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Reablement of older people living with frailty: a review of approaches in rural, remote and island communities

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29 September 2025

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0. EXECUTIVE SUMMARY

This literature review set out to address two questions: (1) How can reablement services that support older people living with frailty be best delivered in rural and/or island (RRI) contexts? (2) How can asset-based approaches (ABA) help reablement services to identify and build on community strengths?

Fifteen publications, covering eight reablement programmes, were found relating to the first question. The programmes were set in rural and remote areas of the UK (N=3), Norway (N=2), Australia (N=2) and Taiwan (N=1). No publications were found concerning the second question. A brief overview of asset-based approaches for similar groups is provided instead.

The studies reported in the publications varied in terms of their aims, the models of reablement (and usual care comparators) examined, the number and level of frailty of the older people in the samples, and the range of RRI locations in which they were set.

Where clinical outcomes, cost-effectiveness and/or service performance of the programmes was assessed, the findings were generally positive when compared with usual care. Where people’s experiences of receiving and/or providing reablement were examined, these revealed the importance of collaboration between staff and older people; of understanding the factors that motivate older people to participate in activities that promote healthy ageing; and of ensuring programmes are culturally and personally meaningful. The involvement of relatives, and provision of follow-up support for those who need more help to sustain their level of skills and independence, were identified as potential areas for improvement.

The success of reablement was influenced by several factors. These included neighbourhood factors (especially deprivation), socioecological factors, structural factors, leadership roles in the community, the pre-existence of established integrated care systems and practices, and the role of education and training as a means of promoting a common understanding of the philosophy and purpose of reablement.

Overall, the small number and heterogeneous nature of the studies, as well as the lack of standardised information on what the programmes entailed, how they were delivered and tailored for the participants, the characteristics of the RRI areas in which the services operated, and the lack of comparative data, made it difficult to assess which models work best, for whom, in which contexts.

ABA has the potential to be used to inform the redesign of reablement services and the development of more collaborative approaches to the promotion of health and wellbeing for older people living with frailty at an individual and collective level. Potential challenges include the extent to which reablement services can widen, lengthen and embed their approach in RRI communities, to help to sustain older people’s skills and independence for longer.

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1. INTRODUCTION

1.1 About this evidence review

This evidence review was conducted as part of an IMPACT Demonstrator project (2025-26) carried out in partnership with NHS Western Isles in Scotland, exploring new models of reablement in this context.

The Western Isles (Na h-Eileanan Siar) is an archipelago located off the west coast of mainland Scotland. The main islands are Lewis, Harris, North and South Uist, and Barra. Spanning 160 miles, the islands are interconnected by roads, causeways, ferries and planes. In the Scottish Government’s 8-fold urban rural classification system, the Western Isles are classified as a ‘very remote rural’ region (Scottish Government, 2024). In 2024, the total population was estimated to be 26,020, with 27.4% over the age of 65.¹ Between 2018 and 2028, both the overall population and the working age population were predicted to drop by around 6%, while the over-75 years of age population was expected to increase by 25%.²

In the Western Isles, reablement services are provided by the [Short-Term Assessment and Reablement Team \(START\)](#). The Team includes Reablement Support Workers, Care and Support Supervisors, Occupational Therapists and Physiotherapists. Reablement is provided for an average of around six weeks, free of charge. It is one of a range of services that take a ‘home-first’ approach to care, improving patient experience, reducing hospital admissions and reducing delayed hospital discharge, leading to enhanced patient outcomes and reduced healthcare costs.

1.2 Background

Reablement programmes for older people have expanded in high-income countries over the past two decades. This expansion has been driven by multiple factors: ageing populations, growing demand for health and social care, people preferring to remain in their own homes and localities, and the relative costs of institutional care and long-term home care. At the same time, there has been an increasing emphasis in many countries on the integration of health and social care, the prevention of ill health and disability, and the promotion of healthy ageing and ‘ageing-in-place’, which is aligned with the philosophy of reablement.

The expansion of reablement programmes has been accompanied by a growing international scientific literature on the topic. A scoping review of publication trends in reablement identified 198 articles published between 1999 and 2022 from 14 countries

¹ NRS Scotland mid-2024 population estimates: <https://www.nrscotland.gov.uk/publications/mid-2024-population-estimates/#>

² NRS Scotland population projections for Scottish areas: <https://www.nrscotland.gov.uk/publications/population-projections-for-scottish-areas-2018-based/#>

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(Guadana et al., 2023). The review highlighted inconsistencies in the way that reablement has been defined in theory and in practice. Similar findings have been reported in earlier works (e.g. Parker 2014; Aspinall et al., 2016; Legg et al., 2016; Pettersson and Iwarsson 2017; Doh et al., 2020; Clotworthy et al., 2021).

The inconsistencies include different concepts being used to describe reablement, such as ‘enablement’ or ‘restorative care’, and it being referred to using umbrella terms, such as ‘intermediate care’ or ‘integrated care’ or ‘transitional care’. The configuration of reablement services also varies in practice (Beresford et al., 2019; Tuntland et al., 2023). For example, differences have been noted in who reablement is provided for, the mix of health and social care staff who provide it, the duration of the service, the settings where it is provided, and whether the service is outsourced or not.

In the United Kingdom (UK), reablement is regarded as a type of ‘intermediate care’ by the National Institute for Health and Care Excellence (NICE):

‘The term “intermediate care” in this guideline refers to all 4 service models of intermediate care described in terms used in this guideline...’ [the models being: bed-based intermediate care; home-based intermediate care; crisis response; reablement] ...

Reablement: ‘Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.’ (NICE, 2017/2024: 5, 18)

According to the Social Care Institute for Excellence (SCIE), reablement is:

‘a strengths-based, person-centred approach that promotes and maximises independence and wellbeing. It aims to ensure positive change using user-defined goals and is designed to enable people to gain, or regain, their confidence, ability, and necessary skills to live as independently as possible, especially after an illness, deterioration in health or injury.’ (SCIE, 2020: 1)

Nationally and internationally, efforts have been made to clarify what reablement is and is not. For example, some have distilled the common features of reablement (eg Doh, 2020; Metzeltin et al., 2022); others have shown how it differs from intermediate care (Parker 2014) and from traditional home care (SCIE, 2020). In the most recent of these publications, Metzeltin and colleagues (2022) describe a Delphi study they carried out in a bid to develop an internationally accepted definition of reablement. A total of 79 experts completed all four survey rounds in 2018/19. The final definition - shown below - was accepted by 79% of the participants (the lowest rate of acceptance was from the UK at 42%):

‘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

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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., 2022: 713)

This definition captures many of the common features of reablement. However, as the authors note, it differs from the prevailing view that reablement is a time-limited approach, of around six weeks in duration. In addition, while the authors claim that reablement is an inclusive approach irrespective of context, they acknowledge that Scandinavian countries were over-represented in their study; they therefore suggest that the definition needs to be contextualised ‘to take into account national and local policy and institutional contexts’ (Metzelthin et al., 2022: 716).

