences of authors from across disciplines and across countries. As a result, the terminology for central concepts and functions of reablement has not been standardised. The main terms used and their variations are as follows:

- *Client*: An older person to whom reablement services are being delivered. It is common for these older people to also be referred to as a patient or a service user.
- *Home care*: In the book referred to as usual/conventional/traditional home care. Services provided within an older person's place of residence, excluding residential aged care homes. The overarching goal of home care is to provide health and social care support to individuals that will enable them to maintain their independence and the highest quality of life. Home care is often not time-bound or as intensive as reablement.
- *Older person*: A person aged 65 years or over, however, some countries modify this to include groups that are a focus for targeted support (for example Māori in New Zealand are classified as an older adult from age 55). The term is synonymous with elderly/older adult.
- *Reablement care/support workers*: Formally employed health and/or social care workers/home carers whose main function is to motivate and assist

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the client in the daily training. They have in many cases received basic training in aged care and/or healthcare, and supplemental training in reablement. They work with other members of the reablement team such as occupational therapists, registered nurses, other health professionals, or social workers.

- *Restorative home care/home support/care*: A term commonly used in Australia, the US, and New Zealand to describe reablement services.

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Note

[1] At times, referred to as the jurisdiction of Western Australia, as this was where reablement was initiated.

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