Since 2014, several reviews have examined the state of research evidence regarding the effectiveness of reablement (e.g. Cochrane et al., 2016; Legg et al., 2016; Tessier et al., 2016; Pettersson and Iwarsson 2017; Sims-Gould et al., 2017; Wilson and Waddell, 2019; Mjøsund et al., 2020; Bennett et al., 2022; Buma et al., 2022; Chen et al., 2022; Lewin et al., 2023; Anthony et al., 2025; Gough et al., 2025). While it was outside the scope of this review to synthesise this evidence (as it lacked a focus on rural, remote and island contexts), it was noted that the two most recent of these reviews - both of which focussed on reablement for older people - came to very different conclusions. On the one hand, Anthony and colleagues (2025) claimed that their rapid review:

‘... identified a significant amount of evidence on the effectiveness of reablement interventions on person-related outcomes and the impact of reablement on service-level outcomes. ...there was evidence to demonstrate that reablement interventions were effective for improving independence in terms of increasing mobility and activities of daily living outcomes. Other outcomes relating to clients’ health reported in the studies identified in this rapid review included quality of life, falls outcomes, grip strength, sense of coherence, mortality and social support. The rapid review findings suggest that reablement interventions were effective in improving quality of life and may have been effective in improving falls outcomes. The review also identified that reablement may have been effective in reducing the risk of mortality and improving clients’ coping in terms of sense of coherence. The review did not identify evidence to suggest that reablement was effective for improving grip strength or increasing clients’ social support.

...Based on the available evidence identified in this rapid review, reablement was found to reduce the need for long term home care services. There was also evidence that reablement interventions were effective in reducing residential care admissions. In terms of other service-level outcomes, there were contradictory findings on the effectiveness of reablement to reduce hospital admissions and inconsistent findings on the effectiveness of reablement to reduce emergency department visits. One study found that reablement was effective in reducing the number of outpatient treatments compared with usual care. The rapid review also found

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contradictory findings on the effectiveness of reablement to reduce community care service use and social care service use.’ (Anthony et al., 2025: 58)

On the other hand, in their scoping review of systematic reviews, Gough and colleagues (2025) concluded:

‘This scoping review summarises the evidence landscape for rehabilitation, reablement, and restorative care approaches in the context of aged care. Despite their role in enhancing independence and quality of life for older people, policy, funding, and terminology variation means the evidence lacks clarity. This fragmented evidence makes it challenging to argue the effectiveness of one approach over another for older people in receipt of aged care services. ... This scoping review did not identify a strong, cohesive evidence base in support of rehabilitation, reablement and restorative aged care approaches.’ (Gough et al., 2025: 1, 10)

While there is still considerable support in policy for reablement approaches in the UK and other high-income countries, questions have been raised about the scope, sustainability and direction of reablement services. For example, it has been suggested that the current focus on functional reablement is too narrow and should be expanded to include social connectivity, to better address the risk of social isolation (Doh, et al., 2020). Others have suggested that more people living with dementia could benefit from the approach (e.g. Rahja and Thuesen, 2023; Metzelthin et al., 2024). And yet others have suggested a need for a paradigm shift in reablement, away from the current model with its emphasis on physical functioning and cost-savings, and towards building stronger, more inclusive communities of care where old age is not treated as a disability and the emphasis is firmly on optimising older people’s capacity and supporting them to achieve their self-defined goals (Clotworthy and Westendorp, 2023; see also Clotworthy et al., 2021).³

1.3 Aims

Building on this knowledge, the present review sought to locate and summarise available evidence to help address the following two questions:

1. How can reablement services that support older people living with frailty be best delivered in rural and/or island (RRI) contexts?
2. How can asset-based approaches (ABA) help reablement services to identify and build on community strengths?

³ Clotworthy and Westendorp (2023) give an example of how older people’s independence in the community can be promoted in a way that exemplifies the holistic, ‘open-system’ approach they advocate: the [Buurtzorg model](#) of integrated care developed in the Netherlands.

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2. METHODS

2.1 Search strategy

Searches for relevant publications were conducted in June-July 2025. The searches covered academic and grey literature containing insights from research, practice-based knowledge and lived experience of adult social care.

Publications were primarily located through searching titles and abstracts listed in the following databases: Allied and Complimentary Medicine Database (AMED), Cochrane reviews, CINAHL complete, DARE, Embase, Medline, Psych Info, PubMed, Scopus, SocINDEX, and Web of Science. These searches were supplemented using Google Scholar and Google search engine. Additional searches were conducted of the indexes of specialist journals (e.g. *Australian Journal of Rural Health*; *Rural and Remote Health*; *The Journal of Rural Health*; *Journal Integrated Care*), and of the websites of relevant organisations (e.g. [National Centre for Remote and Rural Health and Care Information Hub](#); [ReAble Network](#) based at University of Auckland, New Zealand; [Australian Government’s Department of Health, Disability and Ageing Wellness and reablement resources](#)). Some works were also identified through backward- and forward-citation searching.

Different combinations of search terms were tested and adapted for the above sources. A selection of the following terms were used: older people, older adults, elderly, older patients; frail, frailty, prefrailty, social frailty; unpaid carers, informal carers, caregivers, whole-family support; reablement professionals, intermediate care professionals, home rehabilitation professionals, allied health professionals; reablement, reablement services, intermediate care, restorative care, enablement, re-enablement, recovery, reactivation, home care, home rehabilitation, community rehabilitation, service delivery, service improvement, integrated care, early intervention, transitional care, active ageing; home first; asset-based approaches, ABA, strengths-based approaches, local assets, community assets, community-based, social capital, capacity-building, prevention, neighbourhood care, short-term care, sustainable care, ABCD approach; aging in place, aging well, healthy aging, age-friendly; co-production, partnership, collaboration; island, isles, rural, remote, periphery. Alternative forms and/or spellings of these terms were used where appropriate.

To be eligible for inclusion, publications needed to address one or both questions of interest and be published in English between 2014 and May 2025.

Publications were excluded if they covered a mix of urban and rural settings but did not sufficiently differentiate them in the data analysis.

After screening titles and abstracts, candidate texts were read to check their eligibility. Relevant findings and insights from the final selection of publications were noted and are summarised in this report.

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2.2 Terminology used in this report

The terms ‘reablement’ and ‘reablement services’ are used in this report to describe models of care that were self-defined as such in the publications, or which used other terms for similar approaches. ‘Older people’ are defined as people aged 65 or above. Authors’ own definitions of ‘frailty’ were used and included so-called social frailty.

This report describes international research set in self-defined ‘rural, remote and island’ areas. However, it should be noted that national definitions of rurality and remoteness vary and are relative. For example, the [Scottish Urban Rural Classification](#) (2-fold, 3-fold, 6-fold and 8-fold versions) is used in Scotland (Scottish Government, 2024) and there is also a [Scottish Islands Typology](#); the [Modified Monash Model](#) (seven categories) is used in Australia (Australian Government, Department of Health, 2023); the [Geographical Classification for Health \(GCH\)](#) (five categories) is used in health research in New Zealand; and different urban-rural typologies are used in the [Nordic countries](#). This can make comparisons across countries and territories difficult.

Finally, the review includes multiple publications stemming from single research projects examining different aspects of a specific reablement service or programme. In this report, the term ‘project’ is generally used to refer to these multi-faceted studies, where there are two or more publications linked to the work.

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3. FINDINGS

3.1 Characteristics of publications

After screening, 15 publications were found to contain relevant evidence pertaining to the first aim of the review and none were found relating to the second aim.

The 15 publications were linked to eight discrete reablement programmes or services in four different countries: UK (N=3), Norway (N=2), Australia (N=2), and Taiwan (N=1). Almost half the total number of publications (N=7) related to the two Norwegian programmes. Further information on the characteristics of the publications included in the review is provided in Appendix 1.

All the publications were published in peer-reviewed journals, except for an internal evaluation of a ‘Home First’ pilot ‘discharge to assess’ model that was set in Orkney (Orkney Health and Care, 2022).

Overall, the publications were generally considered to be of mixed quality (High = 4; Medium = 4; Low = 5) and relevance (High = 3; Medium = 6; Low = 6). The quality of two publications was not assessed - one was not a standard research report and had little methodological information; the other was a description of the nature and development of a model.

Given the lack of research on the use of asset-based approaches in reablement services for the given population, a short overview of relevant aspects of the wider literature is provided instead.

3.2 Reablement in rural, remote and island contexts

3.2.1 Definitions and models of reablement

Seven of the eight programmes were self-described as ‘reablement’ services. The exception was a ‘community rehabilitation and lifestyle service’ in Australia that was discussed in three publications linked to a single project (Cairns et al., 2022, 2024; Sarovich et al., 2024). These publications were included because, based on the information provided, the service was consonant with the other types of reablement examined in this review.

As reported in the wider literature, the definitions of reablement varied across the eight projects, but shared some similar features (see Table 1).

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Table 1: Definitions of reablement (or similar) used in the eight programmes/services

1 st author/ year/country	Key terms & Definitions
Jacobi 2020 UK	All [reablement] programmes share the aim to enable and ‘re-able’ frail and disabled people to achieve ‘functional independence’, i.e. the ability to live a self-reliant life in which vital everyday activities like dressing, washing, eating, toileting and basic mobility are achieved by the clients themselves without the need for on-going assistance from homecare providers. (Jacobi et al., 2020: 1)
Elston 2022 UK	Intermediate Care (IC) or Transition(al) Care as it is known in some countries [ref] is organised around 10 service elements [refs] which facilitate patient care and transitions between acute, community and home settings, depending on their changing support needs. Typically, IC provides a range of integrated service models providing home-based and bed-based care, sometimes with reablement and crisis response support for up to 6 weeks. These aim to support timely discharge from hospital, promote faster recovery from illness, maximise independent living, and to prevent unnecessary hospital admission and premature admission to long-term residential care [refs]. (Elston et al., 2022: 2)
Orkney Health and Care 2022 UK	4.1. The Home First Service is a discharge to assess model offering up to six weeks of reablement support to enable timely discharge from the hospital and the opportunity to assess patients in their own home. 4.2. The reablement approach supports people to do things for themselves. It is a 'doing with' model, in contrast to traditional care at home which tends to be a 'doing for' model. Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness. (Orkney Health and Care, 2022: 2)
Tuntland 2015; Hjelle et al 2016, 2017a, 2017b; Kjerstad 2016 Norway	Reablement is a timely approach to improve home-care services for older people needing care or experiencing functional decline. The health-care providers are organised into an integrated, coordinated multidisciplinary team whose members work together with the person towards shared goals [12]. The intervention is targeted, multicomponent and intensive, and takes place in the person’s home and local surroundings. The focus is on enhancing performance of daily activities defined as important by the person. The aim is to increase independence in daily activities, and enable people to age in place, be active and participate socially and in the society. (Tuntland et al., 2015: 1) Reablement is an early and time-limited home-based rehabilitation intervention that emphasizes intensive, goal-oriented, and multidisciplinary assistance for people experiencing functional decline. (Hjelle et al., 2016: 575) Reablement is a timely service for home-dwelling older people experiencing a decline in health and function that emphasizes their mastery of valued activities and their social participation in society. [ref] (Hjelle et al., 2015: 576) Reablement is an early and time-limited home-based intervention with an emphasis on intensive, goal-oriented, and interdisciplinary support and assistance for older adults experiencing functional decline. (Hjelle et al., 2017a: 1) Reablement is an early and time-limited home-based intervention with emphasis on intensive, goal-oriented and interdisciplinary rehabilitation for older adults in need of rehabilitation or at risk of functional decline. (Hjelle et al., 2017b: 1581, 1582) Furthermore, reablement is individualised, based on the person’s participation, and his/her resources. Rather than performing personal care and household tasks for people, reablement enables people to relearn skills and regain confidence in performing daily activities themselves. (Hjelle et al., 2017b: 1582)
Eliassen 2023, 2024 Norway	Reablement aims to enable older persons with functional decline to re-engage in meaningful activities. (Eliassen et al., 2023: 1) Reablement is a team-based, person-centered, holistic intervention designed to enhance functioning and support independence in meaningful daily activities at one’s place of residence [ref]. (Eliassen et al., 2024: 3)

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1 st author/ year/country	Key terms & Definitions
Maxwell 2021 Australia	Reablement is a person-centred, goal-directed intervention used to regain, maintain or improve the independence of older clients. (Maxwell et al., 2021: 686)
Cairns 2022, 2024; Sarovich 2024 Australia	For the purpose of the project, community rehabilitation was defined as “a process that seeks to equip, empower and provide education and training for rehabilitation clients, carers, family, community members and the community sector to take on appropriate roles in the delivery of health and rehabilitation services to achieve enhanced and sustainable client outcomes” [ref]. (Cairns et al., 2022: 4268) A remote health service, in collaboration with a University Department of Rural Health and community partners, developed a community rehabilitation and lifestyle service for adults who experience chronic disease, disability or were at risk of functional decline due to frailty. Using an integrated approach, this model of care improves access to specialist and primary healthcare services, delivers targeted group-based rehabilitation and preventative activities, and addresses community and workforce capacity to meet the needs of the remote community. This paper describes a remote primary health care, Integrated Allied Health Service Model , developed with a focus on the co-ordination and integration of care and resources between the health service, education and community. (Cairns et al., 2024: 1)
Song 2021 Taiwan	Reablement services are approaches for maintaining and improving the functional independence of older adults [ref]. The intervention is targeted, focused on enhancing the performance of daily activities defined as important by the person, and takes place in the person’s home and local surroundings [ref]. The aim is to enable people to age in place, be active and participate socially and in society [ref]. (Song et al., 2021: 1)

Different aspects of reablement were examined in the publications, including clinical outcomes, cost-effectiveness and service performance; experiences of people using and providing the service; and factors affecting the success of reablement. The publications also included descriptions of the co-design of reablement programmes and the development of a training programme for staff.

The depth of description of the models of reablement varied, depending on the focus of the studies. Key features of the eight reablement services, based on the information provided in the publications, are summarised in Table 2.

While all the studies included participants who were receiving, delivering or co-designing reablement services in RRI areas, the publications varied in the extent to which the rural context of the service was considered in the data analysis or in discussion of the results. Only two publications, stemming from the same project set in arctic Norway, had a strong focus on rural factors and conditions (Eliassen et al., 2023, 2024). The publications respectively described the development of a socioecological model of reablement, and the appropriateness and feasibility of outdoor reablement in a rural arctic setting, including seasonal availability and accessibility.

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Table 2: Key features of the reablement programmes (N=8)

1st author/yr	Who for	Delivered by	Setting & timing	Other characteristics
Jacobi 2020.	Adults aged 60+, including frail.	Specialist private care company.	UK (Essex). Max 6 weeks. County-wide, including isolated rural communities.	Reablement programmes were tailored to individuals’ needs and involved teaching skills to enable people to live independently or be less reliant on homecare services (p.4). No specific data on what was delivered to individuals.
Elston 2022.	More complex older adults.	SWs & community staff, ‘enhanced’ by GPs, pharmacists, voluntary sector wellbeing coordinator.	UK (Devon). Timing unclear. ‘Enhanced’ service initially provided in coastal community.	Aims to be person-centred, deliver care closer to home, co-ordinate care, reduce need for community hospital beds.
Orkney Health and Care 2022	Adults aged 60+.	OT, home workers, SW, PT.	UK (Orkney). Up to 6 weeks. Low focus on rurality.	This was a 12-month pilot. ‘4.1. The Home First Service is a discharge to assess model offering up to six weeks of reablement support to enable timely discharge from the hospital and the opportunity to assess patients in their own home.’ (Orkney Health and Care, 2022: 2) Diagrams showing the proposed integrated model of working between the Intermediate Care Team, Home First team, and home care service are presented in Appendix 2 (Orkney Health and Care, 2022: Appendix 2).
Tuntland 2015; Hjelle et al., 2016, 2017a, 2017b; Kjerstad 2016.	Adults aged 18+ but most participants were older people.	OT, PT, home care personnel, social educators, nurses, auxiliary nurses, assistants.	Norway. Max 3 months. Rural municipality.	The intervention had general and individual features (tailored). Includes training in ADL, adaptations to environment, exercise programs.
Eliassen 2023, 2024.	Older people.	PT, OT, registered nurse, associate nurse.	Norway (Arctic area). 4-6 weeks.	A co-designed socioecological model that integrates outdoor activities into reablement and promotes ageing-in-place. Person-centred. Includes home visits by inter-professional team.
Maxwell 2021.	Older people.	Care staff and care coordinators, AHPs, nurses.	Australia (regional level). Unclear timing.	No particular model - this study examined staff experiences of delivering reablement (care staff and coordinators only) to help develop training.
Cairns 2022, 2024; Sarovich 2024.	Older Aboriginal and/or Torres Strait	PT, OT, SW, dietician, ST, Indigenous community	Australia (North Queensland). Open access.	Allied health, student-led model. Students had 5-14 weeks placements, working up to 3 days per week for the service. Promotes healthy ageing, ageing-in-place, culturally safe and responsive

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1 st author/yr	Who for	Delivered by	Setting & timing	Other characteristics
	Islander people.	rehabilitation co-worker.		service, relational focus, community and clinical integration.
Song 2021.	Older adults with mild/mod mobility deficits.	PT, OT.	Taiwan (6 rural areas, New Taipei City). 10 weeks.	Community-based intervention program. Includes 2.5h PT or OT session (1.5h group-based, 1h individual), physical and cognitive training, health education and reablement.

Key: AHP = Allied Health Practitioner; GP = General Practitioner; OT = Occupational Therapist; PT = Physiotherapist; SW = Social Worker.

3.2.2 Clinical outcomes

The impact of the reablement programmes on older people’s performance outcomes was examined in three studies (Tuntland et al., 2015; Song et al., 2021; Orkney Health and Care, 2022).

In the first randomised controlled trial (RCT) of reablement conducted in Europe, Tuntland and colleagues (2015) compared a reablement programme lasting up to three months with usual care for 61 older adults living in a rural municipality in Norway. The intervention included a baseline assessment by an Occupational Therapist and Physical Therapist using the Canadian Occupational Therapy Performance (COPM) to identify activity limitations perceived as important by the participant. This information was used to develop a rehabilitation plan. The therapists supervised the delivery of the daily training by homecare personnel. Participants were encouraged to perform the daily activities themselves, rather than the carers. The programme also included individualised adaptations to the environment or the activity, and exercise. Usual care consisted of more compensatory help in the form of personal or practical assistance, safety alarms, meals on wheels, or assistive technology; a few participants also received rehabilitation assisted by an occupational therapist and/or physical therapist. If required, usual care lasted longer than the three-month intervention period. Outcomes were measured at three months and nine months after the programme. Based on their analysis, the authors found that the reablement programme was:

‘a superior intervention [compared] to usual care in terms of improving self-perceived activity performance and satisfaction with performance on a long-term basis in community-dwelling older adults. However, the other outcomes measured showed no significant group differences. The intervention was given to a frail, elderly population, who still demonstrated a significant improvement despite no extra time resources being allocated.’ (Tuntland et al., 2015: 10)

A controlled before-and-after study of reablement was conducted in six rural areas of New Taipei City, Taiwan, by Song and colleagues (2021). Participants included 28 older people with mild to moderate mobility issues, recruited from six adult day centres. The intervention group received 1.5 hours of group courses and 1 hour of individualised

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reablement training a week. These sessions were delivered at the day centres, over a 10-week period, by two specialist rehabilitation staff (qualified PT or OT). The group course included physical training, cognitive training, and health education. Individualised training was provided after a goal was formulated by the participants and therapists at the first visit to identify the problems they encountered and perceived as the most important in performing self-care, productive activities, and leisure activities. The control group also received 1.5 hours of group courses, but with placebo individualised treatments. Examining the outcomes, the authors concluded that:

‘...combining individualized reablement and group-based physical–cognitive training and health education had greater effects on lower extremity function, mobility, cognitive function, and ADL [activities of daily living] function, relative to a control, among rural community-dwelling older adults with mild to moderate mobility deficits.’ (Song et al., 2021: 5)

Finally, an internal evaluation of a ‘Home First’ pilot of a ‘discharge to assess’ model was carried out in Orkney, Scotland (Orkney Health and Care, 2022). Of the 53 people who used the service over the 12-month pilot, 85% were classed as ‘severely frail’ (Orkney Health and Care, 2022: 3). Outcomes were assessed using validated outcome measures and showed an 89% improvement in occupational performance. The service also prevented four individuals having to leave their home and move into residential care. The median time using the service was just under five weeks; the longest package lasted just over 22 weeks and the shortest was one day (Orkney Health and Care, 2022: Appendix 1: 9).

3.2.3 Cost-effectiveness and service performance

The cost-effectiveness of reablement was examined by Kjerstad and Tuntland (2016), as part of a wider study that was linked to the RCT by Tuntland and colleagues (2015). The authors found that reablement was more cost-effective than usual care. They concluded that reablement ‘stands out as a promising intervention, not only because it seems to decrease expenditure, but also because older adults feel they improve their performance and satisfaction in daily life activities. The combination of lower costs and higher effects is the kind of policy measure that will be of interest to policy-makers’ (Kjerstad and Tuntland, 2016: 9).

The effects of an enhanced intermediate care (EIC) service delivered in a coastal community in a rural area of England (Devon) on service activity were also examined in a comparative before-and-after study by Elston and colleagues (2022). The study was conducted following the redesign of the traditional service, which was delivered by Social Workers and community staff, so that it was ‘enhanced’ by having General Practitioners (GPs), pharmacists and the voluntary sector attend the daily interdisciplinary team meeting. Service activities were compared before and after implementation of the new service, using

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performance data from 2015-2017. While recognising that various factors could have contributed to the outcomes, the authors found that:

‘Enhancing Coastal locality’s IC [intermediate care] team was associated with statistically significant increases in IC referral rates, home-based care rates and GP referral rates to EIC, and shorter average length of episode and lower bed-day rates compared to other localities. In addition, the nested case study also suggests that EIC is likely to have contributed to reducing activity across the health and social care system, particularly in primary care, but also in acute care. Although the perceived prevention of reduced ED [Emergency Department] admissions and increased pro-active hospital discharges were relatively small numerically, they accounted for most of the financial benefit of EIC. Coastal also had the lowest GP referral rate to ED, possibly due to the higher rate of GPs referring deteriorating, older people to EIC (actively encouraged by the team), a conclusion also supported by its markedly different rate ratio compared to other localities. In addition, the nested case study showed that nearly one in six referrals had a medical issue, with a third requiring medical input and a seventh pharmacist input. This also suggests that the EIC team was managing more complex patients often with medical as well as therapeutic needs [ref]. Patients with mild to moderate frailty reported receiving moderate to high levels of person-centred coordinated care, with potential for improvement on care planning, “telling your story once” and accessing care through a single point of contact.’ (Elston et al., 2022: 11)

In Orkney, the internal evaluation of the Home First pilot ‘discharge to assess’ service estimated that 530 hospital bed days were avoided by the reductions in delayed discharges, saving just under £500,000 (Orkney Health and Care, 2022: Appendix 1: 6). There was also a reduction of 26.4% in the number of hours of Care at Home support required after discharge from the Home First team and an unstated number of individuals required no ongoing support. It was estimated that, if reablement was applied to the entire Care at Home caseload, there was the potential for 44,330 fewer visits per annum (Orkney Health and Care, 2022: 3).

3.2.4 Experiences

The perspectives of staff, older people or relatives who were involved in five of the reablement programmes were reported in several publications (Hjelle et al., 2016, 2017a, 2017b; Maxwell et al., 2021; Orkney Health and Care, 2022; Eliassen et al., 2023; Sarovich et al., 2024).

Three of these publications were part of a wider study of an integrated multidisciplinary team (MDT) reablement programme in Norway (Tuntland et al., 2015; Kjerstad and Tuntland, 2016). These respectively examined the experiences of the MDT team (Hjelle et al., 2016), the older adults who used the service (Hjelle et al., 2017b), and the relatives who were involved in the process (Hjelle et al., 2017a). Staff perspectives were examined in two focus groups of 14 participants, including health care providers and home care personnel (Hjelle et

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al., 2016). Three themes were identified: ‘the older adults’ goals are crucial’, ‘a different way of thinking and acting – a shift in work culture’, and ‘a better framework for cooperation and application of professional expertise and judgement’. The integrated MDT and older adults worked in collaboration to achieve the person’s valued goals. Older adults were supported to perform the activities, rather than have the team complete the tasks for them. Common meeting times and places for communication and supervision were key. The experiences of eight older adults (four men and four women) aged 64 to 92 years were ascertained in semi-structured interviews (Hjelle et al., 2017b). Four themes were identified, three of which highlighted the importance of understanding the factors that motivate older adults to participate in activities that promote healthy ageing. This work concluded that some individuals may require an individualised follow-up programme to maintain the level of skills and independence attained. Finally, relatives’ experiences of the reablement process were examined in interviews with six participants aged 40 to 70 years (Hjelle et al., 2017a). While they were satisfied with the level of progress made by their family member, they expressed a wish for a follow-up system to verify that it was being sustained over time. They also wanted to be involved in the reablement process and expected more information to be given to them by the MDT. The authors identified a need to foster collaboration and to involve relatives as a resource, and for a system to follow-up the reablement programme.

In the remaining studies, one examined staff (N=27) experiences of reablement as part of a process to co-design a person-centred model for outdoor recreation in reablement using a modified version of the Experience-Based Co-Design (EBCD) approach (Eliassen et al., 2023). This led to the development of a tool for assessing people’s attachment to place and motivation for participating in outdoor activities. Another study examined the process of translating a reablement training programme into practice in a regional Australian community (Maxwell et al., 2021). Two months after receiving the training, 17 direct care staff and care coordinators took part in focus groups or interviews about using the reablement approach with older adults. The authors found that education and training was vital in teaching the principles and values of reablement and reinforcing independence-based practice. Issues were identified with communication between staff, older adults and families; and with gaps in support for staff working in the community. The third study focussed on the experiences of six older people who had participated in a reablement programme for Aboriginal and Torres Strait Islander people in a remote part of Australia (Sarovich et al., 2024; see also Cairns et al., 2022, 2024). The participants were aged 62 to 67 years and had multiple conditions, including frailty. The programme was perceived to be culturally and personally meaningful. The authors concluded that cultural responsiveness, partnership and reciprocity were important elements of the service. Lastly, the Orkney Home First service evaluation briefly captured feedback from people who used the service, family members, Care at Home staff and GPs, which were all positive (Orkney Health and Care, 2022: Appendix 1: 3-4).

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3.2.5 Co-production and co-design of reablement services

There was a strong focus on the co-creation of reablement services in two of the studies. In one, 35 stakeholders (including three reablement recipients) from the health sector were involved in co-designing a model of reablement that incorporated outdoor recreation in arctic Norway (Eliassen et al., 2023, 2024). In the other, a community rehabilitation and lifestyle service was co-designed with Aboriginal and Torres Strait Islander people in a remote area of Australia (Cairns et al., 2022, 2024; Sarovich et al., 2024). This process took two years and introduced an Indigenous perspective on disability (Cairns et al., 2022). The service was designed to be flexible and holistic, pooling collective resources to support the community to enhance wellbeing for all. Stakeholders worked together to build capacity to support community-based healthy ageing, to co-facilitate group programmes by the service and community organisations, and to deliver specialist care for individuals by the service (Cairns et al., 2024). The programme was provided in a centre used by preschool children which also helped to foster inter-generational community connections (Sarovich et al., 2024). The authors note that this collective philosophy contrasted with the individualised funding approach of the Australian government (Cairns et al., 2022).

3.2.6 Influence of contextual factors

Several factors were found to influence the success of the reablement programmes. One study specifically examined the neighbourhood factors that influenced the relative success of a reablement programme provided by a care company in Essex, United Kingdom (Jacobi et al., 2020). It used a management dataset containing postcode and other information on 8,118 people aged 60 years and above who had received the service, along with an Index of Multiple Deprivation (IMD) and Experian Mosaic consumer classifications. The dataset included 2,115 people whose main condition was listed as ‘frailty’ and 293 people who were classified as ‘residents of isolated rural communities’. Using multi-level logistical regression, the authors found that, 13 weeks following the intervention, 59.5% of the sample were no longer requiring ongoing care, 28.4% still needed care, and 12.2% were deceased. Neighbourhood deprivation was a significant factor in reducing the relative likelihood of successful reablement. Previous care was the strongest predictive factor for a negative outcome. According to the authors:

‘The results suggest that in order to optimise reablement, programmes should consider broader social and environmental influences on reablement rather than only individual and organisational aspects. Reablement might also be better tailored and intensified for client groups with particular underlying disabilities and for those displaying specific geodemographic characteristics.’ (Jacobi et al., 2020: 1)

In a similar vein, the opportunities and constraints provided by socioecological factors in arctic Norway were highlighted by Eliassen and colleagues (2022, 2024). They identified a

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need for wider collaborations between health and other sectors to promote access to outdoor recreation by, for example, providing benches, streetlights, toilets and transport; at the same time, they recognised that:

‘The harsh climate in the Arctic threatens the feasibility of implementing outdoor reablement. According to [ref], security is a main pillar of active aging, as a sense of safety may promote independence and physical activity among older people. To mitigate this threat, our model includes assessing the need for aids and equipment that could support older adults and prevent falls.’ (Eliassen et al., 2024: 12)

Other factors that were identified in the studies included leadership roles within the Indigenous community that were key to developing a more culturally responsive model that prioritised relational care and cross-sector relationships, and a collective approach whereby limited resources in the remote community were pooled for the benefit of all (Cairns et al., 2024); structural factors, in the form of common meeting times and places for multidisciplinary staff, which provided an improved basis for collaboration (Hjelle et al., 2016); the pre-existence of established integrated care systems and practices (Elstone et al., 2022); and education and training as a means of promoting a common understanding of the philosophy and purpose of reablement (Maxwell et al., 2021).

As noted above, while all the studies were set in RRI areas (either exclusively or partially), in general there was little explicit discussion of rural characteristics of the contexts in which the services were set, or the challenges and opportunities that these presented, with one major exception (Eliassen et al., 2023, 2024). However, the internal evaluation of the Home First model in Orkney did note that the implementation of video-consulting technology in Scotland ([Attend Anywhere](#))⁴ had enabled the initial pilot to be extended to include people living in the ferry-linked isles, with reablement training being provided by an Occupational Therapist for the Care at Home teams (Orkney Health and Care, 2022: 3). In addition, in one of the Australian studies, the potential transferability of the student-led Community Rehabilitation and Lifestyle service was briefly discussed, the authors suggesting that:

‘The structure of the model, which addresses community, preventative and primary care needs, has the potential to be translatable to other rural and remote communities, with consideration of place-based needs. Models that include student placements are both a rural workforce recruitment strategy [ref] and can address health service gaps in remote communities with a limited local allied health workforce [ref]. (Cairns et al., 2024: 5)

⁴ Attend Anywhere is also known as ‘Near Me’ in some Scottish Health Boards.

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3.3 Asset-based approaches: an overview

3.3.1 Introduction

Given that no publications were found with content directly relating to the second aim of the review, a brief overview of relevant aspects of the wider literature is provided instead. It covers the nature of asset-based approaches, some examples of their use in relation to care models for older people living with frailty and/or in rural contexts, and the factors influencing the success of the approach. The overview is based on the material that was retrieved through the original searches and limited supplementary searches that were possible in the timeframe for this review. The materials include existing evidence summaries carried out by IMPACT on the nature and use of asset-based approaches in health and social care more generally. This section of the report is included as an initial guide and resource for the planned IMPACT project and not as a dedicated review of the wider literature.

3.3.2 What are asset-based approaches?

Morgan and Ziglio (2007) proposed an Assets Model for public health almost two decades ago. The model was influenced by several ideas, including Antonovsky’s (1987, 1996) concept of salutogenesis, which focuses on what creates positive states of health and wellbeing as opposed to what causes negative states; Kretzmann and McKnight’s (1993) work on the technique of asset-mapping; the authors’ own previous work with colleagues for the World Health Organisation (WHO) on the concept of ‘health assets’, meaning the resources that individuals, communities and populations have at their disposal to maintain and sustain health and wellbeing, and to reduce inequalities (Harrison et al., 2004); and work by various academics on potential asset indicators and ways of evaluating the effectiveness of actions informed by ABA.

Around this time, interest in the topic began to grow in Scotland. The Glasgow Centre for Population Health (GCPH) published two briefing papers examining the concepts of health assets, community assets and what have come to be known as asset-based approaches (ABA) (GCPH 2011, 2012). The first briefing paper explains that:

‘Asset based approaches value the capacity, skills and knowledge and connections in individuals and communities. They focus on the positive capacity of individuals and communities rather than solely on their needs, deficits and problems. These assets can act as the foundation from which to build a positive future. The identification and mobilisation of an individual’s or a community’s assets can help them overcome some of the challenges they face.’ (GCPH, 2011: 4)

It adds that ABA are not meant to replace investment in services but may help to reduce demand and dependency on them in the long term and to achieve more effective and efficient services (GCPH, 2011: 6). It also suggests that ABA may lead to new kinds of community-based working and that the principles of ABA:

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‘...could also be utilised to refocus and redesign many existing mainstream services to become more person centred, in a way which is empowering and which can ultimately lead to reduced dependency on public services.’ (GCPH, 2011: 12)

In the two ensuing decades, further research has been published on the nature of ABA and its applications. Rippon and Hopkins’ (2015) review of the conceptual basis of ABA and several case studies in the UK found that ABA had a sound theoretical basis, being underpinned by the well-researched concept of salutogenesis. Drawing on learning from the case studies, the authors began to formulate the ‘Theory of Change for Asset-Based Approaches’ (TCABA) (Rippon and Hopkins, 2015; Rippon and South, 2017). The theory of change has four elements: ‘Reframing towards assets’, ‘Recognising assets’, ‘Mobilising assets’ and ‘Co-producing assets and outcomes’ (Rippon and Hopkins, 2015: 22). An early example of the application of this theory is provided by Astbury and colleagues (2021) in their research on ABA in the field of community pharmacy. The theory has also been adopted and/or adapted by others (e.g. GCPH, 2015: 19).

Various types of ABA and associated methodologies have been documented in the literature (e.g. GCPH, 2011, 2012; Garven et al., 2016). Two examples are briefly described below.

First, ‘Asset Based Community Development’ (ABCD) focusses on the opportunities, strengths and resources in communities. It was originally developed in North America by John Kretzmann and John McKnight (1993) who founded the [ABCD Institute](#). ABCD has been promoted in the UK by Cormac Russell (Russell, 2015; see also Russell and McKnight, 2022) through the partner organisation [Nurture Development](#). An overview of the approach and examples of how ABCD has been used in practice in Local Authorities is provided by Nesta (2020).

Second, the notion of an ‘Asset-based Area’ is relatively new (Fox, 2017, 2021). It involves citizens and organisations working together in an area to create better lives and more inclusive and supportive communities. In a report for Think Local Act Personal (TLAP), Fox (2021) describes the whole-system change that is needed; the report includes a ‘rainbow’ diagram showing ‘that local areas can build a range of asset-based services to meet every level of support need within a community from the preventative end of activity to acute services and crisis-response’ (Fox, 2021: 3).

Fox and Fox (2024) have since published related work advocating a whole-system shift from traditional transactional, deficit-based models of public services towards more relational, strengths-based approaches that are co-produced with citizens. In it, they claim that the introduction of Reablement Services for older people and availability of Direct Payments for disabled people are examples of this kind of approach. However, they add that ‘there is much to do to develop the scale and methodology of these approaches’ (Fox and Fox, 2024: 16). They go on to assert that:

‘Organisations will need redesigning around this ethos. Regardless of the area of public service (health, social care, criminal justice, education, welfare) there are some common characteristics of strengths-based organisations that include:

- Creating new kinds of roles for front-line staff with values-led recruitment to attract people capable of relational, collaborative and person-led working.
- Authentic and relational leaders who also embody the qualities of strengths-based front-line workers, such as self-awareness, strong values and self-reflection. Devolved, flat and self-managed power structures support this.
- Co-creation - the idea that people with lived experience are integral to the design and running of services - will feature in organisational governance structures.
- Striving to be learning organisations which are constantly innovating.’ (Fox and Fox, 2024: 21)

3.3.3 Asset-based approaches and reablement services

Although several case studies of ABA have been documented in the research literature (e.g. Rippon and Hopkins, 2015), none were identified that related to reablement services for older people living with frailty in RRI areas.

However, some more general works were identified that may help to inform the IMPACT project. For example, separate IMPACT literature reviews have examined reablement and social care in a Welsh context (IMPACT, 2025) and new models of homecare and reablement (Goodlad and Morgan, 2025). NHS England has published good practice guidance for integrated care boards that highlight the role of community assets in their new model of community rehabilitation and reablement (NHS England, 2023). Other reports on new models of homecare and reablement have included discussions of ABA (Bennett et al., 2018; Charles et al., 2018; Bennett et al., 2020; Goodlad and Morgan, 2025). These works have drawn attention to the potential role of voluntary and community assets in enhancing wellbeing and preventing or delaying a need for specialist services. Similarly, the British Geriatrics Service has identified a need to identify and mobilise community assets as part of their ‘blueprint’ for preventing and managing frailty in older people (BGS, 2023; see also BGS 2024).

3.3.4 Examples of asset-based approaches

More general conceptual and empirical research has been undertaken examining ABA and ageing and/or the use of ABA in rural contexts. A few selected examples are provided below. The contrast between the ABCD approach to ageing well and more traditional approaches was discussed in a reflective piece by Russell (2011). The health assets that promote health in older age were examined in a review by Hornby-Turner and colleagues (2016). An asset-

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based community approach was used to tackle isolation and loneliness among older people living in a rural area of England through a range of food-related activities (Wildman et al., 2019). Asset-mapping and ABCD were used as a way of tackling social isolation and loneliness through the development of age-friendly communities in Bristol (Beardmore et al., 2022). Others have also suggested that ABA could provide a useful way of reframing debates about the development of dementia-friendly communities (Rahman and Swaffer, 2018) and addressing frailty (Rahman, 2019). Further examples of ABA for integrated care are available on the [SCIE website](#).

The potential benefits of Assets and Capabilities frameworks for addressing health inequalities among rural dwellers in New Zealand was investigated by Jaye and colleagues (2022). This qualitative study was set in a small community in one of the most remote areas of New Zealand, with a population of approximately 650 people. The main village had a population of around 150 people and was located one hour’s drive from the nearest hospital and 45 minutes from local amenities, including the healthcare centre. Some health outreach services were available, but rehabilitation services were only provided in the regional capital 80km away, which had a limited bus service in the summer. In the study, a sample of 17 residents aged 30 to 89 years discussed sources of health and wellbeing and how they managed challenges to them. One participant was Māori, and the rest of the sample were of New Zealand European ancestry. The participants identified a deep attachment to place, a sense of connectedness and belonging, the importance of sociality and community, and sense of purpose as key sources of health and wellbeing. Gaps in services, including in aged care, were identified as a challenge. Distance and isolation were viewed as both an asset and a challenge. Mobility and functionality were regarded as a key for rural living. The authors concluded that:

‘We are not suggesting that community networks are appropriate surrogates for locally delivered health services. We are suggesting that both the Capability Approach and Asset-based Approach offer particular utility to researchers seeking to comprehend the multiple meanings of health and wellbeing in the lived experiences of rural people. While acknowledging the challenges of rural life, these approaches offer alternatives to deficit models of health and wellbeing by considering the local rural cultural and pragmatic values that underpin community networks and support resilience.’ (Jaye et al., 2022: 292)

3.3.5 Reflections on the practice and promise of asset-based approaches

Finally, the general literature on ABA includes some useful reflections on the practice and promise of ABA. For example, drawing on learning from the [Animating Assets](#) action research programme in Scotland, the GCPH produced a report with learning from the four sites that were involved (GCPH, 2015). The report includes practice-based insights into the structural-, community- and practitioner-level factors that enabled and constrained asset-

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based working in the project (GCPH, 2015: 65, 72, 75). Commenting on these factors, the authors note that:

‘Although asset-based approaches clearly align with national policy and the values of community development [...], working in an asset-based way is not always supported by the structures, systems and cultures in which staff operate.’ (GCPH, 2015: 66)

A more fundamental critique of the conceptualisation of ABA in policy regarding the care of older people is provided by Daly and Westwood (2018). They suggest that ABA are essentially individualistic and lack meaningful engagement with macro issues such as the need to reorganise societies to meet the growing need for care. They also question whether ABA are an alternative way of working, given there is already considerable reliance in policy on assets in the form of unpaid carers and given the use of means testing. They urge more critical examination of the concept and collection of evidence about its effectiveness to support future policy regarding the care of older people.

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4. DISCUSSION

4.1 Models of reablement in rural, remote and island contexts

The studies included in this review varied in terms of their aims, the models of reablement (and usual care comparators) they focussed on, the number and level of frailty of the older people in the samples, and the range of RRI locations in which they were set.

The eight models of reablement featured in the studies were generally flexible and personalised, but there was a lack of comprehensive information about the delivery of care and who received what forms of reablement, from whom, where, and for how long, other than the generic model of provision. While all the programmes were set in rural areas, only one project, set in arctic Norway, had a strong focus on the context in which the service was delivered and the associated opportunities and challenges of the existing and new potential socioecological model.

This lack of information about the delivery of care, as well as the rural context of the services in the studies, and the associated communities and workforce, limited the extent to which the first aim of the review could be addressed directly.

The evidence concerning clinical outcomes, cost-effectiveness and service performance, was generally positive in the few studies that examined these effects. Some of the studies also suggested that the success of reablement is influenced not only by the programmes but also by wider contextual factors. The greatest effects may therefore be achieved by improving reablement services and by addressing such factors in collaboration with associated services and sectors in a whole-systems approach where possible.

4.2 Asset-based approaches and reablement

No studies were found on the use of ABA in reablement services for older people living with frailty in RRI areas. However, the potential of ABA has been recognised in the wider literature, including in relation to new models of homecare and the prevention of frailty.

The philosophy of reablement, in terms of being person-centred and focussed on promoting wellness, skills and independence, is generally aligned with ABA. One potential challenge in drawing on ABA is the extent to which reablement services stay focussed on building capacities and personal health assets for individual older people and their relatives while, at the same time, promoting the approach with other health and social care staff and with members of the wider community, for example, through education and training and helping to identify and create resources in the community. This, in turn, is likely to require collaboration with other services and sectors, including public health, housing, transport and the third sector. Another challenge is the current time-limited approach to reablement in the

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UK, when some individuals may benefit from further support and/or follow-up to sustain their skills and independence over a longer period of time.

The evaluation of such personalised and whole-system approaches is also likely to require an approach that is suitable for complex interventions.

4.3 Limitations of the review

This review has several limitations. It covered the period 2014 onwards and did not include earlier research on the topic. The varied conceptualisations of the key terms in the international literature (reablement; rural, remote and island contexts; frailty; asset-based approaches) made it difficult to locate relevant intersecting works and it is possible that some were missed. This includes some works set in RRI areas that may not have self-defined themselves as such; for example, the Orkney evaluation was not self-described as such and was only identified through local knowledge.

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5. CONCLUSION

There is a lack of research on reablement services in RRI areas. The review identified 15 publications linked to eight discrete programmes in the international literature. While some of the studies included comparisons with usual care, there is a lack of research comparing the organisation and delivery of reablement in different settings, including RRI contexts, for older people living with frailty.

In the small number of studies that have been conducted to date, there were some positive findings regarding the clinical outcomes, cost-effectiveness and service performance of the programmes. The studies also identified potential areas for improvement in the services, and some of the external factors that influence the success of reablement programmes in these contexts.

Overall, the small number and heterogeneous nature of the studies, as well as the lack of comprehensive and standardised information on what the programmes entailed, how they were delivered and tailored for the participants, the characteristics of the RRI areas in which the services operated, and the lack of comparative and longitudinal data, makes it difficult to assess which models work best, for whom, in which contexts.

These limitations are not particular to the studies included in the review but reflect some of the issues with the wider literature on reablement where the quality of evidence has been hampered by the different definitions of reablement, by the variations in organisation and practice, and by different tools being used to measure quality of life and other outcomes, as well as different time frames of measurements, small samples, lack of comparisons and controls, and lack of consideration of context.

No studies were found on the use of ABA in reablement services for older people living with frailty in RRI areas. However, the potential of ABA has been recognised in the wider literature, including in relation to new models of homecare and the prevention of frailty. The philosophy of reablement, in terms of being person-centred and focussed on promoting wellness, skills and independence, is generally aligned with ABA. In addition, given the evidence suggesting that the success of reablement is influenced not only by the programmes but also by wider social factors and inequalities, ABA has the potential to be used to inform the redesign of reablement services and the development of more collaborative, whole-system approaches to the promotion of health and wellbeing for older people living with frailty at an individual and collective level. Potential challenges include the extent to which reablement services can, in collaboration with others, widen, lengthen and embed their approach in RRI communities to help sustain older people’s skills and independence for longer.

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Appendix: Characteristics of publications included in the review (N=15)

1st author	year	journal	title	region	programme #
Jacobi	2020	PLOS One	Enabling and constraining successful reablement: Individual and neighbourhood factors	UK - England (Essex)	1
Elston	2022	Int J Integrated Care	Impact of ‘Enhanced’ Intermediate Care Integrating Acute, Primary and Community Care and the Voluntary Sector in Torbay and South Devon, UK	UK - England (Devon)	2
Orkney Health and Care	2022	Internal report	Home First Evaluation (Integration Joint Board meeting 20 April 2022, Agenda Item 7).	UK - Scotland (Orkney)	3
Tuntland	2015	BMC Geriatrics	Reablement in community-dwelling older adults: a randomised controlled trial	Norway	4
Hjelle	2016	J Multidisciplinary Healthcare	The reablement team’s voice: a qualitative study of how an integrated multidisciplinary team experiences participation in reablement	Norway	4
Kjerstad	2016	Health Eco Rev	Reablement in community-dwelling older adults: a cost-effectiveness analysis alongside a randomized controlled trial	Norway	4
Hjelle	2017a	J Multidisciplinary Healthcare	The relatives’ voice: how do relatives experience participation in reablement? A qualitative study	Norway	4
Hjelle	2017b	HSCC	Driving forces for home-based reablement; a qualitative study of older adults’ experiences	Norway	4

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1st author	year	journal	title	region	programme #
Eliassen	2023	Int J Circumpolar Health	Emplacing reablement co-creating an outdoor recreation model in the rural Arctic	Norway	5
Eliassen	2024	BMC Health Services Research	Aging in (a meaningful) place – appropriateness and feasibility of Outdoor Reablement in a rural Arctic setting	Norway	5
Maxwell	2021	HSCC	Staff experiences of a reablement approach to care for older people in a regional Australian community: A qualitative study	Australia	6
Cairns	2022	Dis & Rehab	Developing a community rehabilitation and lifestyle service for a remote indigenous community	Australia	7
Cairns	2024	Aus J Pri Health	Healthy ageing in remote Cape York: a co-designed Integrated Allied Health Service Model	Australia	7
Sarovich	2024	Dis & Rehab	<i>Different meanings... what we want in our lives...</i> a qualitative exploration of the experience of Aboriginal and/or Torres Strait Islander peoples in a co-designed community rehabilitation service	Australia	7
Song	2021	J Env Res & Pub Health	Effects of Community-Based Physical-Cognitive Training, Health Education, and Reablement among Rural Community-Dwelling Older Adults with Mobility Deficits	Taiwan	8